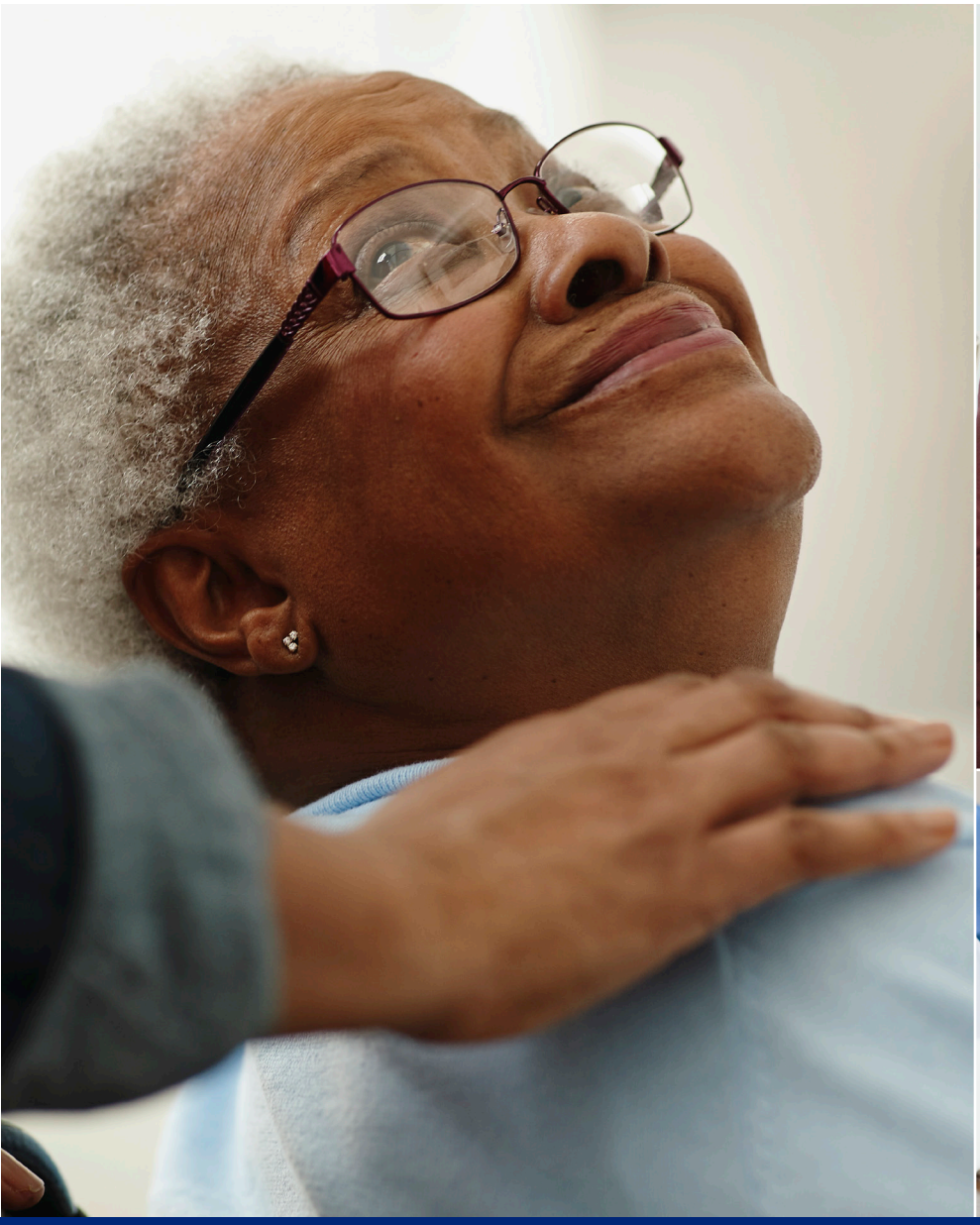
RFQ# 20211210

PUBLIC COPY

UnitedHealthcare of Mississippi, Inc.

United Healthcare Community Plan



RFQ# 20211210

Transmittal Letter

UnitedHealthcare of Mississippi, Inc.

United Healthcare Community Plan

MississippiCAN and CHIP RFQ

Table of Contents

UnitedHealthcare of Mississippi, Inc.
795 Woodlands Parkway, Suite 301
Ridgeland, MS 39157

Transmittal Letter

March 3, 2022

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

RE: RFQ # 20211210; RFx # 3150003991 - MississippiCAN and CHIP

Dear Procurement Officer:

UnitedHealthcare of Mississippi, Inc. is pleased to submit a proposal in response to RFQ # 20211210; RFx # 3150003991. As required by Section 4 of the RFQ, this proposal includes the following sections:

1. Transmittal Letter (Marked)
2. Technical Factors (Unmarked)
3. Management Factors (Marked)

UnitedHealthcare's mission is to help people live healthier lives. We provide managed care services to 7,690,000 Medicaid, CHIP and Dual Special Needs Plan (D-SNP) members in 31 states plus the District of Columbia. In Mississippi, we work closely with the Division of Medicaid to provide services to 162,000 members under the Mississippi Coordinated Access Network (MississippiCAN) program and 28,000 members under the Mississippi Children's Health Insurance Program (CHIP). We look forward to continuing our partnership with the Division of Medicaid.

In accordance with Section 4.1 of the RFQ, UnitedHealthcare of Mississippi, Inc. has provided the responses to the following questions:

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

The bidding entity, UnitedHealthcare of Mississippi, Inc., is a corporation operating under the brand UnitedHealthcare Community Plan of Mississippi (UnitedHealthcare).

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;

The bidding entity, UnitedHealthcare of Mississippi, Inc. is registered to do business and is in "Good Standing" with the State of Mississippi. Our corporate charter number is CN22129230. Please refer to **Att. 4.1-1 Certificate of Good Standing - Mississippi.**

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);

The bidding entity, UnitedHealthcare of Mississippi, Inc. is licensed by the Mississippi Department of Insurance. Our license number is 9500034. Please refer to **Att. 4.1-2 Mississippi Certificate of Authority**.

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

The bidding entity, UnitedHealthcare of Mississippi, Inc.'s Federal Tax ID number is 63-1036817.

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

In the normal course of business, UnitedHealthcare is regularly audited and reviewed by our state and federal regulators. Any deficiency requiring corrective action is handled in a thorough and timely manner. We work collaboratively with our regulators on each and every matter, achieving resolution, issuing a formal response and closing out the matter accordingly. The bidding entity, UnitedHealthcare of Mississippi, Inc., has been sanctioned by a state or federal government within the last 10 years, as listed in **Att. 4.1-3 UnitedHealthcare of Mississippi, Inc. Sanctions Listing.**

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;

The bidding entity, UnitedHealthcare of Mississippi, Inc. is not presently 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;

UnitedHealthcare has experience in contractual services providing the type of services described in RFQ # 20211210; RFx # 3150003991.

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;

If awarded the Contract, UnitedHealthcare of Mississippi, Inc. agrees that any lost or reduced federal matching money resulting from unacceptable performance of a UnitedHealthcare of Mississippi, Inc. task or responsibility, as defined in the RFQ, shall be accompanied by reductions in State payments to UnitedHealthcare of Mississippi, Inc.

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

The bidding entity, UnitedHealthcare of Mississippi, Inc. has not been terminated prior to the end of the Contract period for any reason.

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;

The bidding entity, UnitedHealthcare of Mississippi, Inc. has made no attempt, nor will it make any attempt, to induce any other person or firm to submit or not submit a qualification.

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.

UnitedHealthcare of Mississippi, Inc. has not violated, is not violating, and promises that it will not violate the prohibition against gratuities set forth in 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;

UnitedHealthcare 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. Please refer to **Att. 4.1-4 2022 EEO Affirmative Action Statement of Policy.**

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

UnitedHealthcare agrees to the language in the Division's BAA and DUA without expectation of negotiation.

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

As of the date of this Transmittal Letter, UnitedHealthcare has received Amendments 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11 and 12 from the Division of Medicaid related to RFQ # 20211210; RFx # 3150003991. Amendments 1, 2 and 3 were all issued on Jan. 21, 2022. Amendments 4, 5, 6, 7 and 8 were issued on Feb. 8, 2022. Amendments 9, 10 and 11 were issued on Feb. 10, 2022. Amendment 12 was issued on Feb. 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;

UnitedHealthcare of Mississippi, Inc., has read, understands and agrees to all provisions of the RFQ without reservation and without expectation of negotiation.

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

UnitedHealthcare of Mississippi, Inc., certifies that this qualification 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;

UnitedHealthcare has complete responsibility for developing the strategy, methods, proposed offerings, intellectual property and writing of the RFQ. As part of our staffing model, we use some temporary labor from Optimetra, Inc., Writing Assistance, Inc. and the Menges Group, who are accountable to UnitedHealthcare leadership.

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);

Please refer to **Att. 4.1-5 Subcontractor Statements**, which includes a statement from each subcontractor we use, along with an overview of the general scope of work to be performed by the subcontractor.

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

Please refer to **Att. 4.1-6 Assistant Secretary Certificate** for the certification by Heather A. Lang, Assistant Secretary of UnitedHealthcare of Mississippi, Inc., that the corporate official signing the corporate proposal has the full authority to obligate and bind the corporation to the terms, conditions and provisions of the proposal.

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;

UnitedHealthcare of Mississippi, Inc. 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 the Contract, and it shall not employ, in the performance of the 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

UnitedHealthcare of Mississippi, Inc. will make no public disclosure or news release pertaining to this procurement 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.

UnitedHealthcare of Mississippi, Inc. confirms that our redacted electronic, single-document qualification does not contain trade secrets or other proprietary information.

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

a. Certifications and Assurances Regarding Contingent Fees and Gratuities;

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

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

UnitedHealthcare of Mississippi, Inc. confirms that we have executed and included with the Transmittal Letter, **Appendix D-1 Certifications and Assurances Regarding Contingent Fees and Gratuities**, **Appendix D-2 DHHS Certification Regarding Drug-Free Workplace Requirements** and **Appendix D-3 DHHS Certification Regarding Debarment, Suspension, and Other Responsibility Matters.**

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.

United Healthcare of Mississippi, Inc. has not deviated from the detailed specifications and requirements of the RFQ.

UnitedHealthcare of Mississippi, Inc. looks forward to a continued partnership with the Mississippi Division of Medicaid in its endeavor to focus on quality improvement, collaborative innovation, access to care, and a true commitment to improvement of life for Mississippians. We have the experience and expertise to support and implement the Division's goals for the MississippiCAN and CHIP and its members.

If you have any questions or require clarification of our responses, please feel free to contact me at (601) 718-6541.

Sincerely,

J. Michael Parnell
President and Chief Executive Officer
UnitedHealthcare of Mississippi, Inc.
795 Woodlands Parkway, Suite 301
Ridgeland, MS 39157
Office telephone number: (601) 718-6541
Mobile telephone number: (601) 927-7435
Fax number: (601) 718-6586
Email: J_Parnell@uhc.com

Att. 4.1-1 Certificate of Good Standing

Michael Watson
SECRETARY OF STATE

Office of the Secretary of State
Jackson, Mississippi

Certificate of Good Standing

I, MICHAEL WATSON, Secretary of State of the State of Mississippi, and as such, the legal custodian of the records as required by the laws of Mississippi, to be filed in my office, do hereby certify:

That on the 6th day of August, 1990, the State of Mississippi issued a Charter/ Certificate of Authority to:

UNITEDHEALTHCARE OF MISSISSIPPI, INC.

That the state of incorporation is Mississippi.

That the period of duration is perpetual.

That according to the records of this office, Articles of Dissolution or a Certificate of Withdrawal have not been filed.

That according to the records of this office, a current Annual Report has been delivered to the Office of the Secretary of State.

I further certify that all fees, taxes and penalties owed to this state, as reflected in the records of the Secretary of State, have been paid and that the corporation is in existence or has authority to transact business in Mississippi.

That insofar as the records of this office are concerned, the said UnitedHealthcare of Mississippi, Inc. is in good standing at this time.

Given under my hand and seal of office
the 20th day of January, 2022

Michael Watson

Certificate Number: CN22129230
Verify this certificate online at http://corp.sos.ms.gov/corpconv/verifycertificate.aspx

Att. 4.1-2 Mississippi Certificate of Authority

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

UNITEDHEALTHCARE OF MISSISSIPPI, INC.
795 WOODLANDS PARKWAY
SUITE 301
RIDGELAND, MS 39157

LICENSE NUMBER: 9500034

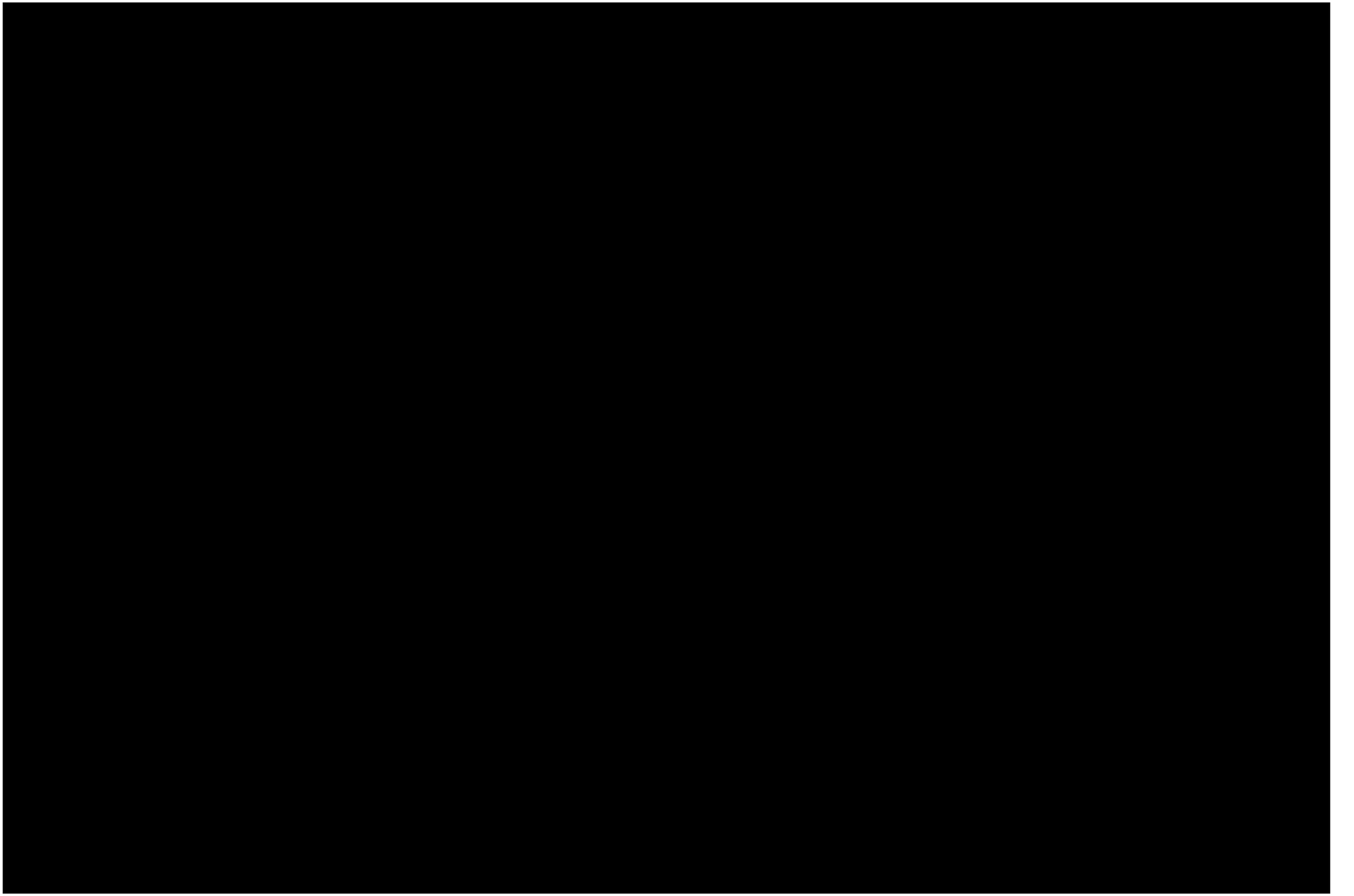
HAS COMPLIED WITH ALL THE REQUIREMENTS OF THE LAWS OF THIS STATE APPLICABLE TO SAID COMPANY AND IS AUTHORIZED TO TRANSACT THE BUSINESS OF:

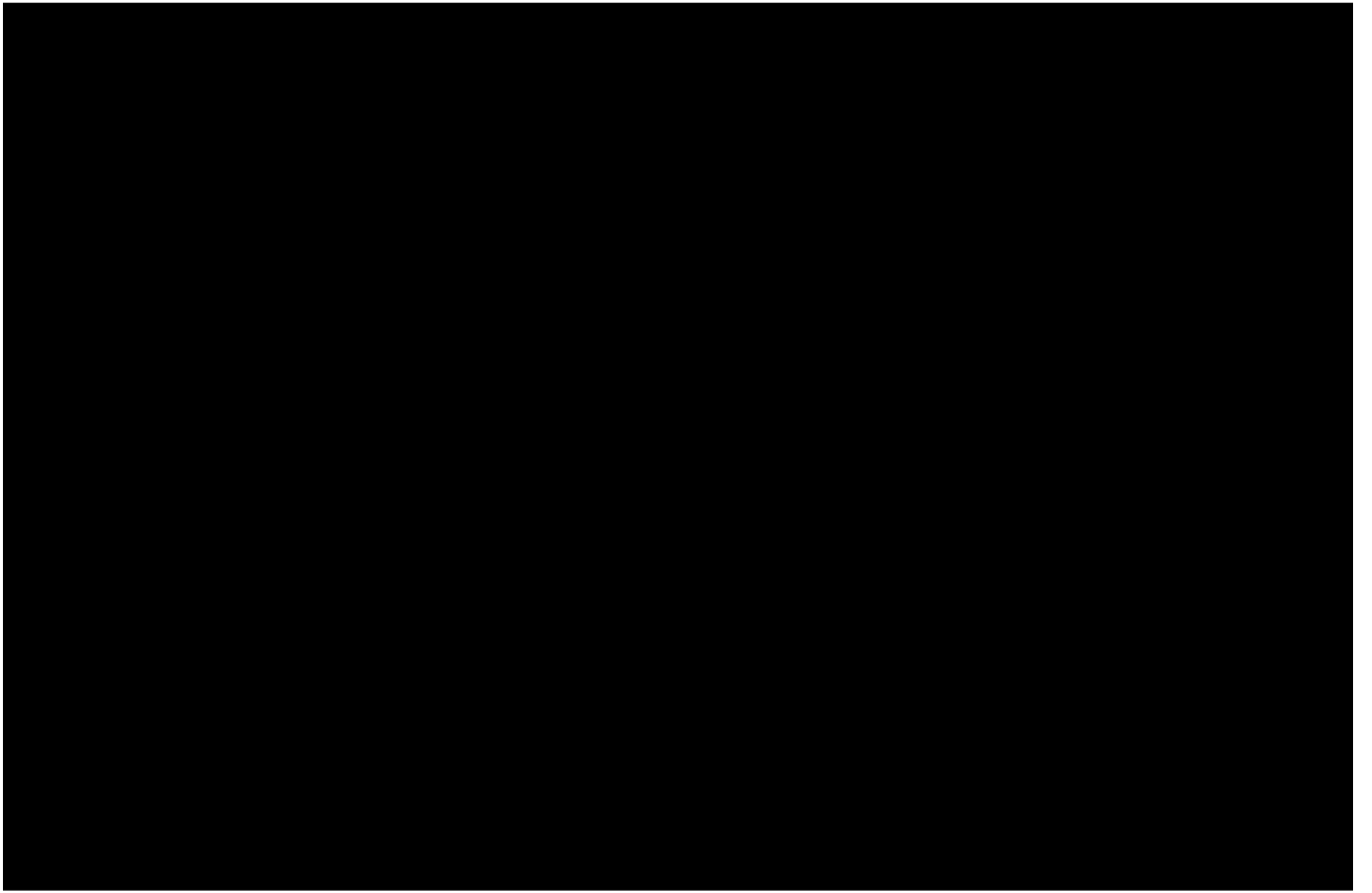
HEALTH MAINTENANCE ORGANIZATION

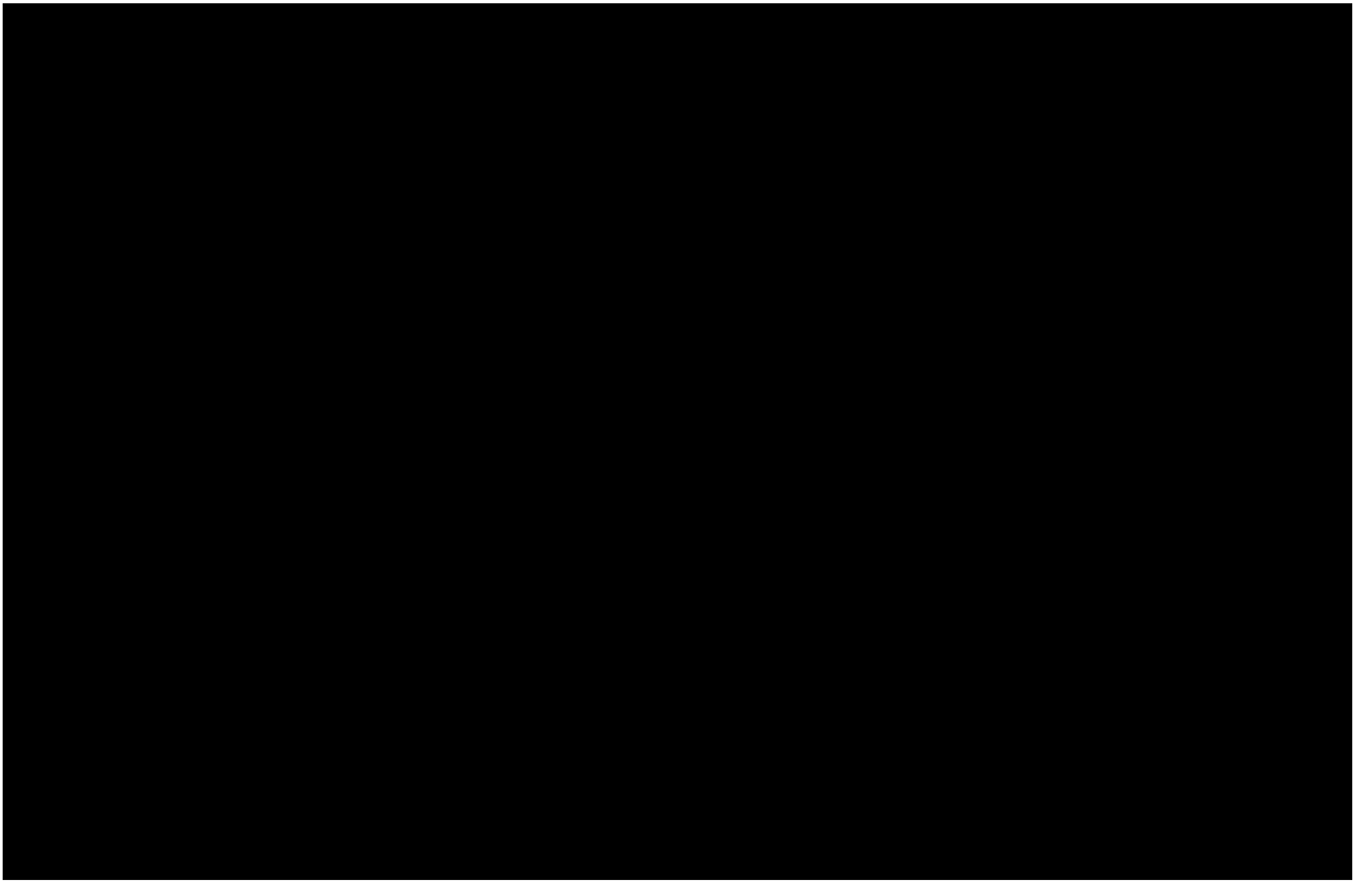
IN ACCORDANCE WITH THE LAWS THEREOF UNTIL: **12/31/2022**

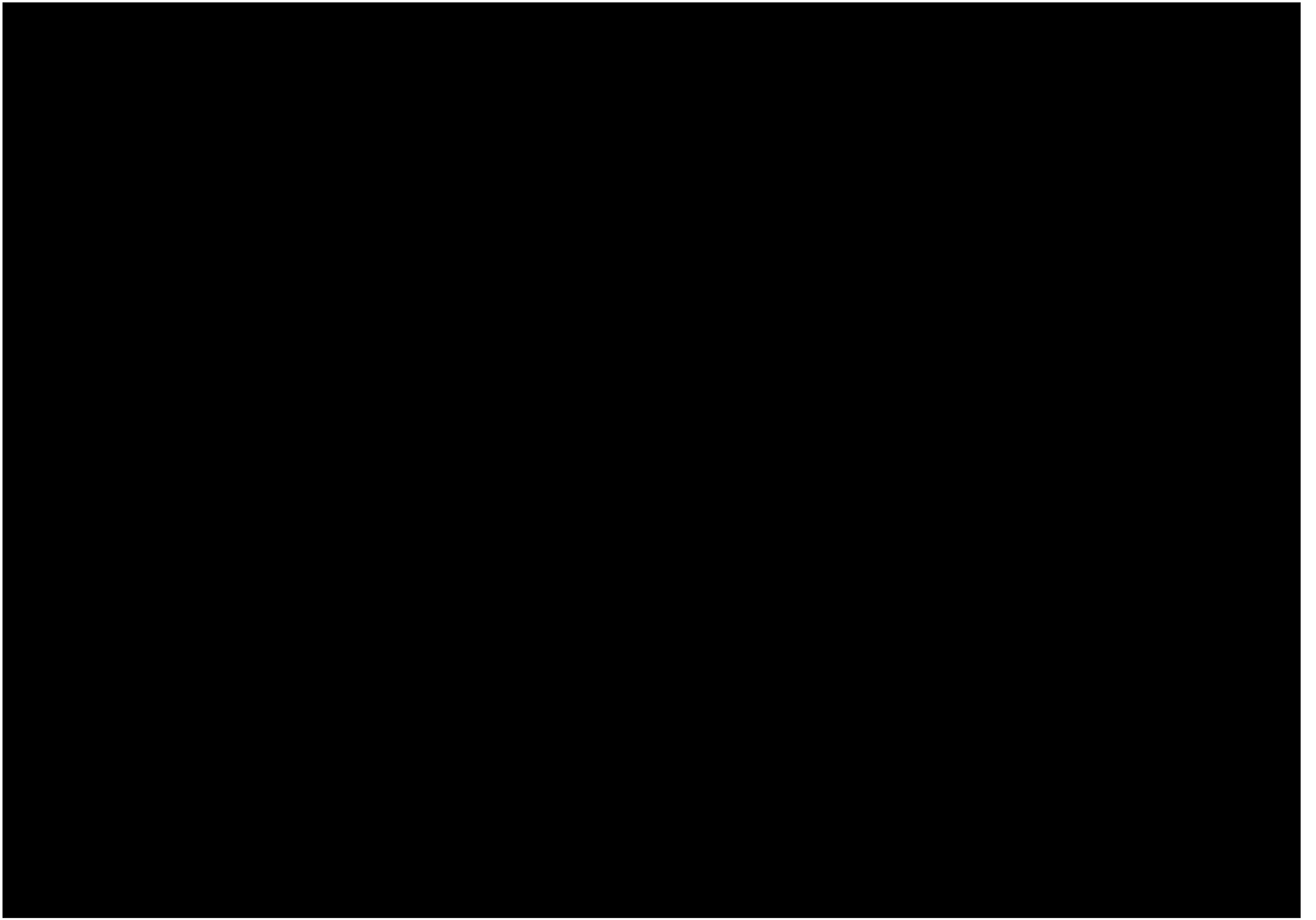
MIKE CHANEY
COMMISSIONER OF INSURANCE

Att. 4.1-3 UnitedHealthcare of Mississippi, Inc. Sanctions Listing









Att. 4.1-4 Equal Employment Opportunity (EEO) Affirmative Action 2022 Statement of Policy

STATEMENT OF POLICY

UnitedHealth Group has a commitment to Equal Employment Opportunity (EEO) and to a work environment free of harassment. The policy of UnitedHealth Group is that people will be employed and promoted on the basis of their individual qualifications for the job and it is therefore the company's policy to prohibit discrimination and harassment against any applicant, employee, vendor, contractor, customer, or client on the basis of race, color, religion, sex, sexual orientation, gender identity, national origin, age, disability, pregnancy, veteran status, genetic information, citizenship status, or any other basis prohibited by federal, state or local laws.

UnitedHealth Group will provide:

1. freedom from abusive, intimidating or offensive behavior on the part of supervisors or other employees. In this regard it should be understood that harassment of any sort will not be tolerated, and that term includes derogatory ethnic, racial or sexist remarks;
2. freedom from sexual harassment. This refers to behavior which is not welcome, which is personally offensive, and which interferes with the work effectiveness of its victims and their co-workers. A separate communication on this subject further amplifies the Policy and is distributed to all employees;
3. freedom from any form of discrimination or intimidating or abusive behavior on the part of any supervisor or other employee as a result of a person's sexual orientation or gender identity;
4. benefits and services as outlined in Company publications; and

UnitedHealth Group is also a federal contractor subject to Executive Order 11246, Section 4212 of the Vietnam Era Veterans' Readjustment Assistance Act of 1974, as amended ("Section 4212") and Section 503 of the Rehabilitation Act of 1973, as amended ("Section 503"). As such, UnitedHealth Group is committed to taking positive steps to implement the employment-related aspects of the company's equal opportunity policy. Accordingly, it is UnitedHealth Group's policy to take affirmative action to employ, advance in employment, and otherwise treat qualified minorities, women, protected veterans, and individuals with disabilities without regard to their race/ethnicity, sex/sexual orientation/gender identity, veteran status, or physical or mental disability. Under this policy, UnitedHealth Group will provide reasonable accommodation to the known physical or mental limitations of an otherwise qualified employee or applicant for employment, unless the accommodation would impose undue hardship on the operation of the company's business.

The company's affirmative action policy also prohibits employees and applicants from being subjected to harassment, intimidation, threats, coercion, or discrimination because they have engaged in or may engage in (1) filing a complaint; (2) assisting or participating in an investigation, compliance review, hearing, or any other activity related to the administration of Section 503, Section 4212, or any other Federal, state or local law requiring equal opportunity for disabled

persons or covered veterans; (3) opposing any act or practice made unlawful by Section 503 or Section 4212 and their implementing regulations, or any other Federal, state or local law requiring equal opportunity for disabled persons or covered veterans; or (4) exercising any other right protected by Section 503 or Section 4212 or their implementing regulations.

The non-confidential portions of the affirmative action program for individuals with disabilities and protected veterans shall be available for inspection upon request by any employee or applicant for employment by contacting HR direct.

Anyone with a question about UnitedHealth Group's Equal Employment Opportunity Policy should contact HRdirect at 1-800-561-0861. All concerns will be handled in confidence.

If you would like to review the Affirmative Action Plan, or need an accommodation, you may contact HR direct at 1-800-561-0861 between the hours of 7:00am and 7:00pm central time, Monday through Friday, or write HR direct Employee Relations at MN008-W210, 9900 Bren Road E., Minnetonka, MN 55343.

A person's race, color, religion, sex, sexual orientation, gender identity, national origin, age, disability, pregnancy, veteran status, genetic information, or citizenship status must not affect our estimation of their character if we are to achieve the objectives of our business, our society, and our country. These moral and economic reasons for supporting the Company policy of nondiscrimination are to be of primary concern to all employees.

Joy Fitzgerald, Chief Diversity Equity and Inclusion Officer

1/28/2022

Date

Att. 4.1-5 Subcontractor Statements

Dental Benefit Providers
A UnitedHealth Group Company

January 19, 2022

J. Michael Parnell
President & Chief Executive Officer
UnitedHealthcare of Mississippi, Inc.
795 Woodlands Parkway, Suite 301
Ridgeland, MS 39157

Re: Commitment to Enter Subcontractor Agreement for Mississippi Division of Medicaid Coordinated Care (MSCAN and CHIP) RFQ #20211210

Dear Mr. Parnell:

This letter is to confirm the commitment of Dental Benefit Providers, Inc. to enter into a Subcontractor Agreement with UnitedHealthcare of Mississippi, Inc., to provide the services as described below.

Scope of Work

Services: Dental Benefit Providers, Inc. will support tasks under this engagement, including dental benefit administration and management services, such as network development and maintenance, provider credentialing and re-credentialing, customer service, oral health education, claims adjudication and payment, utilization review and management, fraud, waste and abuse services, quality management, claims encounter and reporting services, and ongoing account management for Mississippi's MSCAN and CHIP populations.

The individual signing this document is authorized to bind the company to this scope of work.

Sincerely,

Ken Sheldon
President
Dental Benefit Providers, Inc.

January 28, 2022

J. Michael Parnell
President & Chief Executive Officer
UnitedHealthcare of Mississippi, Inc.
795 Woodlands Parkway, Suite 301
Ridgeland, MS 39157

Re: Commitment to Enter Subcontractor Agreement for Mississippi Division of Medicaid Coordinated Care (MSCAN and CHIP) RFQ #20211210

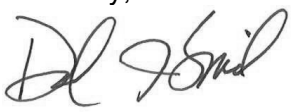
Dear Mr. Michael Parnell:

This letter is to confirm the commitment of eviCore healthcare (eviCore) to enter into a Subcontractor Agreement with UnitedHealthcare of Mississippi, Inc., to provide the services as described below.

Scope of Work
Services: eviCore will support tasks under this engagement, including Radiology Benefits Management for Mississippi's MSCAN and CHIP populations.

The individual signing this document is authorized to bind the company to this scope of work.

Sincerely,



David Smith
President, Medical Benefits Management Solutions
eviCore healthcare

January 17, 2022

J. Michael Parnell
President & Chief Executive Officer
UnitedHealthcare of Mississippi, Inc.
795 Woodlands Parkway, Suite 301
Ridgeland, MS 39157

Re: Commitment to Enter Subcontractor Agreement for Mississippi Division of Medicaid Coordinated Care (MSCAN and CHIP) RFQ #20211210

Dear Mr. Michael Parnell:

This letter is to confirm the commitment of Medical Transportation Management, Inc. (MTM) to enter into a Subcontractor Agreement with UnitedHealthcare of Mississippi, Inc., to provide the services as described below.

Scope of Work
Services: MTM will support tasks under this engagement, including transportation services for Mississippi's MSCAN and CHIP populations.

The individual signing this document is authorized to bind the company to this scope of work.

Sincerely,

Alaina Maciá

Alaina Maciá
President and CEO
MTM, Inc.

MARCH®
Vision Care
GROUP,
INCORPORATED

January 25, 2022

J. Michael Parnell
President & Chief Executive Officer
UnitedHealthcare of Mississippi, Inc.
795 Woodlands Parkway, Suite 301
Ridgeland, MS 39157

Re Commitment to Enter Subcontractor Agreement for Mississippi Division of Medicaid Coordinated Care (MSCAN and CHIP) RFQ #20211210

Dear Mr. Michael Parnell:

This letter is to confirm the commitment of March Vision Care Group, Incorporated to enter into a Subcontractor Agreement with UnitedHealthcare of Mississippi, Inc., to provide the services as described below.

Scope of Work

Services: March Vision Care Group, Incorporated will support tasks under this engagement to provide vision care and related services for Mississippi's MSCAN and CHIP populations.

The individual signing this document is authorized to bind the company to this scope of work.

Sincerely,

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

January 14, 2022

J. Michael Parnell
President & Chief Executive Officer
UnitedHealthcare of Mississippi, Inc.
795 Woodlands Parkway, Suite 301
Ridgeland, MS 39157

Re: Commitment to Enter Subcontractor Agreement for Mississippi Division of Medicaid Coordinated Care (MSCAN and CHIP) RFQ #20211210

Dear Mr. Michael Parnell:

This letter is to confirm the commitment of OptumInsight, Inc. to enter into a Subcontractor Agreement with UnitedHealthcare of Mississippi, Inc., to provide the services as described below.

Scope of Work

Services: OptumInsight will support tasks under this engagement, providing Coordination of Benefits, Audit Recovery Operations, Payment Policy, Subrogation, Prepayment Fraud and Analytics and Claims Cost Management Services for Mississippi's MSCAN and CHIP populations.

The individual signing this document is authorized to bind the company to this scope of work.

Sincerely,

Benjamin Goodman

Benjamin Goodwin
Chief Financial Officer
OptumInsight Inc.

Optum Rx

1600 McConnor Parkway
Schaumburg, IL 60173-6801
P +1 800-282-3232

optum.com

27 January 2022

J. Michael Parnell
President & Chief Executive Officer
UnitedHealthcare of Mississippi, Inc.
795 Woodlands Parkway, Suite 301
Ridgeland, MS 39157

Subject: Commitment to Enter Subcontractor Agreement for Mississippi Division of Medicaid Coordinated Care (MSCAN and CHIP) RFQ #20211210

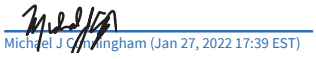
Dear Mr. Michael Parnell:

This letter is to confirm the commitment of Optum to enter into a Subcontractor Agreement with UnitedHealthcare of Mississippi, Inc., to provide the services as described below.

Scope of Work
Services: Optum will support tasks under this engagement, including PBM services for Mississippi's MSCAN and CHIP populations.

The individual signing this document is authorized to bind the company to this scope of work.

Sincerely,



Michael J. Cunningham
Chief Commercial Officer
Optum Rx, Inc.

Optum

January 31, 2022

J. Michael Parnell
President & Chief Executive Officer
UnitedHealthcare of Mississippi, Inc.
795 Woodlands Parkway, Suite 301
Ridgeland, MS 39157

Re: Commitment to Enter Subcontractor Agreement for Mississippi Division of Medicaid Coordinated Care (MSCAN and CHIP) RFQ #20211210

Dear Mr. Michael Parnell:

This letter is to confirm the commitment of OptumHealth Care Solutions, Inc. (Optum) to enter into a Subcontractor Agreement with UnitedHealthcare of Mississippi, Inc., to provide the services as described below.

Scope of Work

Services: Optum will support tasks under this engagement, including Chiropractic and Physical, Occupational & Speech Therapy Networks for Mississippi's MSCAN and CHIP populations.

The individual signing this document is authorized to bind the company to this scope of work.

Sincerely,

Paul Miller
Paul Miller (Jan 31, 2022 15:32 PST)

Paul Miller
VP, Finance
Optum

Optum

January 31, 2022

J. Michael Parnell
President & Chief Executive Officer
UnitedHealthcare of Mississippi, Inc.
795 Woodlands Parkway, Suite 301
Ridgeland, MS 39157

Re: Commitment to Enter Subcontractor Agreement for Mississippi Division of Medicaid Coordinated Care (MSCAN and CHIP) RFQ #20211210

Dear Mr. Michael Parnell:

This letter is to confirm the commitment of United Behavioral Health, Inc., operating under the brand name Optum, to enter into a Subcontractor Agreement with UnitedHealthcare of Mississippi, Inc., to provide the services as described below.

Scope of Work

Services: Optum will support tasks under this engagement, including behavioral health services for Mississippi's MSCAN and CHIP populations.

The individual signing this document is authorized to bind the company to this scope of work.

Sincerely,

Paul Miller
Paul Miller (Jan 31, 2022 15:32 PST)

Paul Miller
VP, Finance
Optum

Att. 4.1-6 Assistant Secretary Certificate

ASSISTANT SECRETARY'S CERTIFICATE

I, Heather A. Lang, the undersigned, hereby certify as follows:

1. That I am a duly elected Assistant Secretary of UnitedHealthcare of Mississippi, Inc., a Mississippi corporation (the "Corporation").

2. That effective July 23, 2007, the Board of Directors of the Corporation, by unanimous Written Consent, adopted the UnitedHealth Group Delegation of Binding Authority Policy and associated guidelines, schedules and supplemental materials (the "Policy") and that a true, correct, and complete copy of those resolutions are attached as Exhibit A to this Certificate, which resolutions have not been amended, repealed, or rescinded and remain in full force and effect.

3. That the Board of Directors of the Corporation has, and at the time of the adoption of the resolutions had, full power and lawful authority to adopt the resolutions and to confer the powers thereby granted to the titles therein named, who have full power and lawful authority to exercise the same.

4. That pursuant to the duly adopted Policy, J. Michael Parnell, holding positions as President and Chief Executive Officer of the Corporation, has been delegated authority to act on behalf of the Corporation in connection with certain agreements including Requests for Qualification ("RFQ") and Requests for Proposal ("RFP") contracts in the State of Mississippi.

5. That Mr. Parnell has authority to sign documents on behalf of the Corporation in connection with the State of Mississippi Division of Medicaid Coordinated Care RFQ.

IN WITNESS WHEREOF, I have hereunto set my hand this 1 day of February 2022.

Heather A. Lang
Assistant Secretary
UnitedHealthcare of Mississippi, Inc.

THIS CORPORATION HAS
NO CORPORATE SEAL

EXHIBIT A

Adoption of UnitedHealth Group Delegation of Binding Authority Policy

WHEREAS, UnitedHealth Group Incorporated, a Minnesota corporation and the ultimate parent of the Corporation ("United"), has established the UnitedHealth Group Delegation of Binding Authority Policy and associated guidelines, schedules, and supplemental materials (collectively, the "Policy") to ensure that actions taken by United's direct and indirect subsidiaries are approved by individuals with an adequate level of seniority and with the involvement of appropriate subject matter experts.

WHEREAS, a copy of the Policy has been provided to the Board of Directors of the Corporation and the Policy, as it may be amended and supplemented from time to time, will be available to the Corporation and its officers, directors, and employees through United's intranet or upon request to United.

WHEREAS, the Corporation desires to adopt the Policy and authorize certain persons to act on behalf of the Corporation.

NOW, THEREFORE, BE IT RESOLVED, that the Policy, as it currently exists and as it may be amended and supplemented from time to time, is hereby adopted by the Corporation.

RESOLVED FURTHER, that, once all necessary approvals have been obtained pursuant to the Policy, the following categories of persons are hereby authorized to act on behalf of the Corporation, including, without limitation, executing contracts in the name of the Corporation:

(1) Any officer of the Corporation.

(2) Any person who, alone or as part of a group of persons, is authorized to approve a particular type of transaction under the Policy (including any "Transaction Authorizer" or "Transaction Approver" as those terms are used in the Policy) is authorized to act on behalf of the Corporation with respect to such type of transaction.

(3) Any person who, in accordance with the Policy, has been properly sub-delegated authority to approve a particular type of transaction under the Policy, is authorized to act on behalf of the Corporation with respect to such type of transaction.

RESOLVED FURTHER, that the Secretary, any Assistant Secretary or any other officer of the Corporation is authorized to certify to the adoption of these resolutions and the authority of persons authorized hereby to act on behalf of the Corporation.

RESOLVED FURTHER, that each of the Corporation's officers is authorized to take any and all actions which they or any of them deem necessary or appropriate in order to effectuate the intent and purposes of the foregoing resolutions, including the execution and delivery of such other documents, instruments, or certificates as they or any of them deem necessary or appropriate.

Appendix D-1 Certifications and Assurances Regarding Contingent Fees and Gratuities

Certifications and Assurances Regarding Contingency Fees and Gratuities

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

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

1. Representation Regarding Contingent Fees

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

2. Representation Regarding Gratuities

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

3. Prospective Contractor's Representation Regarding Contingent Fees

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

UnitedHealthcare of Mississippi, Inc.

Name of Offeror

J. Michael Parnell

Printed name of person attesting for Offeror

Chief Executive Officer

Title of person attesting for Offeror

Signature of person attesting for Offeror

03/03/2022

Date

[END OF RESPONSE]

Certifications and Assurances Regarding Contingency Fees and Gratuities

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

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

1. Representation Regarding Contingent Fees

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

2. Representation Regarding Gratuities

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

3. Prospective Contractor's Representation Regarding Contingent Fees

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

Dental Benefit Providers, Inc.

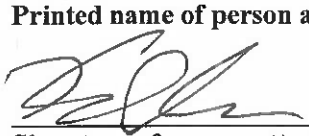
Name of Offeror

Ken Sheldon

Printed name of person attesting for Offeror

President

Title of person attesting for Offeror



Signature of person attesting for Offeror

January 19, 2022

Date

[END OF RESPONSE]

Certifications and Assurances Regarding Contingency Fees and Gratuities

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

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

1. Representation Regarding Contingent Fees

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

2. Representation Regarding Gratuities

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

3. Prospective Contractor's Representation Regarding Contingent Fees

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

eviCore healthcare

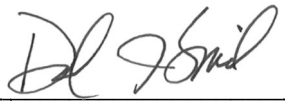
Name of Offeror

David Smith

Printed name of person attesting for Offeror

President, Medical Benefits Management Solutions

Title of person attesting for Offeror



Signature of person attesting for Offeror

1/28/22

Date

[END OF RESPONSE]

Certifications and Assurances Regarding Contingency Fees and Gratuities

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

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

1. Representation Regarding Contingent Fees

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

2. Representation Regarding Gratuities

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

3. Prospective Contractor's Representation Regarding Contingent Fees

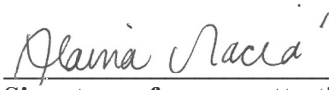
The prospective Contractor (Offeror) represents as a part of such Contractor's qualification that such Contractor [ ] **has [✓] has not** retained any person or agency on a percentage, commission, or other contingent arrangement to secure this contract.

Medical Transportation Management, Inc. (MTM)

Name of Offeror

Alaina Maciá — **Printed name of person attesting for Offeror**

President and CEO — **Title of person attesting for Offeror**



Signature of person attesting for Offeror

1/17/2022 — **Date**

[END OF RESPONSE]

Certifications and Assurances Regarding Contingency Fees and Gratuities

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

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

1. Representation Regarding Contingent Fees

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

2. Representation Regarding Gratuities

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

3. Prospective Contractor's Representation Regarding Contingent Fees

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

March Vision Care Group, Incorporated

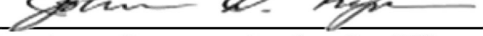
Name of Offeror

John D. Ryan

Printed name of person attesting for Offeror

Secretary & Treasurer

Title of person attesting for Offeror



Signature of person attesting for Offeror

01/25/2022

Date

[END OF RESPONSE]

Certifications and Assurances Regarding Contingency Fees and Gratuities

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

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

1. Representation Regarding Contingent Fees

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

2. Representation Regarding Gratuities

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

3. Prospective Contractor's Representation Regarding Contingent Fees

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

Optum (OHCS)
Name of Offeror

Paul Miller	VP, Finance
Printed name of person attesting for Offeror	**Title of person attesting for Offeror**
Paul Miller Paul Miller (Jan 31, 2022 15:32 PST)	January 31, 2022
Signature of person attesting for Offeror	**Date**

[END OF RESPONSE]

Certifications and Assurances Regarding Contingency Fees and Gratuities

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

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

1. Representation Regarding Contingent Fees

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

2. Representation Regarding Gratuities

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

3. Prospective Contractor's Representation Regarding Contingent Fees

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

Optum Payment Integrity
Name of Offeror

Cheryl Knaut
Printed name of person attesting for Offeror

President, Optum Payment Integrity
Title of person attesting for Offeror


Signature of person attesting for Offeror

1/26/2022
Date

[END OF RESPONSE]

Certifications and Assurances Regarding Contingency Fees and Gratuities

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

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

1. Representation Regarding Contingent Fees

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

2. Representation Regarding Gratuities

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

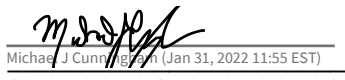
3. Prospective Contractor's Representation Regarding Contingent Fees

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

Optum Rx, Inc.
Name of Offeror

Michael J. Cunningham
Printed name of person attesting for Offeror

Chief Commercial Officer
Title of person attesting for Offeror


Michael J Cunningham (Jan 31, 2022 11:55 EST)
Signature of person attesting for Offeror

01/31/2022
Date

[END OF RESPONSE]

Certifications and Assurances Regarding Contingency Fees and Gratuities

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

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

1. Representation Regarding Contingent Fees

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

2. Representation Regarding Gratuities

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

3. Prospective Contractor's Representation Regarding Contingent Fees

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

Optum (UBH)
Name of Offeror

Paul Miller
Printed name of person attesting for Offeror

VP, Finance
Title of person attesting for Offeror

Paul Miller
Paul Miller (Jan 31, 2022 15:32 PST)
Signature of person attesting for Offeror

January 31, 2022
Date

[END OF RESPONSE]

Appendix D-2 DHHS Certification Regarding Drug-Free Workplace Requirements

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Place of Performance				
Name of Location: UnitedHealthcare of Mississippi, Inc.				
Line 1 (Street Name and Number): 795 Woodlands Parkway				
Address Line 2 (Suite, Room, etc.): Suite 301				
City: Ridgeland	State: MS	Zip Code: 39157	County: Madison	
Mailing Address (P.O. Box):	City:	State:	Zip Code:	County:

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

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

UnitedHealthcare of Mississippi, Inc.

Name of Offeror

J. Michael Parnell

Printed name of person attesting for Offeror

Chief Executive Officer

Title of person attesting for Offeror

Signature of person attesting for Offeror

03/03/2022

Date

[END OF RESPONSE]

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Place of Performance				
Name of Location: Dental Benefit Providers, Inc.				
Line 1 (Street Name and Number): 10175 Little Patuxent Parkway				
Address Line 2 (Suite, Room, etc.):				
City: Columbia	State: MD	Zip Code: 21044	County: Howard	
Mailing Address (P.O. Box):	City:	State:	Zip Code:	County:

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

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

Dental Benefit Providers, Inc.

Name of Offeror

Ken Sheldon

Printed name of person attesting for Offeror

President

Title of person attesting for Offeror

Signature of person attesting for Offeror

January 19, 2022

Date

[END OF RESPONSE]

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

For eviCore healthcare, see below for the seven locations for the performance of work done in connection with the specific grant.

Place of Performance				
Name of Location: eviCore healthcare				
Line 1 (Street Name and Number): 400 Buckwalter Place Blvd.				
Address Line 2 (Suite, Room, etc.):				
City: Bluffton	State: SC	Zip Code: 29910	County: Beaufort	
Mailing Address (P.O. Box): Same as Above	City:	State:	Zip Code:	County:

Place of Performance				
Name of Location: eviCore healthcare				
Line 1 (Street Name and Number): 175 Federal Street				
Address Line 2 (Suite, Room, etc.): Suite 1300				
City: Boston	State: MA	Zip Code: 02110	County: Suffolk	
Mailing Address (P.O. Box): Same as Above	City:	State:	Zip Code:	County:

Place of Performance				
Name of Location: eviCore healthcare				
Line 1 (Street Name and Number): 1575 Garden of the Gods Road				
Address Line 2 (Suite, Room, etc.):				
City: Colorado Springs	State: CO	Zip Code: 80919	County: El Paso	
Mailing Address (P.O. Box): Same as Above	City:	State:	Zip Code:	County:

Place of Performance				
Name of Location: eviCore healthcare				
Line 1 (Street Name and Number): 730 Cool Springs Boulevard				
Address Line 2 (Suite, Room, etc.): Suite 800				
City: Franklin	State: TN	Zip Code: 37067	County: Williamson	
Mailing Address (P.O. Box): Same as Above	City:	State:	Zip Code:	County:

Place of Performance				
Name of Location: eviCore healthcare				
Line 1 (Street Name and Number): 1420 South Babcock Street				
Address Line 2 (Suite, Room, etc.):				
City: Melbourne	State: FL	Zip Code: 32901	County: Brevard	
Mailing Address (P.O. Box): Same as Above	City:	State:	Zip Code:	County:

Place of Performance				
Name of Location: eviCore healthcare				
Line 1 (Street Name and Number): 80 Spring Lane				
Address Line 2 (Suite, Room, etc.):				
City: Plainville	State: CT	Zip Code: 06062	County: Hartford	
Mailing Address (P.O. Box): Same as Above	City:	State:	Zip Code:	County:

Place of Performance				
Name of Location: eviCore healthcare				
Line 1 (Street Name and Number): One Express Way				
Address Line 2 (Suite, Room, etc.):				
City: St. Louis	State: MO	Zip Code: 63121	County: St. Louis	
Mailing Address (P.O. Box): Same as Above	City:	State:	Zip Code:	County:

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

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

eviCore healthcare

Name of Offeror

Davis Smith

Printed name of person attesting for Offeror

President, Medical Benefits Management Solutions

Title of person attesting for Offeror

Signature of person attesting for Offeror

1/28/22

Date

[END OF RESPONSE]

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Place of Performance				
Name of Location: MTM Corporate Office				
Line 1 (Street Name and Number): 16 Hawk Ridge Circle				
Address Line 2 (Suite, Room, etc.):				
City: Lake St. Louis	State: MO	Zip Code: 63367	County: St. Charles	
Mailing Address (P.O. Box): 16 Hawk Ridge Circle	City: Lake St. Louis	State: MO	Zip Code: 63367	County: St. Charles

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

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

Medical Transportation Management, Inc. (MTM)

Name of Offeror

Alaina Maciá

Printed name of person attesting for Offeror

President and CEO

Title of person attesting for Offeror

Alaina Maciá

Signature of person attesting for Offeror

1/17/2022

Date

[END OF RESPONSE]

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

March Vision Care Group, Incorporated

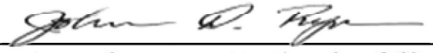
Name of Offeror

John D. Ryan

Printed name of person attesting for Offeror

Secretary & Treasurer

Title of person attesting for Offeror



Signature of person attesting for Offeror

01/25/2022

Date

[END OF RESPONSE]

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(2) requiring such employ to par icipate sa isfactorily in a drug abuse assis ance or rehabilita ion program approved for such purposes by a Fed ra , State, or local health, law enforcement, or other appropriate agency;

G. Making a good faith ffort to continue o main ain a drug-free workplac hrough implementation of paragraphs A, B, C, D, E, and F.

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

Place of Performance					
Name of Location: Optum Payment Integrity					
Line 1 (Street Name and Number): 11000 Optum Circle					
Address Line 2 (Suite, Room, etc.):					
City: Eden Prairie	Sta MN	Zip Code 55344	County: Hennepin		
Mailing Addr ss (P.O. Box): 11000 Optum Circle	City: Eden Prairie		State: MN	Zip Code: 55344	County: Hennepin

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

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

Optum Payment Integrity

Name of Offeror

Cheryl Knaut

Printed name of person attesting for Offeror

President, Optum Payment Integrity

Title of person attesting for Offeror

Signature of person attesting for Offeror

01/26/2022

Date

[END OF RESPONSE]

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Place of Performance				
Name of Location: Optum Rx, Inc.				
Line 1 (Street Name and Number): 1600 McConnor Parkway				
Address Line 2 (Suite, Room, etc.):				
City: Schaumburg	State: IL	Zip Code: 60173-6801	County: Cook	
Mailing Address (P.O. Box): N/A	City:	State:	Zip Code:	County:

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

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

Optum Rx, Inc.

Name of Offeror

Michael J. Cunningham

Printed name of person attesting for Offeror

Chief Commercial Officer

Title of person attesting for Offeror

Michael J Cunningham (Jan 27, 2022 17:39 EST)

Signature of person attesting for Offeror

01/27/2022

Date

[END OF RESPONSE]

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

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

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

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

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

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

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

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

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

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

    d. "Employee" means the employee of a grantee directly engaged in the performance of work under a grant, including (i) all direct charge employees; (ii) all indirect charge employees unless their impact or involvement is insignificant to the performance of the grant; and (iii) temporary personnel and consultants who are directly engaged in the performance of work under the grant and who are on the grantee's payroll. This definition

does not include workers not on the payroll of the grantee (e.g., volunteers, even if used to meet a matching requirement; consultants or independent contractors not on the grantee's payroll; or employees of subrecipients or subcontractors in covered workplaces).

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

A. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession, or use of a controlled substance is prohibited in the grantee's workplace and specifying the actions that will be taken against employees for violation of such prohibition; B. Establishing an ongoing drug-free awareness program to inform employees about:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Place of Performance				
Name of Location: UnitedHealthcare of Mississippi				
Line 1 (Street Name and Number): 795 Woodlands Parkway				
Address Line 2 (Suite, Room, etc.): Suite 301				
City: Ridgeland	State: MS	Zip Code: 39157	County: Madison	
Mailing Address (P.O. Box):	City:	State:	Zip Code:	County:

Please note that all UnitedHealth Group businesses, including Optum, operate under a Drug Free policy which is compliant with Federal law. The corporate addresses for United Behavioral Health, Inc. (operating under the brand name Optum) and OptumHealth Care Solutions, who are subcontractors to UnitedHealthcare of Mississippi are listed in the tables below:

Place of Performance				
Name of Location: OptumHealth Care Solutions, Inc.				
Line 1 (Street Name and Number): 1100 Optum Circle				
Address Line 2 (Suite, Room, etc.):				
City: Eden Prairie	State: MN	Zip Code: 55314	County: Hennepin	
Mailing Address (P.O. Box):	City:	State:	Zip Code:	County:

[√] Check if there are workplaces on file that are not identified here. Optum operates and provides Medicaid services in various sites across the United States.

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

Optum
Name of Offeror

Paul Miller
Printed name of person attesting for Offeror

VP, Finance
Title of person attesting for Offeror

Paul Miller
Paul Miller (Jan 31, 2022 15:32 PST)
Signature of person attesting for Offeror

January 31, 2022
Date

[END OF RESPONSE]

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

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

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

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

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

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

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

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

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

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

    d. "Employee" means the employee of a grantee directly engaged in the performance of work under a grant, including (i) all direct charge employees; (ii) all indirect charge employees unless their impact or involvement is insignificant to the performance of the grant; and (iii) temporary personnel and consultants who are directly engaged in the performance of work under the grant and who are on the grantee's payroll. This definition

does not include workers not on the payroll of the grantee (e.g., volunteers, even if used to meet a matching requirement; consultants or independent contractors not on the grantee's payroll; or employees of subrecipients or subcontractors in covered workplaces).

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

A. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession, or use of a controlled substance is prohibited in the grantee's workplace and specifying the actions that will be taken against employees for violation of such prohibition; B. Establishing an ongoing drug-free awareness program to inform employees about:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Place of Performance				
Name of Location: UnitedHealthcare of Mississippi				
Line 1 (Street Name and Number): 795 Woodlands Parkway				
Address Line 2 (Suite, Room, etc.): Suite 301				
City: Ridgeland	State: MS	Zip Code: 39157	County: Madison	
Mailing Address (P.O. Box):	City:	State:	Zip Code:	County:

Please note that all UnitedHealth Group businesses, including Optum, operate under a Drug Free policy which is compliant with Federal law. The corporate addresses for United Behavioral Health, Inc. (operating under the brand name Optum) and OptumHealth Care Solutions, who are subcontractors to UnitedHealthcare of Mississippi are listed in the tables below:

Place of Performance				
Name of Location: United Behavioral Health, Inc. (operating under the brand name Optum)				
Line 1 (Street Name and Number): 425 Market Street				
Address Line 2 (Suite, Room, etc.):				
City: San Francisco	State: CA	Zip Code: 94105	County: San Francisco	
Mailing Address (P.O. Box):	City:	State:	Zip Code:	County:

[√] Check if there are workplaces on file that are not identified here. Optum operates and provides Medicaid services in various sites across the United States.

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

Optum
Name of Offeror

Paul Miller
Printed name of person attesting for Offeror

VP, Finance
Title of person attesting for Offeror

Paul Miller
Paul Miller (Jan 31, 2022 15:32 PST)
Signature of person attesting for Offeror

January 31, 2022
Date

[END OF RESPONSE]

Appendix D-3 DHHS Certification Regarding Debarment, Suspension, and Other Responsibility Matters

DHHS Certification Regarding Debarment, Suspension, and Other Responsibility Matters

Primary Covered Transactions
45 CFR Part 76,

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

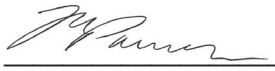
    a. Are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded by any Federal department or agency;
    b. Have not within a three-year period preceding this qualification been convicted of or had a civil judgment rendered against them for commission of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

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

UnitedHealthcare of Mississippi, Inc.
Name of Offeror

J. Michael Parnell
Printed name of person attesting for Offeror

Chief Executive Officer
Title of person attesting for Offeror


Signature of person attesting for Offeror

03/03/2022
Date

[END OF RESPONSE]

DHHS Certification Regarding Debarment, Suspension, and Other Responsibility Matters

Primary Covered Transactions
45 CFR Part 76,

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

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

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

Dental Benefits Providers, Inc.
Name of Offeror

Ken Sheldon
Printed name of person attesting for Offeror

President
Title of person attesting for Offeror

Signature of person attesting for Offeror

January 19, 2022
Date

[END OF RESPONSE]

DHHS Certification Regarding Debarment, Suspension, and Other Responsibility Matters

Primary Covered Transactions
45 CFR Part 76,

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

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

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

eviCore healthcare
Name of Offeror

David Smith
Printed name of person attesting for Offeror

President, Medical Benefits Management Solutions
Title of person attesting for Offeror

Signature of person attesting for Offeror

1/28/22
Date

[END OF RESPONSE]

DHHS Certification Regarding Debarment, Suspension, and Other Responsibility Matters

Primary Covered Transactions
45 CFR Part 76,

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

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

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

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

Alaina Maciá	President and CEO
Printed name of person attesting for Offeror	**Title of person attesting for Offeror**
Alaina Maciá	1/17/2022
Signature of person attesting for Offeror	**Date**

[END OF RESPONSE]

DHHS Certification Regarding Debarment, Suspension, and Other Responsibility Matters

Primary Covered Transactions
45 CFR Part 76,

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

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

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

March Vision Care Group, Incorporated

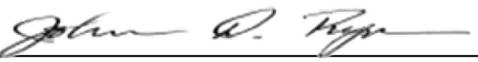
Name of Offeror

John D. Ryan

Printed name of person attesting for Offeror

Secretary & Treasurer

Title of person attesting for Offeror



Signature of person attesting for Offeror

01/25/2022

Date

[END OF RESPONSE]

DHHS Certification Regarding Debarment, Suspension, and Other Responsibility Matters

Primary Covered Transactions
45 CFR Part 76,

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

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

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

Optum (OHCS)
Name of Offeror

Paul Miller
Printed name of person attesting for Offeror

VP, Finance
Title of person attesting for Offeror

Paul Miller
Paul Miller (Jan 31, 2022 15:32 PST)
Signature of person attesting for Offeror

January 31, 2022
Date

[END OF RESPONSE]

DHHS Certification Regarding Debarment, Suspension, and Other Responsibility Matters

Primary Covered Transactions
45 CFR Part 76,

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

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

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

Optum Payment Integrity
Name of Offeror

Cheryl Knaut
Printed name of person attesting for Offeror

President, Optum Payment Integrity
Title of person attesting for Offeror

Signature of person attesting for Offeror

1/26/2022
Date

[END OF RESPONSE]

DHHS Certification Regarding Debarment, Suspension, and Other Responsibility Matters

Primary Covered Transactions
45 CFR Part 76,

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

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

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

Optum Rx, Inc.
Name of Offeror

Michael J. Cunningham
Printed name of person attesting for Offeror

Chief Commercial Officer
Title of person attesting for Offeror

Michael J Cunningham (Jan 27, 2022 17:39 EST)
Signature of person attesting for Offeror

01/27/2022
Date

[END OF RESPONSE]

DHHS Certification Regarding Debarment, Suspension, and Other Responsibility Matters

Primary Covered Transactions
45 CFR Part 76,

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

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

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

Optum (UBH)
Name of Offeror

Paul Miller
Printed name of person attesting for Offeror

VP, Finance
Title of person attesting for Offeror

Paul Miller
Paul Miller (Jan 31, 2022 15:32 PST)
Signature of person attesting for Offeror

January 31, 2022
Date

[END OF RESPONSE]

Amendments 1 – 12

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)

J. Michael Parnell

(Printed)

Chief Executive Officer

(Title)

UnitedHealthcare of Mississippi, Inc.

(Company)

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

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

Receipt of Amendment #2 Acknowledged:

Printed Name: J. Michael Parnell

Signature: 

Title: Chief Executive Officer

Company: UnitedHealthcare of Mississippi, Inc.

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

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

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

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

Appendix E

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

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

Appendix F

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

4.3.1.~~1~~2:Corporate Experience

Appendix H

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

Receipt of Amendment Acknowledged:

(Signature)

J. Michael Parnell

(Printed)

Chief Executive Officer

(Title)

UnitedHealthcare of Mississippi, Inc.

(Company)

Amendment #4 to RFQ 20211210: RFQ Questions and Answers

RFQ #: 20211210 / RFx#3150003991

Date: February 7, 2022

RFQ Name: Mississippi Division of Medicaid Coordinated Care

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

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

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

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

Receipt of Amendment 4 Acknowledged:

(Signature)

J. Michael Parnell

(Printed)

Chief Executive Officer

(Title)

UnitedHealthcare of Mississippi, Inc.

(Company)

Amendment #5 to RFQ 20211210: RFQ Corrections and Clarifications

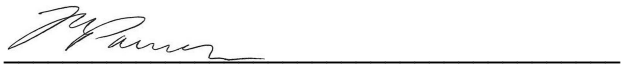
RFQ #: 20211210 / RFx#3150003991

Date: February 7, 2022

RFQ Name: Mississippi Division of Medicaid Coordinated Care

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

Receipt of Amendment 5 Acknowledged:



(Signature)

J. Michael Parnell

(Printed)

Chief Executive Officer

(Title)

UnitedHealthcare of Mississippi, Inc.

(Company)

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

RFQ #: 20211210 / RFx#3150003991

Date: February 7, 2022

RFQ Name: Mississippi Division of Medicaid Coordinated Care

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

Receipt of Amendment 6 Acknowledged:

(Signature)

J. Michael Parnell

(Printed)

Chief Executive Officer

(Title)

UnitedHealthcare of Mississippi, Inc.

(Company)

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

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

Offeror attests to the following:

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

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

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

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

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

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

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

Receipt of Amendment 7 Acknowledged:

(Signature)

J. Michael Parnell

(Printed)

Chief Executive Officer

(Title)

UnitedHealthcare of Mississippi, Inc.

(Company)

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

RFQ #: 20211210 / RFx#3150003991

Date: February 7, 2022

RFQ Name: Mississippi Division of Medicaid Coordinated Care

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

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

Receipt of Amendment 8 Acknowledged:

(Signature)

J. Michael Parnell

(Printed)

Chief Executive Officer

(Title)

UnitedHealthcare of Mississippi, Inc.

(Company)

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

RFQ #: 20211210 / RFx#3150003991

Date: February 10, 2022

RFQ Name: Mississippi Division of Medicaid Coordinated Care

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

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

Receipt of Amendment 9 Acknowledged:

(Signature)

J. Michael Parnell

(Printed)

Chief Executive Officer

(Title)

UnitedHealthcare of Mississippi, Inc.

(Company)

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

RFQ #: 20211210 / RFx#3150003991

Date: February 11, 2022

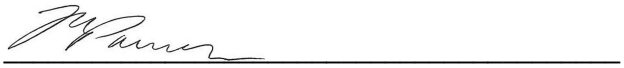
RFQ Name: Mississippi Division of Medicaid Coordinated Care

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

This document contains the follow:

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

Receipt of Amendment 10 Acknowledged:



(Signature)

J. Michael Parnell

(Printed)

Chief Executive Officer

(Title)

UnitedHealthcare of Mississippi, Inc.

(Company)

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.	

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)

J. Michael Parnell

(Printed)

Chief Executive Officer

(Title)

UnitedHealthcare of Mississippi, Inc.

(Company)

Amendment #11 to RFQ 20211210: Reporting Manuals

RFQ #: 20211210 / RFx#3150003991

Date: February 11, 2022

RFQ Name: Mississippi Division of Medicaid Coordinated Care

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

- MississippiCAN Reporting Manual
- CHIP Reporting Manual

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

Receipt of Amendment 11 Acknowledged:

(Signature)

J. Michael Parnell

(Printed)

Chief Executive Officer

(Title)

UnitedHealthcare of Mississippi, Inc.

(Company)

Amendment #12 to RFQ 20211210: Responses Regarding Amendment 9

RFQ #: 20211210 / RFx#3150003991

Date: February 16, 2022

RFQ Name: Mississippi Division of Medicaid Coordinated Care

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

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

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

Receipt of Amendment 12 Acknowledged:

(Signature)

J. Michael Parnell

(Printed)

Chief Executive Officer

(Title)

UnitedHealthcare of Mississippi, Inc.

(Company)

RFQ# 20211210

Technical Qualification (Blind Evaluation)

UnitedHealthcare of Mississippi, Inc.

MississippiCAN and CHIP RFQ

Table of Contents

4.2.1 Executive Summary

4.2.1 Executive Summary (Unmarked): Pass/Fail

The Executive Summary shall condense and highlight the contents of the qualification in such a way as to provide a broad ...

The Executive Summary should be no more than ten (10) single-spaced typed pages in length. Staff organizational structure and key ...

As a mission-driven organization with several decades of experience, we are excited about the opportunity to serve Mississippians. Our bold, local strategy will connect people and communities to innovative programs and deliver the highest quality care to our members to improve health outcomes, elevate the quality of life and increase value for the state.

For over 45 years, our organization has been providing managed care services to millions of Medicaid and Children's Health Insurance Program (CHIP) members in more than 30 states. This success is best reflected by our ability to quickly adapt to local needs in states with populations similar in size and demography of the Mississippi Medicaid and CHIP populations.

We understand that each state has its own challenges, opportunities, and priorities so we customize our approach and solutions to address the needs of local communities and offer our industry-leading resources. We understand Mississippi Division of Medicaid's four central matters: Quality, Collaborative Innovation, Access and Commitment and have developed five core areas of focus, described below, to align our efforts to prioritize the health and wellbeing of every member and community.

Based on America's Health Rankings, Mississippi lags all other states in health, social and economic factors. Mississippians experience poor maternal and infant outcomes and a high prevalence of obesity and chronic diseases such as diabetes, heart disease and kidney disease. Relative to other states, Mississippi reports higher rates of frequent mental stress and drug-related deaths. These health challenges coupled with factors like low health literacy, a severe health care workforce shortage and more food deserts than anywhere in the country, creates a unique opportunity to improve the health of Mississippians for which we are well equipped.

Throughout this offer, we aim to demonstrate that we are fully committed to partnering with all stakeholders who prioritize the health of Mississippians. Our actions and partnerships are aimed at delivering innovative, culturally competent services that advance health, health equity and contain costs. We look forward to fulfilling the Mississippi Division of Medicaid's aims.

1. Proposed work plan;

The Division has placed both quality and collaborative innovation at the center of this procurement. We will collaborate with the Division and the other chosen coordinated care organizations (CCOs) to deliver a seamless implementation Our proposed approach and work plan reflect the Division's current and enhanced program requirements. Our experience partnering with more than 25 Medicaid agencies has allowed us to develop work plans that assure we remain on schedule and can accommodate program changes that may arise.

Under the direction of our chief executive officer, a dedicated team of experienced leaders will organize and manage the full implementation, from preparation to go-live, to steady state. Our experienced chief operating officer (COO) will serve as the implementation leader and, alongside the compliance officer, will ensure full

operation status outlined by the model contract. The COO will use our proposed detailed work plan to monitor all aspects of the project and identify potential risks before issues or problems occur.

We apply Project Management Body of Knowledge (PMBOK) – driven project management principles to all implementations within a stage gate framework. Stage gate reviews monitor dependent requirements, confirm status details and identify potential risks and issues. The stage gate framework goal is to prepare for flawless implementation through the use of proactive measures and associated mitigation plans for each phase.

PMBOK - Stage Gate Overview

- **Stage Gate 1 – Requirements Assignment:** The project startup phase begins at the RFQ release. At this first stage gate, we complete a detailed walk-through of contractual requirements and RFQ commitments and communicate with all operational teams that will support the RFQ and contract requirements.
- **Stage Gate 2 – Network Readiness:** We review network potential at several stage gates, but we use this focused full network review to confirm we can meet the contractual obligation in time for go-live. We finalize all provider communication strategies at this time.
- **Stage Gate 3 – Requirement Readiness:** We conduct a detailed review of progress and use this stage to adjust any go-live contingency plans and risk mitigation and have proactive discussion of member transition planning.
- **Stage Gate 4 – Pre-Go-Live Readiness:** At 60 days before go-live, the implementation team assesses operational readiness across all functions. We review detailed go-live monitoring plans, with contingency planning to accommodate potential risk.
- **Stage Gate 5 – Go-Live Readiness:** At 30 days before go-live, the implementation and business alignment teams assess any changes in operational readiness across all functional areas and identify temporary manual workarounds that may be needed.

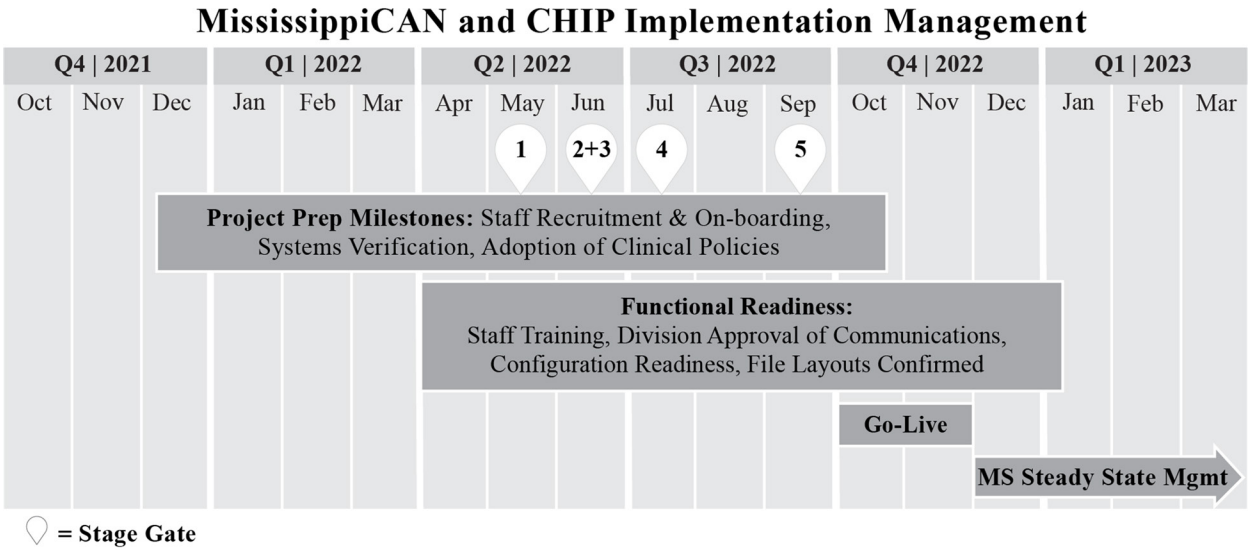


Figure 1. Illustrative Work Plan and Schedule Summary. Throughout implementation our process will go through various stages. This assumes a contract award in September and an aggressive go-live date of October 1st.

Quickly following a successful implementation, our entire team will begin demonstrating our commitments to Mississippi through steady-state and collaborative forward planning. During this shift, we will create an environment aimed to transform the traditional health care approach of episodically healing illness and instead focus on engaging and enhancing the health of populations and meeting individual member's needs, whether those needs are medical, behavioral, housing, transportation, social, or health literacy, and more.

We are prepared to provide a full work plan and schedule for immediate review as requested by the Division.

Steady State: Our Five Core Areas of Focus

To support the Division of Medicaid in achieving its goals, we take a person-centered approach that integrates all aspects of health and wellness. This approach goes beyond integrating physical and behavioral health care. It maximizes wellness, incorporates the community, identifies and addresses social determinants of health (SDOH), and drives toward achieving health equity. All of which collectively improves health and health outcomes in a more meaningful way. Our integrated approach centers on five areas of focus:

- **Advancing Population Health Outcomes:** Our population health approach addresses health disparities, access to care, and enhances member experiences so all members have maximized opportunities to reach their healthiest potential. We deploy sustainable programs and initiatives to remove obstacles to care so that value-driven, equitable health care is provided for all. We employ predictive systems and algorithms that identify racial, ethnic and geographic disparities, emerging trends, and even areas of environmental risks. By focusing on population health, we are able to scale programs and care delivery models that can best impact Mississippians in all areas of the state. This includes employing technology to enhance member and provider experience across the full care continuum, promoting medical homes and community organizations, providing clinical and health equity-based incentives, and including impactful value-added benefits -- all of which prioritize the overall health and wellness of the individual and community.

Advancing Population Health Outcomes

- **Driving Innovation and Value:** Innovation is paramount in our company and we deploy our solutions to impact overall healthcare delivery and local communities where we serve members. We will drive cost effective, value-based payment methods in Mississippi by increasing provider reimbursement to those committed to higher quality of care. Our tools span the spectrum of technology readiness and sophistication. Where providers and members may not be ready for advanced technological tools, we gain an understanding of their preferences, adapt to meet their needs, and work directly with them to advance their readiness.

Driving Innovation and Value

- **Increasing Access to High Quality Care:** Merely providing access to traditional health care services falls short of our core purpose, so we will build a network of traditional and non-traditional providers and health-focused stakeholders to help us develop unique solutions to improve quality and equitable delivery of health care. These stakeholders will be both established and emerging partners who are committed to providing high-quality services in Mississippi. Our network will be well equipped to advance our focus on value-driven care. We acknowledge that access to high-quality medical care does not always translate into attaining wellness. Therefore, we directly engage our members to make certain we meet their basic needs, such as stable housing, food, and transportation. We have long supported innovations like telehealth to provide access in health professional shortage areas, medically underserved areas or rural regions and will work with the Division to deploy a sophisticated telehealth strategy to offer both virtual visits and physician-to-physician specialty consults. These efforts have resulted in proven results such as in other states similar to Mississippi, our telehealth strategy demonstrated a resolution of 77% of health issues without having to refer to in-person care and we decreased ER visits by 46%.

Increasing Access to High Quality Care

- **Nurturing Local Partnerships:** Roughly sixty five percent of Mississippians who receive Medicaid and CHIP benefits live in rural areas where health care resources range from few to non-existent. For that reason, we will collaborate with, and actively support, community and faith-based organizations, local businesses, community centers and other local resources. We will do this by providing needed funding, volunteering, and providing donations of necessities to improve community health. Through these partnerships we collaboratively work to address the complex roots of inequities, which elevates individual and community health and creates sustainable action. To support local needs, **we have already committed $5.9 million of future investments**

Nurturing Local Partnerships

in Mississippi communities, including $1 million this year to address food insecurity, which is negatively impacting Mississippians of all ages and backgrounds.

- **Achieving Operational Excellence:** Simplifying the health care system is good for everyone and will result in improved satisfaction, better outcomes, and lower cost for members, providers, and Mississippi. We will continue to make significant investments to accelerate operational excellence, including an array of solutions ranging from employing our advanced risk stratification techniques to identify and actively engage members, to improving data sharing and detecting waste in the health care system. We deploy sophisticated systems to support providers and members to improve outcomes and lower the total cost of care. Our ultimate outcome is an experience that exceeds the expectations of our members, providers and state partners.

Achieving Operational Excellence

2. Staff organizational structure;

Our organizational structure celebrates Mississippi's people, ideas and experiences. Our leadership team will be comprised of Mississippians who have experience in health care and supporting underserved populations. We will employ a local and inclusive workforce that reflects the diverse backgrounds of the people we have the privilege to serve, and we will foster a culture where all team members are appreciated, valued and able to reach

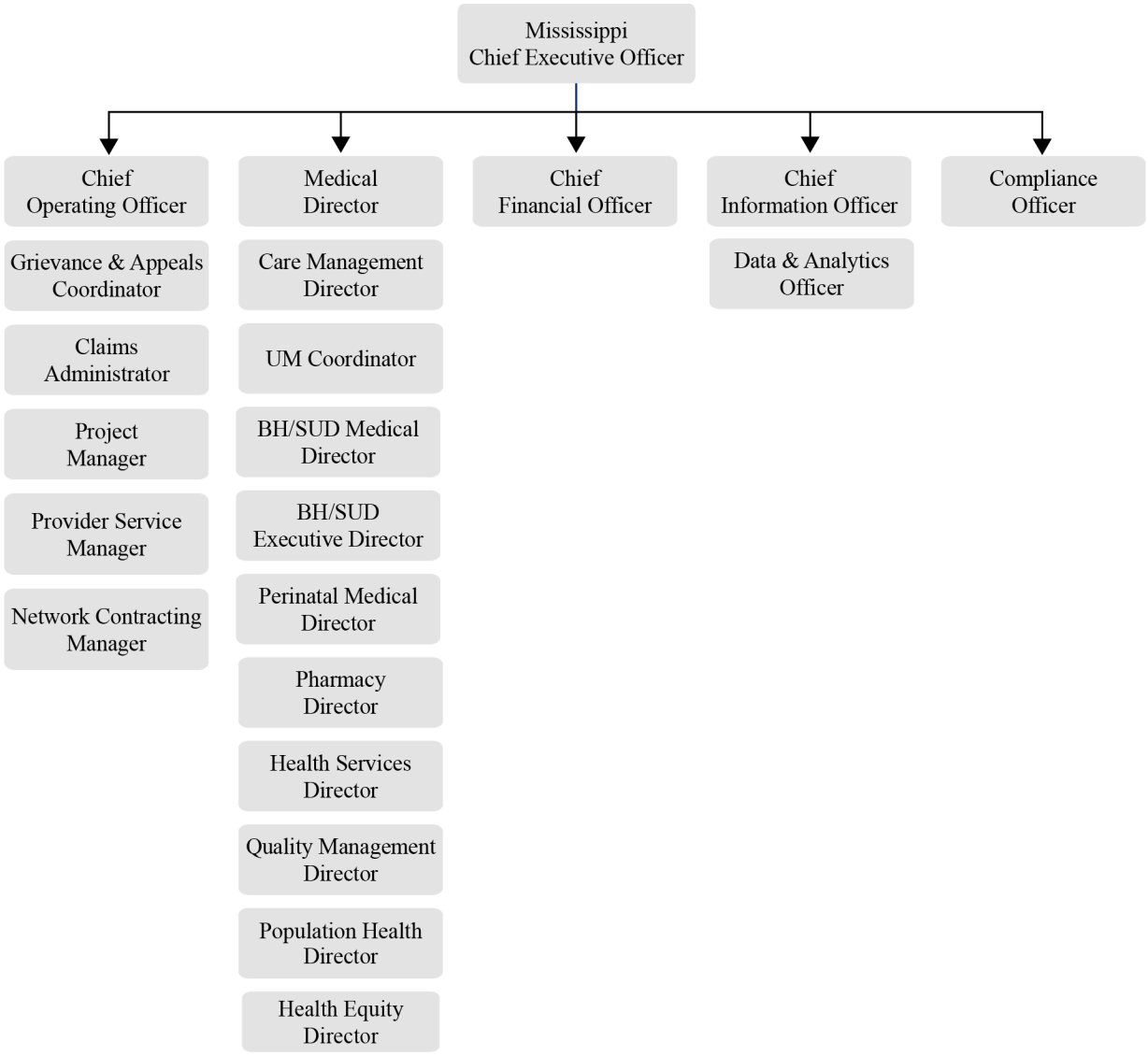


Figure 2. Mississippi organizational structure.

their fullest potential. Our organizational culture is designed to empower employees at all levels to think boldly, ask questions and take initiative to create unique solutions. Everything we accomplish is possible only because our team works in collaboration with committed partners — people who share our passion, purpose and vision to improve health outcomes and quality of life for Mississippians.

3. Key personnel; and,

Distinguishing our proposal will be a team of Mississippians who are passionate about improving health in their home state. Their knowledge of the state, relationships with providers and stakeholders, and passion for Mississippi will serve as the purpose for their service.

We Know Mississippi

Our proposed frontline staff and leadership team are long-term residents of Mississippi who have a wealth of experience in coordinated care operations and personal knowledge of the local health care needs of Mississippians. This experience includes a deep understanding of challenges faced in rural communities and underserved urban areas. Further, we recruit our workforce based on their familiarity with underserved populations, community-based resources and knowledge of health equity challenges in Mississippi.

Key Staff Positions

- **Chief Executive Officer (CEO):** The CEO directs the strategic development, growth and operations of the health plan. The CEO is accountable for ensuring our efforts align to the Division's four core matters: Quality, Collaborative Innovation, Access and Commitment and our resources are directed to improving the health of our members and their communities. Qualifications include seven or more years of successful senior leadership experience, 10 or more years of health care experience and five or more years of related managed care experience.
- **Chief Operating Officer (COO):** The COO is the primary point of contact for all health plan operational issues and is responsible for management and administration of multiple functions and general business operations, health services and the medical management team. The COO will be instrumental in collaborating with other CCOs to identify opportunities to streamline administrative efforts to improve the experience for members and providers. Qualifications include proven ability to execute short- and long-term growth and profitability targets, at least eight years of people management experience and three or more years of experience in strategic planning and development.
- **Chief Financial Officer (CFO):** The CFO oversees all aspects of strategic financial planning, analysis and operations. The CFO will assist the CEO in identifying and making investments to bolster the ability of communities to address health and social needs. Qualifications include at least 10 years of finance experience, ability to effectively support, train and perform transactional-based finance and accounting transactions and advanced strategic focus combined with operational, analytical and project management skills.
- **Chief Medical Officer (CMO):** The CMO, functioning as the contractually required medical director, is responsible for all clinical decisions and provides clinical oversight, expertise, leadership and direction for the administration of the MississippiCAN program and CHIP. The CMO will oversee our efforts to effectively address the health challenges across the state and partner with other CCOs, providers, and other stakeholders to support collaborative innovation. Qualifications include Mississippi medical license; advanced knowledge of managed care industry and Medicaid; background in primary care medicine that includes pediatrics, extensive knowledge of wellness and EPSDT; and demonstrated ability to work with peers and other health care providers to resolve disease management, quality management, utilization management and complex care issues.
- **Perinatal Health Director:** The perinatal health director provides strategic leadership and is accountable for all clinical programs for perinatal and infant health. The perinatal health director will be responsible for

working with clinical and community partners to develop unique solutions to improve maternal outcomes across Mississippi. Qualifications include five or more years' experience providing direct care or care coordination to at-risk pregnant individuals receiving Medicaid services; significant experience working with community-based partners to increase pregnancy compliance programs; and experience engaging individuals who need specialty services to support them through difficult pregnancies, birth experiences and parental support after birth. This physician will have an unrestricted Mississippi medical license.

- **Behavioral Health Director:** The behavioral health director manages development and implementation of affordable, evidence-based treatments, and action planning. An in-depth knowledge of current BH/SUD treatment modalities is required. The behavioral health director will build solutions and partnerships to expand access to services and to integrate behavioral health as an integral component to achieving improved outcomes for members and communities. Qualifications include at least five years' experience providing and supervising treatment service for mental illness and substance use disorders and an unrestricted Mississippi medical license.
- **Chief Information Officer (CIO):** The CIO is responsible for overseeing and maintaining information systems that enable data validation, correct claims payment and timely and accurate reporting. This position is a key contact for IT efforts and will work with the appropriate delivery areas for IT projects for MississippiCAN and CHIP. The CIO will assist the entire leadership team in developing tools to improve the administrative experience for members, providers, and the Division. Qualifications include 10 or more years of professional IT experience, seven or more years of professional IT management experience in a large enterprise environment and five or more years of experience leading teams or managing workloads for IT team members.
- **Compliance Officer:** The compliance officer monitors changes to contracts, laws and regulations to ensure compliance and establishes and implements standard policies, procedures, processes and best practices across the company to promote compliance. The compliance officer will ensure operating discipline and performance to enable us to exceed the State's expectations. Qualifications include three or more years' experience in direct management of a health plan compliance program, experience leading government program audits and compliance initiatives and experience developing relationships with regulatory agencies.
- **Project Manager:** The project manager oversees the implementation of the contract requirements during all phases of the project. The project manager will ensure seamless implementation and collaboration with the State. Qualifications include three or more years of business project management experience, three or more years of experience in a deadline-driven environment and knowledge of Medicaid programs, particularly with Medicaid managed care programs, with relevant experience navigating similar complex projects.

Additional Key Administrative Positions Include:

- Provider Service Manager
- Network Contracting Manager
- Member Services and Marketing Director
- Quality Management Director
- Care Management Director
- Utilization Management Coordinator
- Population Health Director
- Health Equity Director
- 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.

Current Environment

Mississippi battles some of the most prevalent indicators of poverty, disability and chronic illness in the nation. The state is challenged with low health literacy, limited access to care, a small health care workforce, and a shortage of resources to address basic needs. At the same time, Mississippi has been a leader in telehealth

adoption and programs that have improved childhood vaccination rates, reduced alcoholism and cigarette smoking.

We are committed to creating the conditions for people to thrive. We are aligned with the Division's aim to improve health outcomes and quality of life, and we will enable change by creating an environment that shifts from reactive episodic treatment to proactive care that provides members with solutions that address social needs and provides them tools to be proactively engaged in health promotion, avoidance of chronic disease and overall wellness. Our processes are designed to meet the needs of members of all ages and adjust to accommodate unique nuances within the MississippiCAN program and CHIP.

MississippiCAN and CHIP Requirements

We have thoroughly reviewed and understand the requirements of the Division as outlined in Appendix A: Sample Contract. We will structure our program to build on the Division's foundation to improve health outcomes and quality of life for members. Our five core areas of focus -- advancing population health outcomes, increasing access to high quality care, driving innovation and value, nurturing local relationships, and achieving operational excellence -- will improve the health of MississippiCAN and CHIP members and will create programs that are both sustainable and impactful. To inform our proposal, work plan, and approach, we used the four matters central to the Division's procurement aims.

Quality

The Division is emphasizing numerous quality-based improvements, including approaches to care management, SDOH and health literacy campaigns. To go beyond traditional physical-behavioral health needs, we will incorporate SDOH, environmental influences, health literacy and other individual and population health aspects in our fully integrated care delivery approach. We will be fully accredited by the National Committee for Quality Assurance (NCQA), with additional NCQA distinctions in Multicultural Health Care, and Health Equity. We will be a leader in raising quality standards as measured by HEDIS®, Medicaid's overall Quality Improvement Strategy, and the Division's Potentially Preventable Hospital Return initiative.

Each member will be assigned a personal contact who is a member of their care management team as the basis of our integrated care management approach. We will use customizable algorithms, which complement the risk levels outlined in the model contract, to risk-stratify individual members for targeted intervention strategies. These algorithms use data gathered at intake, ongoing touchpoints, claims activity, provider health interfaces, geographical variations and weather events. This information creates an intensity level for each member that allows us to create a clinically relevant individual medical treatment plan and achievable goals. We empower members to achieve their health goals and we provide additional assistance as needed in supporting them to lead a healthy life.

Our approach includes a continuum of engagement, including face-to-face and technology-based methods. This may include engaging a provider on behalf of a member, advocating for public assistance or simply inviting a member to a community event that will be beneficial. All approaches are designed to meet each member where they are geographically and on their wellness journey.

Collaborative Innovation

We are eager to collaborate with the Division and other CCOs to create uniform systems that will leverage plans' experience, knowledge and creativity while providing consistency and ease of administrative burden for providers, members, and the Division. We are a leader in data analytics and technology and have a proven ability to bring multiple stakeholders together to impact change. Nationally, we are leading payment reform and practice transformation.

We are constantly developing and evolving our alternative payment models (APMs). These APMs include no-risk quality incentives, similar to those permissible in Mississippi, bundled payments and sophisticated full-risk capitated models. We have learned our value-based programs (VBPs) need to be true partnerships with providers, state Medicaid agencies and other health plans, with joint goals and objectives that are achievable based on each provider's readiness. Having a suite of models allows us to meet providers at their current capabilities with the right payment structure to enhance quality and improve value of care. This approach supports providers to take on more responsibility and risk in managing the populations they serve with the ultimate benefit of improving member health at lower costs. We will align our VBP with Mississippi Medicaid's quality improvement strategy and the potentially preventable hospital return initiative. When legislation allows, we are ready to partner with the Division and providers who are willing to enter into risk based VBP arrangements, which further enhance provider earning potential while promoting higher clinical accountability.

Access

The Division seeks CCOs who will address all barriers to access, whether those are geographic or as a result of social barriers. We will create a paradigmatic shift from reactive episodic treatment to proactive care that overcomes barriers. This will be accomplished by providing members and providers with advanced technologies, solutions that address social needs, a comprehensive network of high-quality PCMH-committed providers, and strong relationships with community-based organizations. By addressing barriers to care, we will foster relationships among members, providers and their communities, which change how care is delivered.

We will retain and reward providers who have care models that help achieve better outcomes for Mississippians. We will provide a robust provider network that exceeds the access standards outlined in the model contract. We are confident that our provider access will exceed NCQA accreditation standards and the standards set forth in Appendix A, Draft Contract. Beyond mere accessibility, we will focus our network and partnerships on quality and efficiency, driven by a value-based approach that aligns with our person-centered model.

Commitment

The Division expects a true commitment and willingness to invest in communities through partnerships with other organizations and an investment in human capital. We have already committed over $5.9 million to communities and residents of Mississippi. We intentionally look to local community-based organizations, including faith-based organizations, food pantries, community centers, housing and employment organizations, employers and other community organizations to support our population health approach. This strengthens the overall well-being of our members and their communities. Our experience has shown that these partnerships and investments better reach our members and reduce care avoidance. Examples of our partnerships in states like Mississippi include:

- **Condition Focused:** Based on available data and supported by our observation of the state, we know that a significant cost driver and health challenge facing Mississippi is maternal and infant health. For this reason, we have already made significant financial investments in Mississippi with a significant portion of our investments focused on reducing teen pregnancy, supporting pregnant individuals and care for the sick and well babies of Mississippi. We are committing to expand the use of Long-Acting Removable Contraceptives (LARCs) by providing benefit and use training to rural non-OBGYN providers. In addition to maternal and neonatal health costs, diabetes and diabetes-related diseases continue to influence the overall health status of Mississippi. In response, nearly all our VBP models will include measures to improve diabetic care.
- **Food Insecurity:** Mississippi is more impacted by food insecurity than any other state in the nation. With more food deserts per capita than any other state, we will make food security a priority. We have a reputation for developing relationships with community partners who directly affect and interact with

members. Mississippi-based organizations, in partnership with us, will provide students in grades K-12 and their families facing food insecurity with regular access to nutritious food. Due to capacity, location and demographic composition, we propose that school districts be sites of our ongoing food pantries in collaboration with other organizations. When we directly fund and connect these organizations, these types of interventions solve immediate needs and address some of the complex roots of inequities by empowering families and engaging communities.

- **Local Presence:** We are committed to a strong local presence, including a projected over 200 full-time employees based in Mississippi, living in various communities across the state. We will partner with local community-based organizations that represent and serve the MississippiCAN and CHIP populations. To further enhance this community-based approach, we will have local field-based care providers who will perform home visits to members.

Conclusion

We are committed to creating lasting change in Mississippi. Our proposal goes into greater detail about what we will do for the Division and our members. We are confident that we will effectively improve the health status of our members, seamlessly administer both MississippiCAN and CHIP programs, and work collaboratively with all stakeholders, including the Division of Medicaid, other state agencies, contractors, and Mississippi's group of providers and community-based organizations. We sincerely appreciate your consideration and time in reviewing this submission.

[END OF RESPONSE]

4.2.2 Methodology/Work Statement

4.2.2.1 Member Services and Benefits (Unmarked)

A. Delivery of Covered Services

1. Children

a. The Division has a special interest in ensuring timely and robust developmental screening and early ...

i. MississippiCAN Services: Describe the Offeror's proposed approach to ensure children receive timely ...

Healthy children are of paramount importance in the MississippiCAN program and CHIP. In 2020, 28% of Mississippi's children, including 46% of Black children lived in poverty, and nearly 40% of children ages 10 – 17 across the state were noted to be obese.[1] We know the impact poverty, inequitable access to health care and limited options for basic needs have on child development and growth into successful adulthood. We will partner with the Division of Medicaid to make sure children enrolled in our health plan receive timely and comprehensive services.

Our pediatric care model centers on delivering whole-person care. We will prioritize primary and preventive care services and address acute and chronic physical and behavioral health needs through the highest quality of care. We will focus on enabling care that will bolster health equity and remove barriers created by social determinants of health (SDOH). We will look beyond the provision of care rendered by traditional providers, engaging community stakeholders to ensure health care and basic needs are met through culturally competent and age-appropriate methods.

We will follow the most current edition of Bright Futures as published by the American Academy of Pediatrics (AAP), and we use their published periodicity schedule for all phases (infancy to late adolescence) of pediatric preventive care. This includes routine preventive dental services and scheduled vision and hearing screenings. Our disease prevention efforts will center on proper timing of vaccinations as outlined in the Recommended Childhood Immunization Schedule set forth by the Advisory Committee on Immunization Practices (ACIP).

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

Our Early and Periodic Screening, Diagnostic and Treatment and Child Wellness Team

Under the direction of our Early and Periodic Screening, Diagnostic and Treatment (EPSDT)/child wellness manager, our EPSDT coordinators will use our claims and care management systems to track members eligible for services; initiate outreach, including reminders and follow-ups; make referrals; run performance data reports; and evaluate program effectiveness. Our EPSDT/child wellness manager will work with the care management team to refer members identified with special health care needs for follow-up and supportive services.

Our EPSDT team will use policies and procedures to make sure our EPSDT program complies with RFQ Attachment A – Draft Contract Sections 4.1.3, 6.2.6, 8.20 and 16.2.2.

Our EPSDT Policies

Our EPSDT policies will provide a guiding framework and direction on how we will manage preventive and comprehensive services for children to ensure the early identification, diagnosis and treatment of conditions before they become more complex. The clinical policies will incorporate the latest evidence-based guidelines and are based on American Academy of Pediatrics, Bright Futures, and will align with the Division's Administrative

In a state of similar size and population, we achieved a 99% compliance rate for wellness screenings in children less than 1 year old.

[1] Mississippi State Department of Human Services Office of Rural Health and Primary Care 2021 Annual Report.

Code. The administrative policies will outline billing and reimbursement procedures and how our staff will support providers on enrolling as an EPSDT provider, maximizing services, adhering to periodicity schedules, and how referrals can be made for children. The policies will provide guidance on the utilization management for services provided under the EPSDT guidelines for children under age 21. These policies will ensure we meet all requirements outlined in the model contract. We will make our clinical and administrative policies, procedures and evidence-based clinical practice guidelines available to providers on our provider website.

Our EPSDT Procedures and Processes

Our EPSDT procedures and processes are aimed at ensuring children enrolled in MississippiCAN receive services to help them reach their full potential and lead healthy lives. These include tracking member utilization, intervening when there are missed services, and helping EPSDT providers support their practices. We will monitor member utilization and contact parents or guardians of children who are due or past due for wellness screenings by phone, mail and in-person care management visits and other methods based on member communication preferences. For providers participating in EPSDT, we will promote clinical practice guidelines and apply billing guidelines and claims logic to support proper reimbursement and enhanced payments for EPSDT providers who render these services. We will update our provider quality scorecard, which provides insight into children in need of EPSDT such as immunizations services twice monthly and make it available through the provider portal and on demand, allowing providers to access their scorecard any time. Our EPSDT/child wellness manager will monitor EPSDT compliance rates monthly, update our comprehensive plan and present findings during quarterly Provider Advisory Committee meetings, allowing network provider input on our EPSDT strategy.

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

We will encourage members to obtain services through several means with a clear commitment to honor member choice for how they prefer outreach and contact. We will design targeted member and provider incentives to encourage the completion of wellness screenings and work with community partners to provide education about the importance of child wellness exams.

Our member outreach program will include direct mail campaigns, automated and live reminder calls, text messages and email based on member preferences for communication.

In a state similar to Mississippi, we mailed over 7,000 flyers each quarter. A large volume rural clinic saw a 9% increase in well-child visits in 2021. Many additional clinics showed a 5% – 6% improvement in 2021 over 2020 rates.

Routine and Special Mailings

Using a monthly report of members who are past due for preventive services, our EPSDT team will send reminder mailings to members' homes. We will prepare special mailings for clinics, practices or community-based organizations (CBOs) who wish to reach out to members for health and wellness events.

We will send educational reminders such as flyers and postcards that clearly show the due or past due screening needed, how to arrange transportation, how to contact their PCP and a description of the member incentive that can be earned.

Automated/Live Reminder Calls

We will make three attempts to reach members through live voice calls annually to encourage completion of annual child wellness exams. If, after the child's birthday, we have not received a claim indicating the child completed the screening, we will mail a reminder card and add the member to the next month's list for another call.

Using Incentives to Encourage Preventive Care Participation

Member incentives are effective ways to provide education on the importance of child wellness exams and allow members to earn rewards for completing exams and immunizations. We will offer a free Prepaid $25 Mastercard Gift Card for children who complete their annual wellness exam and teens who complete all required adolescent immunizations. In a state similar to Mississippi, we delivered nearly 3,000 gift cards for members ages 5 – 18 for completion of wellness exams over the last three years, **which corresponded with a 10% improvement rate in overall EPSDT performance.**

Technology

We will employ cellphone texting options, a secure member portal and a mobile app that will encourage parents and our teen and adolescent population to better engage in their health. These three modalities can provide custom reminders based on the services needed at a particular time. The portal and app will help locate providers and our care managers to help schedule appointments.

Using Provider Partnerships to Improve Wellness Participation

Our quality management provider education program will offer resources for providers to quickly identify assigned members with care gaps, view best practices to improving quality performance and find collaborative opportunities to improve wellness screenings and immunizations for children.

- Each month, we will partner with providers to host on-site screening events at clinic locations throughout the state. We will schedule these events during weekdays, after-hours or on weekends to provide working parents and their kids an opportunity to participate. We will contact members with open care opportunities to schedule event appointments.
- Accountable care organizations (ACOs) and patient-centered medical homes (PCMHs) have a strong reputation of providing high-quality clinical services. We will identify such practices in Mississippi that focus on pediatric care. We will incentivize and partner with them to bring their mobile health services to community events to close EPSDT care gaps. A partnership with a clinic in a similar state has contributed to a **6% improvement in screening rates for children between the ages of 5 and 18 since 2019.**

Nurturing Community Relationships to Improve Wellness Participation

Our member engagement strategy will include engaging key community stakeholders to strengthen our member preventive care goals. Initiatives we plan to deploy in Mississippi include:

Nurturing Local Partnerships

- **School District Partnerships:** Many children who play sports use the sports physical as a substitute for a well visit with their PCP. Our EPSDT team and quality nurses will partner with schools and local EPSDT certified providers to perform wellness screenings for high school sport teams through our mobile care partnership.
  - We will establish relationships with schools to sponsor wellness events where students will receive information on dental care, wellness and nutrition. We will collaborate with our mobile providers so members can receive wellness exams at the event.
  - We will partner with elementary, middle and high schools for poster and essay contests. In similar states, these contests have engaged students through participative education and have helped them understand the importance of completing wellness exams. **In a state similar in size to Mississippi, 3,290 students participated in such events from 2018 to 2021.** We will use these strategies and anticipate greater results after emerging from the COVID-19 pandemic.
- **Community-Based Organizations:** In a similar state, the EPSDT team partnered with a Boys & Girls Club after-school program to host a holiday health fair where a local pediatric clinic was on-site to complete

wellness visits in their mobile unit. Such opportunities have been identified in Mississippi and will be a key strategy to encourage member engagement.

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

We anticipate early and consistent preventive care and screening will improve health outcomes by mitigating communicable diseases, identifying the risks of serious illness early, facilitating early interventions, supporting health literacy and addressing health disparities. **In states of similar size and population makeup, our EPSDT programs showed improvements of 10.47% in well-child visits in the first 15 months of life and a 4.14% adolescent rate, respectively, from 2018 to 2019.**

Human papilloma virus (HPV) has increased in prevalence and is a known predictor of cervical cancer. Mississippi has the highest age-adjusted cervical cancer mortality rate in the United States at 3.5 per 100,000. In a state similar to Mississippi, we partnered with the American Cancer Society and other coordinated care organizations (CCOs) for a project to improve HPV vaccination rates for children over age 9. The interventions helped child wellness teams plan and implement quality improvement projects that contributed to a **6.81% improvement of the Immunizations for Adolescents (IMA) measure and 6.08% improvement of the HPV vaccination rate**.

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

Using our care management system and as shown in the following figure, we will deploy our process for reminders, follow-ups and member outreach that will include a cadence of direct mail, automated and live voice calls, email and text messages for members who have opted to receive text messages. Our written notifications will adhere to state language and literacy requirements.

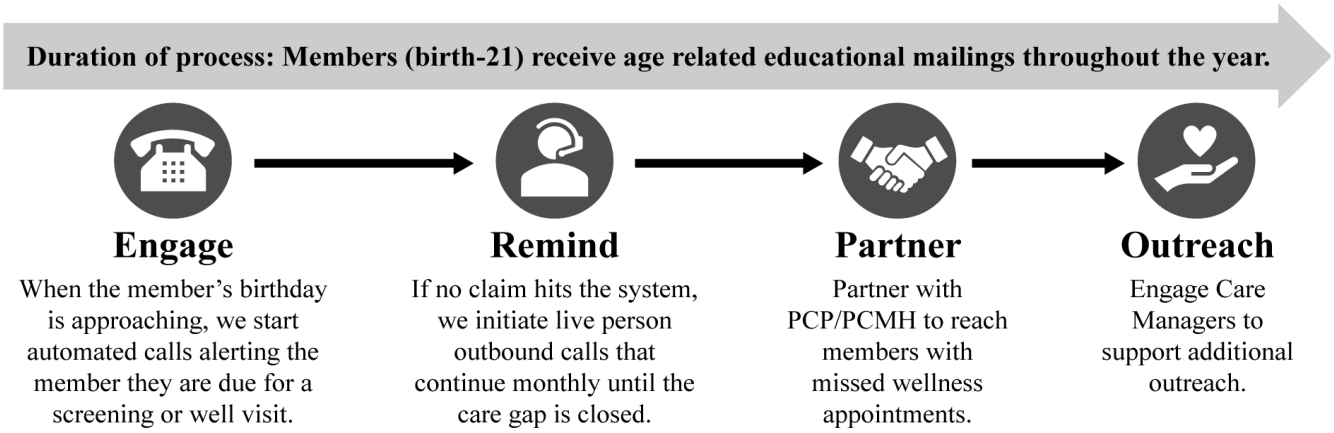


Figure 1. Process for Reminders, Follow-ups and Outreach.

Routine and Special Mailings: Using the monthly report of members who are past due for preventive services, our EPSDT team will schedule reminder mailings. We will prepare special mailings for clinics or practices who wish to reach out to their members.

We will send educational reminders such as flyers and postcards that clearly show the due or past due screening needed, how to arrange transportation or find their PCP and a description of any relevant member incentive.

Live Voice Calls: We will make three attempts to reach members through live voice calls annually to encourage completion of the annual child wellness exam. If, after the child's birthday, we have not received a claim indicating the child completed the screening, we will mail a reminder card and add the member to the next month's list for another call. We will use those opportunities when members call us to remind them of recommended care needs and gaps.

Texting Campaigns: We will deploy a member outreach program that will add email and texting options for reminders. The goal of this program is to improve engagement by reaching members through their preferred contact methods.

Home Visits: We will develop and implement a protocol for home visits for members who do not respond to reminders or outreach by seeking needed care.

Foster Care Children: We will work with the Mississippi Department of Child Protection Services (MDCPS) county office to secure appointments and arrange transportation, if needed, for foster care members who are due or past due for EPSDT screenings or follow-up care.

5. How the Offeror plans to communicate to the Member that Cost sharing in any form is not allowable on ...

Our policies and procedures will ensure we comply with federal and state regulations regarding member cost sharing restrictions in accordance with 42 C.F.R. § 457.520. Ensuring members know there is no financial barrier to care is critical to improving birth outcomes in Mississippi. We will notify our members that cost-sharing is prohibited in this population through our welcome letter, member ID card, member handbook and a member welcome guide. Our member services team will be trained to relay this information telephonically if called upon. Our **perinatal member outreach** team will contact every identified pregnant member to perform a **comprehensive risk assessment**, answer benefit questions, inform the member there is no cost sharing for pregnancy-related services and **assist in scheduling prenatal appointments**.

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

To drive improvements in quality and member outcomes, we recommend including the following innovative alternative payment models (APMs) in the final Mississippi Medicaid value-based purchasing work plan.

Primary Care Provider Member Engagement Bonus: We propose using a member engagement bonus for PCPs. In this program, PCPs will be rewarded for completing annual screenings and immunization series for hard-to-reach members.

Pediatric Patient-Centered Medical Home Accountable Care Organization: Based on Mississippi Medicaid enrollment data, over 70% of members enrolled in managed care are children; we propose to deploy a Pediatric Accountable Care program exclusively for NCQA-recognized PCMH providers. Our Pediatric PCMH ACO will provide a total cost of care incentive for practices with greater than 80% pediatric populations. This model will drive overall improvements in the quality and efficiency of care for our pediatric members, including appropriate, efficient utilization of high-cost, high-intensity clinical settings; reduced hospital readmissions; and reduced hospital admissions for chronic disease complications.

ii. CHIP Services: Describe the Offeror’s proposed approach to ensure CHIP Members receive timely ...

Our well-child program will include provisions for CHIP members and will be developed in conjunction with the MississippiCAN EPSDT program. We will include the same culturally competent staff for CHIP who are trained in delivering age-appropriate care. We will recognize and adhere to the program differences; however, our goal for both programs will remain the same — supporting healthy children living to their fullest potential. Our approach will emphasize preventive care to promote health, detect disease and provide resources to prevent injury and future health problems.

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

Our CHIP-covered services and child wellness policies will provide a guiding framework and direction on how we will ensure our members receive timely and appropriate wellness services, including, but not limited to, well-child visits and immunizations, following all statutory, regulatory and contractual requirements. The policies will provide guidance for our staff and providers on follow-up activities, interventions, communication

and referrals to be made on behalf of children, performance data reporting and program evaluation. These policies will ensure we meet all requirements outlined in the model contract.

The policies will outline detailed processes and procedures for tracking, identifying and engaging families of children who should receive preventive care services, reminding them about follow-up visits and working with the families to follow their treatment plans. We will monitor member utilization and contact parents or guardians of children who are due or past due for wellness screenings by phone, mail and in-person care management visits and other methods based on member communication preferences. We will update our provider quality scorecard, which provides insight into children in need of preventive care services such as immunizations, twice monthly and make it available through the provider portal and on demand, allowing providers to access their scorecard any time. Our EPSDT/child wellness manager will monitor compliance rates monthly, update our comprehensive plan and present findings during quarterly Provider Advisory Committee meetings, allowing network provider input on our child wellness strategy.

Our clinical policies and procedures will comply with the CHIP State Health Plan using the periodicity schedules of the American Academy of Pediatrics Bright Futures Guidelines for periodic health screenings and the ACIP recommendations for immunizations. Providers will be able to access our CHIP-covered services and child wellness policies along with pediatric evidence-based clinical practice guidelines via the provider website.

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

Our Child Wellness Team

Our child wellness team will support all efforts of the CHIP. Led by our child wellness manager who will oversee all program activities, we will maintain a unified approach, and pediatric program activities will be implemented concurrently for children enrolled in either the MississippiCAN program or CHIP.

CHIP Member Outreach Activities

The outreach program for CHIP members will include strong partnerships with providers, schools, churches and community organizations. We will empower members to participate fully in their health care by providing the tools and support they need to obtain services. We will educate members about how to use technology supports, including the secure member portal and our mobile app. Within 30 days of enrollment, we will connect with members to complete the initial Health Risk Screening and educate them on their covered services and benefits. Our approach includes:

Enrollment Information: We will emphasize the benefits and importance of preventive services and wellness in our welcome packet and member guide.

Automated/Live Reminder Calls: All members will receive calls annually to encourage completion of the annual child wellness exam. If, after the child's birthday, we have not received a claim indicating the child completed the screening, we will mail a reminder card to the member.

Member Incentives: Incentives are exciting ways for members to earn rewards for completing wellness exams. We will send a $25 Mastercard Reward card for completing wellness exams and for select adolescent vaccinations.

Routine Mailings: Our team will use a monthly report to identify members who are due for wellness visits and sends direct mail pieces describing the screening or vaccination that is due. We will complete special mailings for individual clinics who want to contact their patients or plan to hold health events.

Well-Child Clinic Days: We will establish clinic day partnerships with providers, such as pediatricians and federally qualified health centers (FQHCs), to hold monthly clinic days at several sites across the state. We will contact members to schedule well-child appointments on weekdays, after-hours and on weekends.

Mobile Care Partnership: We will identify and partner with a clinic that brings a mobile health unit to community events to allow members to close care gaps during the event. In a state similar to Mississippi, our Q4 2021 mobile unit collaboration, phone calls, reward incentives and member mailings contributed to the completion of **4,059 wellness exams for members ages 10 – 14 on CMS-416, an increase of 24% over Q3 2021**.

School District Partnerships: Our child wellness team will partner with schools to complete wellness exams for high school sports teams through our mobile care partnership. We will establish relationships with schools to sponsor wellness events where students will receive information on dental care, wellness and nutrition. Members can complete wellness exams via the mobile care unit. We will work with school-based clinics to make sure members are receiving wellness exams.

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

Our approach emphasizes preventive care to promote health, detect disease and provide resources to prevent injury and future health problems. Our programs have achieved success in several states whose demography are similar to Mississippi. Before the pandemic, our collaborative approach demonstrated improvement in the well-child visits for children ages 3 to 6 with a **7.52 percentage point increase from 2018 to 2019. We saw a 4.86 percentage point increase in the completion of adolescent well-child visits.**

Our pilot with the American Cancer Society to improve HPV vaccination rates in a state similar to Mississippi has improved immunizations by 6.81%. We are tracking the impact on health outcomes and believe the increase in immunizations will result in a decrease in cervical cancer among adult females over time.

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

We will provide the following outreach, reminder and follow-up activities for new members:

- Our outreach will start with welcoming each member to our health plan and informing them of their wellness benefits, including recommended wellness exams following the Bright Futures periodicity schedule. Our CHIP member education outreach will include annual reminder calls to encourage completion of a wellness exam, required immunizations, annual dental visit and a flu shot. The automated call will be triggered during the month of the member's birthday and will be repeated each month until the member completes the exam. As an enhancement for members who opt in, we will use text and email reminders considering members' preferences for outreach.
- Our child wellness team will monitor member compliance with the Bright Futures periodicity schedule. When members continue to have open care gaps, the well-child team will execute live call reminder campaigns. We will develop a protocol for home visits for members who do not adhere to reminders and follow-up outreach.
- Service navigators will engage members who have gaps in care quarterly and work with the member toward resolution such as scheduling an appointment or providing education, engaging the behavioral health crisis support line or recording grievances and appeals. In a state similar to Mississippi, in 2021 our service navigators assisted members by engaging in over **1,400 discussions about gaps in care.** In the same time frame, **200 health care appointments were directly scheduled while interacting with this team.**

5. How the Offeror plans to communicate to the Member that Cost sharing in any form is not allowable on ...

Our approach to ensuring pregnant CHIP members are aware that there is no cost sharing for pregnancy-related assistance will be consistent with our approach for MississippiCAN pregnant members. Ensuring members know there is no financial barrier to perinatal care is critical to improving birth outcomes in Mississippi. We will communicate to our member population broadly through our welcome letter, member ID card, member handbook and member welcome guide. This information will clearly inform members there is no cost for preventive and pregnancy-related assistance. Our perinatal member outreach team will contact every identified

pregnant member to perform a comprehensive risk assessment, answer benefit questions, inform the member there is no cost sharing for pregnancy-related services and help schedule prenatal appointments.

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

Our innovative methods to augment care delivery in the CHIP population are not separate and distinct from what we are proposing for the MississippiCAN population. Administering the two programs concurrently will better support overall outcomes in Mississippi, alleviate provider burdens associated with multiple processes and allow members to seamlessly move between CHIP and MississippiCAN if eligibility changes. In fact, our pediatric value-based purchasing (VBP) programs we have implemented in states similar to Mississippi include all provision of services, and the models we plan to propose to the Division will be applicable to both MississippiCAN and CHIP.

Health Equity Incentive: In addition to the PCP member engagement bonus and pediatric PCMH ACO innovations described in our response to question six in the MississippiCAN section above, we will address disparities in member health outcomes through the Health Equity Incentive we are proposing for PCPs and PCMHs. We will stratify key HEDIS measures by member characteristics (e.g., race/ethnicity) to identify disparities within a provider's patient panel. Providers can earn higher incentives for improving care for all and for reducing an identified gap often experienced by historically marginalized groups.

Non-Emergency Transportation: Our value-added non-emergency transportation services for CHIP members will mirror the current benefit in place for MississippiCAN members. This benefit will include unlimited rides to and from covered services, gas mileage reimbursement, meals and lodging and commercial flights for health care services.

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

There is a disproportionate burden of disease borne by racial and ethnic minority populations and the rural and urban poor. Health disparities not only affect the groups facing inequities but limit overall improvements in quality care and the health status for the broader population, resulting in costs that could have been avoided. Our strategy to address these disparities will require community, caregiver and child engagement.

Engaging and Listening to Community Voices

Our planned Community Partnership Advisory Committee will meet quarterly and focus on issues such as member and caregiver satisfaction, service delivery, community engagement, quality of covered services or provider access issues. This grassroots forum will represent a broad cross section of our CHIP families composed of the racial, ethnic and linguistic groups that make up 5% or more of our membership. Through this interactive forum, we will empower members to actively participate in care delivery and program development.

Analyzing and Understanding Barriers

In our care delivery models, we will track every pediatric HEDIS measure by age race, ethnicity and county to identify disparities so we can design appropriate interventions and track their progress. We will employ geospatial mapping capabilities that overlay social determinant data with member addresses. The resulting map will allow us to observe population clusters with drilldown capabilities to the member location. This capability will provide insight on how to overcome disparities that may be associated with environmental factors such as pollution, flood zones and natural disasters.

Collaborating with Providers

We will collaborate with our pediatric providers to monitor and reduce disparities by implementing our Health Equity Program (HEP) incentives. Like other alternative payment models, the HEP will identify members attributed to provider panels with open care opportunities. The HEP provider scorecard will display compliance

rates of attributed members sorted by race and ethnicity to easier identify disparities between populations for measures included in the program.

2. Behavioral Health Services

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

Our Experience and Capacity

We will bring more than four decades of experience offering programs and claims payment for Medicaid behavioral health and substance use disorder services. Foundational to our programs are evidence-based practices, member-centered integration of care, our internal research and analytics and the collective experience of our clinical leadership. The impact is measurable and notable. For example, between 2015 and 2019 in a state similar to Mississippi, by connecting our high-risk members to peer support services in their communities, **we achieved a 50.6% reduction in inpatient and ER spend.**

To support the behavioral health and substance use disorder needs of *pediatric and adolescent members* in Mississippi, upon implementation, we will have contracts in place with a comprehensive network of providers who can provide all the services indicated in the RFQ and model contract. These providers will deliver a continuum of pediatric behavioral health and substance use disorder treatment services, from community-based to acute inpatient. We have already identified numerous in-state willing providers for our MississippiCAN and CHIP telehealth network, and we will continue to expand this list. In partnership with the state, local providers and advocates, we will bring our expertise, experience and resources to offer a full range of high-quality services throughout Mississippi, as we have done in states across the country.

Best Practice Model of Care: We follow a member-centered model of care delivered in the least restrictive, most clinically appropriate setting, designed to allow children and adolescents with behavioral health/substance use disorder conditions to thrive in supportive environments. We stress the importance of family support and evaluate social determinants of health (SDOH) to identify natural supports and factors beyond health care, which are barriers to well-being. Through interviews with the member and their family and using screening tools such as those listed below, we will assess for behavioral health and substance use disorder needs and for related issues and supports such as Adverse Childhood Experiences, need for developmental services, risk for out-of-home placement and engagement in community and school-based program services. This screening will identify comorbid physical health conditions such as diabetes, asthma and obesity.

Screening Tools

- Child Stress Disorders Checklist-Screening Form (CSDCSF)
- Children with Special Health Care Needs (CSHCN)
- Pediatric Symptom Checklist 17 (PSC-17)
- Pediatric ACEs and Related Life-events Screener (PEARLS)
- Car; Relax; Alone; Forget; Friends; Trouble (CRAFFT)

Our care managers will be in regular contact with our members and their families to assist in accessing services and identifying solutions. As needed, our care team will bring a member case to our weekly interdisciplinary team of care managers, psychiatrists and psychologists to evaluate options. We will have a separate process for members in a psychiatric residential treatment facility (PRTF), with weekly rounds to assist members with transition back to the home and community.

Direct Payment Experience

Nationally, in 2021, **we paid 99.69% of clean Medicaid behavioral health/substance use disorder claims within 30 days, most of which are electronically adjudicated for immediate payment**. We will accept claims through both electronic and paper options. We will offer user-friendly billing training to providers,

including online self-service options. We will track claims trends to identify any abnormalities or claims filing issues, and our in-state provider relations team will be available for assistance when needed. We will employ many payment approaches, ranging from fee-for-service to increasingly sophisticated VBP, including incentives, bundled payments, combined physical-behavioral health models and shared savings models. We will structure our provider agreements to promote positive outcomes for the members with minimal provider administrative burden.

Compliance with the SUPPORT Act

We will support and comply with federal regulations in the SUPPORT Act and the Mental Health Parity Addiction Equity Act. This will include compliance through our medication management programs, augmenting point-of-sale utilization management that will be provided by the state's Pharmacy Benefit Administrator. Our Antipsychotic Monitoring in Pediatrics Program, through which we monitor and manage proper use of antipsychotic medications in children and adolescents, including children in foster care, will be one component of our approach.

Our Antipsychotic Monitoring in Pediatrics Program consists of retrospective drug utilization review through claims extracts and coordination of care intervention by a pharmacist. In 2020, in a similar state to Mississippi, this effort resulted in a net reduction of antipsychotic medications for 168 children.

b. Describe the Offeror's direct experience in service delivery and payment and/or capacity to manage service ...

Our Experience and Capacity

To support the behavioral health/substance use disorder needs of *adult members* in Mississippi, we will establish a comprehensive network of providers, including behavioral health providers, substance use disorder providers, virtual visit and telemental health providers and medication-assisted treatment (MAT) providers, to meet the behavioral health needs of Mississippi members. Our network will include providers serving specialty populations, such as older adults and pregnant members, and will be fully capable of providing services to adults with behavioral health/substance use disorder conditions from diagnosis to outpatient services and inpatient services, and post-discharge through recovery and stability.

We have more than four decades of experience offering programs and claims payment for behavioral health/substance use disorder services to adults.

Best Practice Model of Care: For adults with behavioral health/substance use disorder conditions, we will follow a recovery and resiliency-focused, member-centered model of care, delivered in the least restrictive, most clinically appropriate setting. Our integrated care management will help adults with behavioral health/substance use disorder conditions recover and lead stable, productive lives. For early intervention and to increase access to care, our initial Health Risk Screening will integrate mental health/substance use disorder screening and condition-specific screenings. Additional screening tools may include the following:

- Patient Health Questionnaire (PHQ-9)
- Generalized Anxiety Disorder (GAD-7)
- Drug Abuse Screen Test (DAST-10)
- Maryland Assessment of Recovery Scale (MARS-12)
- Adverse Childhood Experiences (ACEs)

In addition, our advanced analytics will identify primary behavioral health/substance use disorder conditions and comorbid conditions such as hypertension, diabetes, obesity and cardiovascular disease. We will assess and address unmet social determinants such as homelessness, unemployment and lack of transportation and other needs. Through our screening and assessment specific to adults, we will:

- **Identify** the need for additional assessments/interventions such as MAT, any background of trauma or signs of abuse, physical health conditions and opportunity to link to medical care
- **Assess** history of treatment, including ER utilization; medication adherence; need for peer or other supports; and presence of or interest in executing a psychiatric advance health care directive
- **Close** gaps in access to care, affordable medications or community supports

Our regional interdisciplinary treatment team (ITT) will formulate care plans specific to each member's needs and circumstances to afford each member their best chance of success. In 2021, in a state similar to Mississippi, our care management program produced the following outcomes:

- Seventy percent of members in care management had a behavioral health outpatient visit within 90 days of engagement.
- Only 7% of members in care management had an inpatient admission within 90 days of engagement, compared to 15% for those not enrolled in care management.
- Forty-seven percent of members in care management adhered to their behavioral health medications in the 90 days following care management engagement compared to 35% of members not enrolled in care management.

Direct Payment Experience for Behavioral Health and Substance Use Disorders

Our claims processing experience covers adults in employer-sponsored plans and Medicare and Medicaid plans, and in 2021 **we paid 99.69% of clean Medicaid behavioral health/substance use disorder claims within 30 days.** Through VBP incentives in our provider agreements, we will shift the focus from general service provision to quality and efficacy for our members.

Compliance with the SUPPORT Act

In compliance with the SUPPORT Act and through our Abused Medications Program, we will provide education and clinical engagement with opioid prescribers regarding optimal prescribing guidelines geared toward adult members. Our nationwide program results from 2017 to 2021 show that MAT prescribing increased 42%, and the number of members with concurrent use of opioids and benzodiazepines dropped by 71%, showing the efficacy of program outreach in remediating risky prescribing patterns.

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

We will provide evidence-based treatment through a personalized plan for each member, and we will pay providers quickly using payment strategies that help providers improve their care delivery and promote positive outcomes for members.

Approach to Service Delivery

We will use proactive risk stratification to identify members for care management services. Regionally-based care teams will facilitate the delivery of member-centered and fully integrated services for members with complex needs. We will consider and incorporate the presence of racial, ethnic and geographic disparities, such as transportation, housing, service availability and disease prevalence, into a member's journey to recovery and design a treatment plan for each member and solutions tailored to the needs of each population. In addition, we will offer programs for special populations such as pregnant members with substance use disorder, identifying substance use early in pregnancy and connecting members to a specialized care manager for enhanced support.

Integrated Care Management: Each member enrolled in care management will be provided a locally based integrated care team and a care manager who is best suited to address the member's needs and to resolve gaps in care. The care team may include a variety of providers, support coordinators and CBOs involved in the member's care. Our care managers will serve members who live in their region, sharing their regional experience and expertise on available local resources.

Recovery and Resiliency: Our care management model is member-centric and incorporates recovery and resiliency principles into every facet of care. It will promote integrated care within the community, providing education, support and advocacy in meeting the member's needs.

Peer Support: We will use a peer support model to promote recovery through living testimony and reinforce resilience and self-management. For Mississippi, we will employ in-state peer support specialists and a recovery and resiliency manager who will oversee our peer support model. From 2015 to 2019, in a state similar to Mississippi, we connected our high-risk members to peer support services in their communities and achieved a 50.6% reduction in inpatient and ER spend.

Provider Outreach: We will listen to and support providers with solutions that ease their administrative processes, including offering VBP initiatives and practice transformation support so they can deliver efficient, effective, high-quality care to our members. Our network management approach will include continuous monitoring and feedback from frontline staff to understand and address our members' access challenges and clinical and cultural needs. We will employ an in-state, field-based provider relations team with behavioral health experience to support providers.

Approach to Payment

We will support all standard billing and claims processes, including payments at encounter rates when indicated. To reward quality and efficiency, we will have progressive VBP models, and we will incorporate these in many of our provider agreements, including with providers in rural counties. Based on provider readiness, our approach may include incentives, bundled payments and shared savings. We will continually seek to expand VBP in our network to all eligible providers, and we regularly help providers prepare for new, more rewarding VBP models. Recognizing the exceptional toll that opioid use disorder places on our members and their families, in a similar state, we are piloting a VBP program to increase the use of MAT and engagement and retention in treatment.

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

Behavioral health/substance use disorder innovations we will implement, subject to approval by the Division, in caring for MississippiCAN and CHIP members include:

Respite Care: To support families of children with serious emotional disturbance (SED), we will establish a respite program offering both direct care and training for respite caregivers. This value-added benefit will serve up to 200 of our member families per year across the state through respite providers certified by the Department of Mental Health. In addition, we will contract with an in-state children's behavioral health organization to help craft the program details, train families on the use of respite and train additional individuals in the provision of respite care to children with SED.

School-Based Access to Care: In another state, we purchased and delivered iPads to a rural school district where 85% of the students are enrolled in Medicaid. We then partnered with a local provider group to make staff available during school hours for virtual appointments to increase access to care. We did not limit the use of the iPads to only our members. We will now bring this initiative to scale by partnering with the Mississippi Department of Education and spending up to $200,000 deploying iPads to needy districts to assist school staff in connecting students with physical and behavioral health services and social services.

Addressing Medication Concerns: Through one initiative, we will provide medications at discharge to reduce medication errors and readmissions rates while removing barriers to medication access. Another program will monitor and optimize the medication regimen of high-cost members to reduce utilization of inpatient and ER services and improve member outcomes. Through advanced analytics, we identify and support members at risk for nonadherence to antidepressant, antipsychotic, mood stabilizer or MAT.

Behavioral Health Self-Care and Peer Support App: Members aged 13 and over can use our self-help app, an evidence-based mobile care solution, to access on-demand help for stress, anxiety, depression and common behavioral health conditions. While relatively new to Medicaid, in our employer-sponsored contracts this app serves over 4 million users and **60% of active users report significant clinical improvement within 30 days.**

Intensive In-Home Assessment and Treatment: We will bring our intensive in-home assessment and treatment program experience in providing short-term, intensive, individualized and family-based services to children and youth between the ages of 6 and 17 who are at imminent risk of being removed from their home due to the child's high-risk behaviors. A multidisciplinary team will provide in-home, evidence-based, trauma-informed treatment to help families heal from trauma, leading to improved behaviors. These positive outcomes will contribute to increased placement stability, school success, a reduction in psychiatric hospitalization, enhanced family relationships and reduced foster care placement.

Bright Heart Health: In response to the substance/opioid use disorder epidemic and the need for treatment access across Mississippi, we will use the specialty provider Bright Heart Health to offer statewide MAT telehealth services to supplement services provided by Mississippi providers.

Medication-Assisted Treatment/Emergency Room Collaborative: This new initiative, designed in partnership with ASAM, will train ER physicians on initiating MAT in the ER. We will connect ER physicians and MAT providers so members can continue their treatment seamlessly. Our care manager, and a peer support specialist when applicable, will support the member in their journey.

Crisis System Redesign: In other states, we have worked with members, providers, hospital systems and other local constituents and stakeholders to transform the region's crisis system into a community-based, recovery-oriented response system integrating peer supports and a no-force approach to care. We are happy to share our experience and expertise in this regard with the Division, including the creation of a Recovery Response Center, which has resulted in 91% consumer satisfaction rate in other states.

Flexible Support Funding: We will make flexible support funds available for use at care managers' discretion to reduce lengths of stay and increase community stability. Up to $250 per person can fund nonstandard needs in the community for members in residential or inpatient settings and ready for discharge, and children receiving wraparound services. Examples include, but are not limited to, utility deposits, room furnishings and youth activity expenses.

Collaboration and Support: Enhanced by our experience in many states across the country, we have the knowledge and skills to bring innovative solutions to address many of the identified needs in Mississippi, such as timely appointments post-discharge, crisis services to prevent hospitalization, care management connects that begin before discharge, flexible funding to address gaps and an empowerment manager (SDOH/housing navigator) to assist with accessing affordable accessible housing, ease of medication access and intensive in-home services. We stand ready to partner with the Division and other state partners to put innovations in place to move Mississippi forward.

e. How will the Offeror address racial, ethnic, and geographic disparities in delivery of and outcomes ...

Foundational to our company's operating philosophy are our policies on equal opportunity, equity, diversity and inclusion, which we apply both internally and externally. Our three-tiered approach encompasses breaking down barriers to care and building health equity for *members*, the *health systems* in which we operate and the *communities* in which our members live. According to a 2018 study by the CDC, Black Americans are more likely than white Americans to report persistent symptoms of emotional distress, but only a third receive the mental health care they need. We know that roughly half of Mississippians live in rural or poor areas, where there are higher levels of unemployment, poverty, health disparities and lower levels of educational attainment and access to care. Many of these communities present with higher rates of behavioral health needs and substance use disorders. Our strategy to address these disparities in the states we serve is a multipronged solution:

Figure 2. Health Equity Venn Diagram. Interconnectivity of health equity issues.

- Continue to recruit locally based talent with direct experience supporting our members
  - Including a health equity leader within the clincal team to oversee, monitor and implement positive change
- Engage with the community and listen to the concerns expressed
  - Moving the voices and input of marginalized communities to a level equal with others by asking them about preferences and engaging with them in their preferred way
- Analyze and understand the barriers to achieving health equity
  - Stratifying data by race, ethnicity, language, gender and geography to identify disparities
- Design innovative solutions and deploy them in the community
  - Implementing solutions that address the structural drivers and root causes of disparities based on input obtained directly from members
- Evaluate the impact of solutions and improve them
  - Assessing and tracking the success of solutions by analyzing member- and population-based outcome trends

Addressing Mississippi disparities will include:

- Moving toward value-based care and risk sharing that promotes health equity by rewarding providers for seeing that all their clients can access high-quality behavioral health care
- Offering training in Mental Health First Aid through trusted CBOs in vulnerable communities. Mental Health First Aid is a skills-based course that trains participants to identify signs of a mental health or substance use crisis and assist others to obtain help
- Verifying all our staff are trained in cultural sensitivity and that culturally and linguistically appropriate services are integrated into each program
- Engaging communities of color in community events by hosting them in local neighborhoods, outreaching through local CBOs and providing engaging programs

In each region, we will partner with community mental health centers (CMHCs), FQHCs and private providers, and we will use regionally based care teams with knowledge of each region's characteristics and challenges to

reduce disparities in access and quality. This will include offering an extensive telehealth provider network for behavioral health, substance use disorder and MAT providers to increase access to care in areas with health provider shortages. Further, we created a Disparities Dashboard that stratifies race, ethnicity, language and disability status by HEDIS® measures, identifying areas for targeted strategies to address risk factors. We will use this tool to work with CBOs, provider partners, the Division and the other CCOs to help overcome disparities.

3. Perinatal and Neonatal

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

Our Direct Experience in Perinatal and Neonatal Services Delivery and Payment

Our organization has more than four decades of Medicaid/public sector experience delivering and paying for perinatal and neonatal services. We support more than 120,000 pregnant Medicaid members and their newborns annually across more than 25 states that often include rural and urban geographies and population demographics similar to Mississippi. With our breadth of experience engaging members, collaborating with providers and cultivating local partnerships, we are well equipped to partner with the state to address Mississippi's maternal and infant health challenges, including preterm birth rates and related disparities. We will implement evidence-based and innovative initiatives to support member access to prenatal, perinatal and postpartum care, improve outcomes and reduce disparities. We will back our programs with member and community insights, robust analytics and the collective experience of our clinical leadership and providers.

Experience Highlights

- Over $14 million invested to innovate and improve maternal and infant outcomes across the United States
- Improved care utilization in a similar state — timely prenatal care up from 86% to 91%, postpartum visits up from 53% to 73%
- Reduced geographic disparities in postpartum care by 40% for pregnant members living in a rural county in a similar state through community health worker outreach

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

Approach to Delivery of Perinatal and Neonatal Services

Pregnancy and birth are life-course events that present unmatched opportunity for women and babies to receive and engage in interventions that will set the course for the rest of their lives. When opportunities are managed with positive birth and maternal outcomes in mind, we can most effectively invest in the future of Mississippi. The perinatal period allows for behavioral modification, such as tobacco cessation, addressing alcohol and drug use, healthy eating and proper health care. The period following birth creates an opportunity to establish health habits such as proper nutrition, social development and vaccinations. Our approach to the delivery and payment of perinatal and neonatal services is to reduce disparities and improve perinatal outcomes, such as preterm birth, severe maternal morbidity, low birth weight and C-section rates. To promote the long-term health and well-being of moms and babies, we will quickly identify and engage members in care and offer a comprehensive range of supports, including care management, substance use disorder (SUD)/behavioral health services and community resources.

Member Engagement and Education Enables Connection to Care Delivery

We will identify pregnant members as early as possible through our pregnancy-specific identification and risk-stratification tool. We will compile a weekly file of newly identified pregnant members using data from member eligibility files, claims data, provider referrals, obstetrical risk assessment forms (OBRAFs) and Health Risk Screenings. We will offer financial incentives to increase provider submission of OBRAFs to create enhanced opportunities for engagement through earlier identification. Our perinatal member outreach team will contact every identified

Members participating in our Pregnancy Rewards Program attend 14% more physician visits and have a 5.7% lower rate of ER utilization than nonparticipants.

pregnant member to perform a comprehensive risk assessment, answer benefit questions and assist in scheduling prenatal appointments. The team will identify any barriers the member may have, such as transportation or childcare needs, make sure members are aware of their benefits and the importance of prenatal care and connect the member to appropriate resources. All Mississippi members will have access to our mobile-friendly Pregnancy Rewards Program, which offers rewards such as gift cards for completing important doctor visits such as prenatal, postpartum and well-child through an infant's first 15 months of life.

We will send educational information to members weekly on topics such as symptoms to watch for, baby's development, what to expect during pregnancy, SIDS prevention and breastfeeding. We will send appointment reminders and links to relevant resources and events.

Perinatal and Neonatal Care Management Coordinates Care and Improves Outcomes

Advancing Population Health Outcomes

We will enroll all pregnant members in Mississippi in our perinatal care management program, staffed by our local care managers. We will identify and engage members as early as possible to ensure they receive the services necessary to promote a healthy pregnancy and birth. Our risk stratification tool incorporates medical, behavioral and social risk factors to stratify members into three risk tiers for optimal clinical impact. All pregnant members will be stratified as high risk. We will use the results of the Health Risk Screening, which incorporates medical, behavioral and social risk factors, to tailor interventions for pregnant members. Acknowledging significant racial inequities, such as that Black infants are twice as likely to die as white infants, in maternal and infant health outcomes seen in Mississippi, we will design care management interventions to reduce such inequities. For example, a perinatal care manager will perform enhanced outreach to pregnant members of color who need additional support. The perinatal care manager will help address member barriers to care and connect them to culturally responsive and respectful perinatal and neonatal services. Aligned with the model contract, our perinatal care managers will refer high-risk pregnant individuals to the Mississippi Department of Health's PHRM/ISS program. For those choosing to participate in PHRM/ISS, our perinatal care management teams will maintain surveillance and coordinate with PHRM/ISS to ensure members receive needed supports. We recognize that periodontal health during pregnancy correlates with perinatal and postnatal outcomes, so we will offer an enhanced dental benefit to support this population. Members will be eligible for enhanced dental services, including coverage for routine preventive exams, minor restorative and periodontal services, and our dental care management program. For families who experience the Neonatal Intensive Care Unit (NICU), our NICU care management program staff will support the family while the baby is in the NICU and help them prepare for the care delivery transition, coordinating at-home services and equipment, ensuring there is a feeding plan (breast milk or formula) and arranging for community services needed.

Access to Substance Use Disorder and Behavioral Health Services

We know pregnant members face challenges in accessing SUD services, including provider shortages, practice policies limiting treatment of pregnant members, transportation, scheduling barriers and co-occurring behavioral health disorders. We will offer a free, anonymous 24-Hour SUD Helpline staffed by behavioral health clinicians. Our perinatal care managers will receive SUD training to support these members in navigating the complexity of concurrent SUD perinatal management. We will refer pregnant and postpartum members struggling with SUD or behavioral health conditions to a licensed behavioral health clinician care manager who will perform behavioral health assessments, review medications and connect members to resources such as CMHCs, MAT providers and other local programs such as Catholic Charities' Born Free/New Beginnings program. Born Free/New Beginnings is a residential program for pregnant and parenting members with chemical dependency. We will offer telehealth OUD/SUD/MAT support for members with access barriers, including pregnant and postpartum members.

Value-Added Benefits Will Support Improved Perinatal and Neonatal Outcomes

We will address the social determinants of health (SDOH) needs of our perinatal members through value-added benefits and community-based partnerships. We will offer value-added benefits, such as home-delivered meals, to deliver nutritious, prepared meals to members experiencing food insecurity. Recognizing transportation can create significant barriers to care and other needs, we will offer an enhanced transportation benefit for pregnant members, which provides rides to community resources such as WIC offices, food banks and social services appointments. We know baby supplies and resources can be costly but are critical to getting families off to a strong start. In addition to value-added benefits for car seats, we will partner to expand the reach of community organizations who provide baby supplies, parenting resources and other SDOH supports to members and families, such as the Diaper Bank of the Delta, Mississippi SIDS and Infant Safety, and Baby and Me Tobacco Free.

In five states similar to Mississippi, we provided more than $1 million in maternal health grants to support the capacity of more than 25 community organizations servings members and families.

Nurturing Local Partnerships

Approach to Payment for Perinatal and Neonatal Services

Our approach to payment will include the use of alternative payment models (APMs), evidence-based clinical policies and strong utilization management (UM) to drive quality care and enable appropriate care.

Alternative Payment Models and Clinical Policies

Alternative payment models can drive greater provider accountability for care. Our Obstetrical (OB) Quality Gap Closure Incentive will reward obstetrical providers with bonus payments for closing HEDIS measures around timeliness of prenatal and postpartum care. We will propose our Maternity Retrospective Shared Savings program that rewards obstetric providers for achieving quality measures, increasing care coordination and reducing costs. We will provide practices with clinical transformation support tools to improve their outcomes, contributing to increased shared savings opportunities. We will use clinical policies to encourage adherence to evidence-based care. For example, our C-section policy removes financial incentives for early, elective or unnecessary interventions.

Payment Models Drive Results

Our OB Quality Gap Closure Incentive has resulted in a 39% year-over-year increase in prenatal and postpartum rates for targeted providers.

In three states where the Maternity Retrospective Shared Savings program is implemented, initial year one results show providers demonstrating a 4% reduction in C-section rates, accompanied by a 5% savings reduction.

Utilization Management Enables Appropriate Payment for Appropriate Level of Care

We will deploy two UM programs to ensure appropriate care and payment for perinatal and neonatal services. Our NICU UM program will be staffed by board-certified neonatologists and experienced NICU registered nurses who will collaborate with providers to determine appropriate levels of care and facilitate safe and timely discharge to home or lower levels of care. Our Perinatal UM program will include board-certified OB/GYNs and experienced maternity registered nurses who will ensure the appropriate application of evidence-based care for members in inpatient or specialized outpatient care during the perinatal period.

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

Innovative Delivery and Payment Approaches: Building on Core Approach

Driving Innovation and Value

Due to the high prevalence of preterm births in Mississippi, we will invest over **$2 million** in Mississippi to deploy evidence-informed and innovative efforts aimed to reduce preterm rates, severe maternal morbidity and avoidable C-sections.

Evidence-Based Home Visiting in Delta Region: We will invest over $1 million in a multiyear partnership with a national maternal health organization to test an evidence-based home visiting program administered in

collaboration with Historically Black Colleges and Universities. The program will target Black pregnant members in seven underserved counties in the Mississippi Delta affected by disparities in perinatal health such as race, income, education and rural location. Registered nurses, licensed social workers and CHWs who live in and reflect the ethnicities of the local community will perform outreach and program management for pregnant members and their babies from prenatal to two years postpartum.

Remote Patient Monitoring: Chronic conditions, such as diabetes and high blood pressure, place pregnant and postpartum individuals and their neonates at greater risk for poor outcomes. Remote patient monitoring (RPM) for these conditions is an innovative way to modernize maternity care and support management of these conditions, especially where there are access challenges. We will invest $550,000 in RPM for pregnant members with high-risk conditions, such as diabetes and high blood pressure, in at least six provider practices, including FQHCs. Recognizing that chronic conditions disproportionately impact women of color, we will commit to a program offering group sessions with education and social support for Black women and enroll them in high-risk RPM. Led by a physician or nurse practitioner, a CHW and a public health specialist, the sessions will offer education, enhanced understanding of RPM and a space for mom-to-mom social support.

Expanding Access to Group Prenatal Care: Group care programs are an innovative care delivery model shown to reduce preterm birth rates and disparities among Black individuals by combining elements of traditional prenatal care with cohort-based education and social support. We will expand this model in the state to improve outcomes. We will partner with a national prenatal care organization and commit $100,000 to support members in high-need areas.

Increasing Doula Care Options: We will invest $130,000 to launch doula pilots in collaboration with local doula organizations in the Jackson/Metro area and Delta region. Understanding that Mississippi sees some of the worst perinatal outcomes and racial inequities in the nation, and that doula support is an evidence-based intervention shown to improve outcomes, including C-section and preterm birth rates, enhanced experience and reduced disparities in perinatal care, we will offer doulas as an enhanced benefit for all Mississippi high-risk pregnant members.

Doula Benefit for All
We will offer doulas for all perinatal Mississippi members to improve outcomes such as preterm birth, reduce c-section rate and uplift the voices of Black members in their pregnancy journeys.

Addressing the Health Care Workforce Shortage: There is a physician workforce shortage in Mississippi, and OB/GYNs are no exception. With a significant number of Mississippi women receiving care by non-OB/GYN providers, there is often a knowledge deficit of effective contraceptive methods such as long-acting reversible contraceptives (LARCs). A recent study reported that only 29% of family practice physicians and 22% of general nurse practitioners claimed having sufficient experience with LARC insertion. To address this, we will partner with local OB/GYNs and fund up to $200,000 for LARC and contraceptive training workshops for all provider types.

Hospital Quality Improvement and Strategic Provider Partnerships: We will deploy quality improvement interventions that place the patient at the center of the decision-making process, ensure respectful care practices and create a culture of health equity. In 2021, we provided nearly $3 million to a national partner to reduce disparities in maternal outcomes in six states by collaborating with hospitals to improve race/ethnicity data collection to better track birth inequities. In a state of similar demographic makeup, we provided $50,000 for a provider's Mobile Women's Health Program staffed by a nurse practitioner, case manager and interpreter with a goal of expanding access to perinatal care. We commit to bringing this innovation to Mississippi.

Increasing Access to High Quality Care

Improving Care Delivery through Advanced Payment Innovation: To drive improvements in quality and member outcomes, we recommend the Division consider including the following innovative APMs in the final Mississippi Medicaid value-based purchasing work plan. Building on our OB Quality Gap Closure Incentive

previously noted, we propose layering on our health equity incentive, which tiers the incentives with higher payments for improving outcomes among those with the greatest racial disparities. Our obstetrical risk assessment form (OBRAF) incentive rewards providers for timely submission of OBRAF to encourage earlier identification of pregnant members, as we know early engagement is crucial to improving outcomes. If approved, we will offer this incentive to all providers in the state.

d. How will the Offeror address racial, ethnic, and geographic disparities in delivery of and outcomes ...

We recognize the persistent and stark disparities in perinatal birth outcomes in Mississippi. We will work to design and deploy interventions targeting racial, ethnic and geographic disparities. We will apply an equity lens to our approach by engaging and listening to the communities these disparities impact, training staff and providers on disparities and using data to monitor disparities and evaluate outcomes.

Design and Deploy Interventions to Target Disparities: Reducing disparities is central to "what" initiatives we support, "how" we design those initiatives and "where" we deploy them. For instance, our proposed Mississippi investments to expand group prenatal care and doula support are informed by evidence demonstrating positive impact on racial disparities. Our remote patient monitoring investments will address the racial disparities associated with hypertension and diabetes among Black women and geographic disparities experienced by women living in rural communities with limited care access. Our OB-Quality Gap Closure Incentive will increase provider accountability to driving equitable outcomes, and our Home Visiting effort will focus on seven primarily Black communities in the rural Mississippi Delta.

Proven Results for Black Members
As a result of efforts to address disparities in one of our states, the percentage of Black members accessing postpartum care visits increased from 37% to 83%, and timely prenatal care increased from 51% to 84%.

Shape Healthy Equitable Reproductive Outcomes: Through an established evidence-based program, we can transform pregnancy outcomes for Black women and improve overall health and well-being. We will do this by engaging pregnant members exactly where they are, by coupling prenatal education and inspiration with virtual group meetings and individual check-ins for higher risk members. All sessions will be led by culturally sensitive individuals chosen to create a safe, trusted, peer-to-peer and peer-to-professional community. The program will include unlimited access to virtual evidence-based information, maternal-specific remote patient monitoring equipment, mom-to-mom social media and virtual pregnancy celebrations, access to partnered providers and more. This program is benchmarked to achieve 95% healthy pregnancies. At the end of the program, we hope to see healthy women who are equipped to start effective family planning and healthy babies who will transition into our well-baby and well-child programs.

Engage and Listen to Members and Community Voices: To inform our strategies and investments, we will prioritize relationships with our members and community partners and apply insights directly from those we serve. For example, to better understand the perinatal disparities experienced by communities of color in Mississippi, we will conduct enhanced outreach to our members of color based on need. The perinatal care managers will conduct telephonic and face-to-face outreach activities to elevate our members' voices and create opportunities for our perinatal care managers to address barriers to care and connect members to respectful perinatal and neonatal services. Our investment in doula care will further supports member empowerment.

Train Providers and Staff on Disparities: We will offer specifically designed trainings for all providers and their staff to address the impact disparities have on pregnancy and birth. The health equity training was developed in partnership with national partners, including the Centers for Disease Control and Prevention, and a Historically Black College or University medical school.

Use Data to Monitor Disparities and Evaluate Outcomes: Our Mississippi perinatal team and Mississippi quality director will continuously monitor outcomes of all initiatives by race, ethnicity and geography to understand the disparities in the state and make sure resources are focused where they can have greatest impact.

4. Chronic Conditions

We recognize the unique challenges of Mississippi provider shortages that exacerbate health care access issues, systemic inequities that drive significant health disparities and severe socioeconomic pressures that contribute to a high chronic disease burden. Fifteen percent of Mississippians report having diabetes, 70% of Mississippians report being overweight and 82% of Mississippians report taking medication for high blood pressure. We understand that burden of disease in Mississippi is overwhelmingly tied to chronic conditions such as diabetes, hypertension and cardiovascular diseases. Our approach to improving the health of our members with chronic conditions includes a combination of population-based efforts, member-specific outreach, provider-enabled engagement and comprehensive care management supported by our NCQA-accredited quality management program.

a. Describe how the Offeror will implement innovative programs to improve the health and well-being of ...

How We Will Implement Innovative Diabetes Programs

Dedicated to a Healthier Mississippi

Mississippi has a diabetes epidemic.[2] Approximately 308,000 people in Mississippi, or 13.6% of the adult population, have been diagnosed with diabetes. Another 35.6% are pre-diabetic, and this does not include the additional 75,000 Mississippians who have diabetes and may not know it. While the impact on member health is evident, there is also a significant financial impact. Direct medical expenses for diagnosed diabetes in Mississippi are estimated at $3.4 billion each year, and another $990 million is spent on indirect costs from lost productivity due to diabetes.

Foundational to our approach to implementing innovative programs is knowing where and for which members these programs are most needed. We will use our Hotspotting tool, risk stratification and care management systems to evaluate conditions in our communities so we can develop tools, create initiatives and programs and deploy resources where they will be most effective.

Hotspotting: Our Hotspotting tool will allow our teams to segment the population using over 50 filters such as risk factors, geography and demographic data, including ethnicity, diagnosis, type of utilization, cost of care, SDOH needs and mental health or substance use. Hotspotting will provide population summaries and a detailed member-level list to help guide any clinical outreach or intervention. The data can be applied to quickly target interventions for specific subpopulations and is ideal for informing our population health strategy and mitigating health disparities or leveraging local community resources.

Member Identification and Risk Stratification: Our risk stratification engine will use initial Health Risk Screening (HRS), claims data, our SDOH registry, ongoing HRSs, care management referrals and information we gather from members and providers during staff interactions to identify members at risk for or diagnosed with pre-diabetes and diabetes.

Some of the innovative programs we will implement to combat the obesity and diabetes epidemic in Mississippi include:

Healthy Nutrition Programs

Poor nutrition and resulting obesity can lead to pre-diabetes, diabetes and many other chronic conditions. Poorer communities are often food deserts and locations where inexpensive high calorie-high sodium foods are available and promoted more heavily. We commit to launching effective programs to help bring nutritious food and food education to Mississippi through programs like these:

[2] American Diabetes Association

- **Nutrition Education Program:** This program will provide communities with nutrition education, food budgeting and meal preparation programming; engage families through events; and provide referrals for community nutrition resources and ingredients for healthy dishes. In a state of similar size and demographic makeup, more than 8,000 youth and family members have participated in our sponsored nutrition programming. In partnership with a community-based entity, we reached more than 65,000 youth and families with healthy living programs.
- **Home-Delivered Meals:** We will invest **$1 million per year** to bring high-quality, nutritionally tailored meals with menus designed by dietitians and professional chefs, tailored to health conditions. This program will provide members the power to choose what they want to eat. These meals will be nutritionally balanced, diabetes-friendly, renal-friendly and heart-friendly. We will partner with a community care package and meal service program that offers vegetarian options, pureed meals for those with difficulty swallowing (dysphagia) and meals for cancer support (higher in protein and calories to help prevent weight loss).

Social Determinants of Health – Fitness Program

We will offer a complete fitness solution where eligible members can customize their fitness routine with unlimited access to a large network of fitness locations nationwide, plus a digital library of more than 20,000 on-demand and livestreaming classes, including cardio, strength, yoga and a workout builder to create personalized workouts that walk members through each exercise. This program will support an individual's interests, goals and needs to help them live their healthiest life — all with the convenience of a single membership. We are committing to **over $600,000 per year** to bring this program to our members. Offering a digital fitness program will help to address the disparities in access to safe and adequate exercise facilities in a mostly rural state where transportation and poverty can limit even the most motivated person to take control of their fitness. Promotion of fitness combined with health nutrition is the foundation of managing both diabetes and obesity and improving cardiovascular health.

Advancing Population Health Outcomes

Virtual Patient Monitoring – Diabetes: Our virtual diabetes management program is an interactive remote patient monitoring (RPM) program we will use to monitor blood glucose, food intake and insulin use along with weight and blood pressure through Bluetooth connection to an app. Program participants will receive a free advanced blood glucose meter with unlimited lancets and test strips delivered to the member's home. The program includes 24 hours a day, seven days a week live coaching and real-time nurse monitoring. Nurses will respond to alerts if a member's glucose is out of range, or the member has not tested as scheduled. Virtual diabetes management includes alerts to the member's PCP and personal caregivers. An artificial intelligence (AI) coach will deliver messages tailored to the member's behavior and help the member make correlations between behavior and actions, enabling member condition self-management.

Driving Innovation and Value

Local Monitoring and Management: This RPM partnership will include close communications with the medical staff at a local medical center to cross-refer patients and provide strong care management supports for these members. Remote patient monitoring beyond the defined benefits of MississippiCAN and CHIP will be expanded to allow for more intensive services aimed at better diabetes control and overall health. This will allow members who would typically need to travel far distances to the nearest provider for care to stay in close contact with the clinical staff needed to help manage their care.

b. Describe the Offeror's direct experience in service delivery and payment and/or capacity to manage service ...

Our service delivery and payment programs for chronic health conditions cover more than 4 million members in more than 25 sates. We support families and children with high prevalence and debilitating chronic illnesses, such as cardiovascular disease, asthma, diabetes, HIV/AIDS and high-risk pregnancies. Our approach to payment for services rendered for chronic diseases leverages a suite of alternative payment models (APMs) to

support provider enablement, clinical intervention pathway tools, such as our behavioral health tools for providers and comorbidities job aid for PCPs and other providers, and traditional billing and claims support, including encouraging electronic transactions. We will use evidence-based clinical policies and strong utilization management (UM) practices to drive quality care and ensure appropriate payments for appropriate care. We will employ field-based and office-based clinicians to manage members and work with providers.

In addition to traditional reimbursement for services, our VBP will include incentive opportunities to address chronic conditions. All proposed VBPs for Mississippi will include efforts to improve HbA1c. Central to our hospital VBP, and aligned with the Division's efforts to reduce readmissions, we propose including hospital VBP that includes measures for COPD, asthma and cardiovascular disease.

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

Our Approach to Care Delivery for Chronic Health Conditions

We strongly encourage the PCMH model and want all members to benefit from engagement with a medical home. Our member and provider resources will be designed to support co-management of chronic diseases with PCMH and non-PCMH PCPs, and we will purposefully seek specialists for our network based on quality. We will work with PCPs to make sure they are equipped to care for members with chronic diseases, and we will assist with navigating specialty care when needed. Our network of hospitals, primary care, specialty care, hospital, dental, dialysis, vision and behavioral health, urgent care, pharmacy and key subspecialty providers will provide members access to medically necessary covered services.

Member and Provider Education and Outreach

We will support our members and providers in the management of chronic conditions through our communication strategies. We will provide information about chronic illness management to all members through our population-based wellness awareness campaigns. We will use health fairs, clinic days, member workshops and home visits to meet members in their communities, encourage preventive care and help those living with diabetes, sickle cell, cardiovascular disease, chronic lung diseases and asthma on the road to self-management. When members are diagnosed with a chronic condition, we will send reminders and make live and automated calls reminding them of services that are due or past due. We will provide disease-specific education and outreach and support providers in their efforts to engage members in self-management through provider enablement tools.

Population-Based Wellness Awareness Efforts	**Member-Specific Outreach**	**Provider-Enablement and Partnership**
Each communication channel provides regular content focused on timely wellness: ▪ Member materials and handbooks ▪ Quarterly member newsletters ▪ Community health events ▪ Community health initiatives with community-based partners	Triggered by data in our care management platform and quality reporting systems that note gaps in care, members receive individualized outreach through: ▪ Mailings, emails and member portal communications ▪ Automated and live telephone outreach ▪ Care manager or service navigator outbound call ▪ Face-to-face engagement with CHW/care manager, peer support or other care team member ▪ Member incentives programs	The following tools are targeted to encourage gaps in care closure: ▪ Sharing HEDIS analytics for patient panel ▪ Provider scorecard ▪ Provider portal with member gaps in care noted ▪ PCMH and CMHC case consults for medium- and high-risk members ▪ Quality incentive programs

Care Management

As part of our evidence-based approach, we have coalesced extensive research to create condition-specific care pathways that guide our care managers' intervention approaches. As described in response to question a. above, we will use HRS information and data through our predictive modeling engine to identify and risk stratify members with chronic conditions. Conditions such as chronic obstructive pulmonary disease (COPD),

congestive heart failure (CHF), diabetes and SUD, for example, will have defined interventions and engagement strategies grounded in the most current evidence and aligned with a readiness to change model. By connecting members who have unmanaged or chronic health conditions with targeted, condition-specific tools and services, we will help them self-manage their conditions to prevent future exacerbations.

Our Approach to Payment for Chronic Health Conditions

Driving Innovation and Value

To improve quality and member outcomes, we recommend the Division consider the following innovative APMs in the final Mississippi Medicaid value-based purchasing work plan.

Our Quality Gap Closure Incentive Program focuses on closing gaps in care and improving quality outcomes. This model includes key HEDIS® and CMS Core Set metrics aligned with state quality objectives, such as asthma, diabetes care, cancer screening, well-child visits, prenatal and postpartum care, readmission reductions and preventable ER use. We will design flexible provider incentives to meet the ongoing and changing priorities of the Division and our members. Participating providers will receive standard reimbursement and opportunities to earn additional incentive payments for closing gaps in care. This program will be deployed widely to PCMHs, and PCPs including FQHCs, RHCs, and pediatricians.

PCP Member Engagement Bonus: We propose using a member engagement bonus for PCPs. In this program, PCPs will be rewarded for improving access to preventive care by engaging hard to reach members, getting them in for an annual visit and addressing care opportunities, including annual screenings and/or immunizations.

We will address disparities in member health outcomes through **our proposed Health Equity Incentive** for PCPs/PCMHs. While all our APMs address health equity by identifying members with care opportunities, we know improving health equity and reducing disparities in outcomes requires focused intentional strategies. This program aims to address disparities for key HEDIS measures important to the Division. In this program providers can earn higher incentives for bringing members in for care and decreasing disparities.

Shared Savings for Improved Quality and Savings in Chronic Conditions

To help improve the management of diabetes, we propose using our **Diabetes Shared Savings** program, which builds on standard reimbursement and offers shared savings opportunities dependent upon clinical outcomes and total cost of care. This approach will give the provider who is accountable for diabetes management the opportunity to be rewarded for quality and savings. We hope to pilot our Diabetes Retrospective Shared Savings program in Mississippi as willing providers are identified. In addition to our Diabetes Retrospective Shared Savings program, we have other chronic condition retrospective shared savings programs that could impact care in Mississippi. These programs focus on critical, high-cost conditions and procedures such as asthma, COPD, cardiac and gastroenterology procedures and opioid use disorder (OUD).

In our diabetes shared savings program, we saw a 2.5% improvement in the management of diabetes from providers participating in this program from 2017 to 2020.

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

Our community-based initiatives to close gaps in care and reduce health disparities initiative has already committed **more than $8 million** to communities on projects such as partnering with an urban Public Housing Agency and local providers to address childhood asthma in public assisted housing. This initiative is the evolution of efforts we have executed in five other communities with community, family, and individual needs similar to those faced by Mississippians.

Cardiovascular Disease and Hypertension Task Force: Our medical director and clinical leaders will meet regularly to review member data and trends to identify opportunities for improved outcomes. This approach was developed in a state of similar size in response to the link between chronic diseases and disparate COVID-19

infections, hospitalizations and mortality rates. In the similar state, we adopted an evidence-based "Tuck-in" program, in partnership with willing providers, and used a telephonic care management model that could be followed with field-based interventions. Members were selected based on diagnosis and received 1:1 weekly outreach from a care manager to assess vital signs, medication adherence, diet and physical activity. The care manager ensured members were connected to services, supports and supplemental resources. In the similar state, our local field-based nurses worked directly with the members' PCMHs to assist with any needed medical interventions related to their cardiovascular disease. **We launched the program in 2021 with three willing provider groups, and over the course of a year, there was an observed 42% reduction in ER utilization and 72% reduction in hospitalizations.**

Unlimited PCP and PCMH Visits: We believe continued access to care is essential for the health of all Mississippians, including supporting continued care for those with chronic and providing preventive services to prevent further development of chronic conditions in the future. **We commit to investing over $700,000 annually** to support unlimited primary care visits to manage medically necessary conditions.

Targeted Text Messaging: Our national clinical quality texting project focuses on the members**'** preference for how they want to communicate. The goals of the program are to improve member outreach, engagement, and satisfaction while better empowering them to manage their health. Live now in 17 states, the texting campaign is an opt-in program for members who receive targeted text messages for diabetes management and three other categories, including well child, pregnancy and overall women's health.

Community Partnerships: We will work with local partners and build upon our national relationships to support communities across Mississippi. We will partner closely with the Mississippi chapter of the American Diabetic Association to increase testing for HbA1C and support education activities through community-based events. Similarly, large health-focused local organizations can be especially effective in helping providers and members co-manage chronic diseases. The Community Health Center Association of Mississippi is especially critical to this approach, and we will partner with them to build upon their strong history of enhancing the quality of care for members with diabetes across the state.

Value-Based Purchasing with Pharmacies: Members with chronic diseases have trusted relationships with their pharmacies and visit them more frequently than they visit their medical providers, which provides an opportunity to engage members more often. We plan to partner with Pharmacy Quality Solutions (PQS) to implement an outcome-based performance program in collaboration with Mississippi pharmacy providers, incentivizing pharmacists who provide enhanced pharmacy services, such as medication adherence counseling for members who are/are at risk for noncompliance and management of hypertension, which includes the measurement of blood pressure values. A recognized leader in managing performance information for pharmacy-related quality measures, PQS is already engaged with 92% of pharmacies in Mississippi, and this VBP will represent one of the first programs in the country where a health plan has established a value-based arrangement with community pharmacies to controlling blood pressure.

Mitigating Environmental Triggers for Asthma: In 2017, the overall asthma prevalence among Mississippi's children ages 0 – 17 was 11.4%, disproportionally affecting more Black children than white. Environmental triggers are the most common reason for exacerbations. Dust mite and cockroach infestations have been identified as a driver of exacerbations of asthma in children. Children who are exposed to these pest allergens have three times as many asthma hospitalizations per year compared with other children with asthma. We will offer pest control treatment to MississippiCAN and CHIP members who have been identified to have a pest problem by care management screening, home visits, assessment tools, provider referral or self-referral.

Medication Management at Hospitals: We will deploy a clinical medication management program that builds on the medication reconciliation process performed by hospitals. A hospitalization for a chronic disease is unfortunate, but it provides an opportunity to re-evaluate a member's care plan. We have medication

management programs that are built on partnerships with hospitals. We commit to embedding clinical pharmacists in willing hospitals to better manage members' medications and make sure all necessary prescriptions are filled and the replaced ones are properly discarded.

e. How will the Offeror address racial, ethnic, and geographic disparities in delivery of and outcomes ...

For those who face obstacles to health due to characteristics such race, ethnicity and geography, the consequence is a disproportionate burden of disease borne by our most vulnerable populations. Addressing health disparities in the delivery and outcomes of our members with chronic conditions cannot happen in a vacuum. It is more than a health problem; it is a community problem and, as such, requires the involvement of the entire community.

Analyzing and Understanding Barriers

We will stratify performance measure data quarterly by race/ethnicity, language, gender and geography to monitor and analyze disparities across all teams.

Designing and Deploying with Community Partners

We understand and are tackling the complex structural drivers and root causes of disparities and we will actively and collaboratively design innovative solutions and deploy them in the community.

The prevalence of asthma in Mississippi is among the highest in the country and disproportionately impacts Black children. We will combat this issue by **investing $50,000 annually** in partnership with an organization that is dedicated to addressing the social determinants of health and advancing racial and health equity through the creation of healthy, safe and energy efficient homes. A key strategy in addressing asthma is improving air quality by removing pests, mold, tobacco smoke, volatile organic compounds (VOCs) and other asthma triggers. The mission of our local partner is to eradicate unhealthy housing and inequities for children, seniors and families to ensure better health, economic and social outcomes for low-income communities of color.

Evaluate our Impact and Evolve

We will evaluate the impact of our solutions for our members by reviewing population-level outcomes for targeted communities. For example, we will implement a provider targeted incentive, the Health Equity Incentive program that will aim to address disparities seen between populations for key HEDIS chronic condition management measures important to MississippiCAN and CHIP members. In this program providers can earn higher incentives for bringing members in for care and decreasing the disparity seen between the two populations. The outcomes of this program will be monitored in a Quality Provider Scorecard that will be updated twice a month. The scorecard is available to providers on demand via the Provider portal and will track progress of improving quality scores by race and ethnicity.

5. Foster Children

a. Describe the Offeror's experience or capacity to manage the care of foster children, and your ability to ...

Over the past five years, we have served 95,000 unique children and young adults in nearly 20 states who have experienced similar trauma, vulnerabilities and health care needs as those in foster care in Mississippi. Our trauma-informed care model uses the philosophy that trauma presents on a spectrum; therefore, working with people who have experienced trauma emphasizes the need to infuse trauma-informed principles into our everyday work. Those principles include **safety; trustworthiness and transparency; peer support; collaboration; empowerment, voice and choice; and cultural and gender issues.** The dedicated staff who will serve our children in foster care will have child welfare experience and will receive ongoing training in trauma-informed care and related topics. Secondary trauma needs to be at the forefront of policy, prevention, training and care. We have developed extensive training on the importance of secondary trauma, specifically what it is and how to prevent it. We will require annual training for all member facing staff and we will offer trauma-informed care training for all providers serving foster children.

Care Management Tiers and Assignment for Children in Foster Care

We recognize the complex needs of children in foster care, especially those in temporary placements. We will initially stratify every child new to the foster care system or new to our foster care program as high risk. All children will be assigned to a specialized foster care team, comprised of care managers and service navigators. All children in foster care will be assigned a designated care manager as their primary point of contact. We will match children in adoption assistance with a service navigator who will be their primary point of contact, unless we identify them as medium or high risk, at which time we will match them with a care manager. The navigator can route any child to a care manager if an urgent or immediate need is identified for engagement and crisis management.

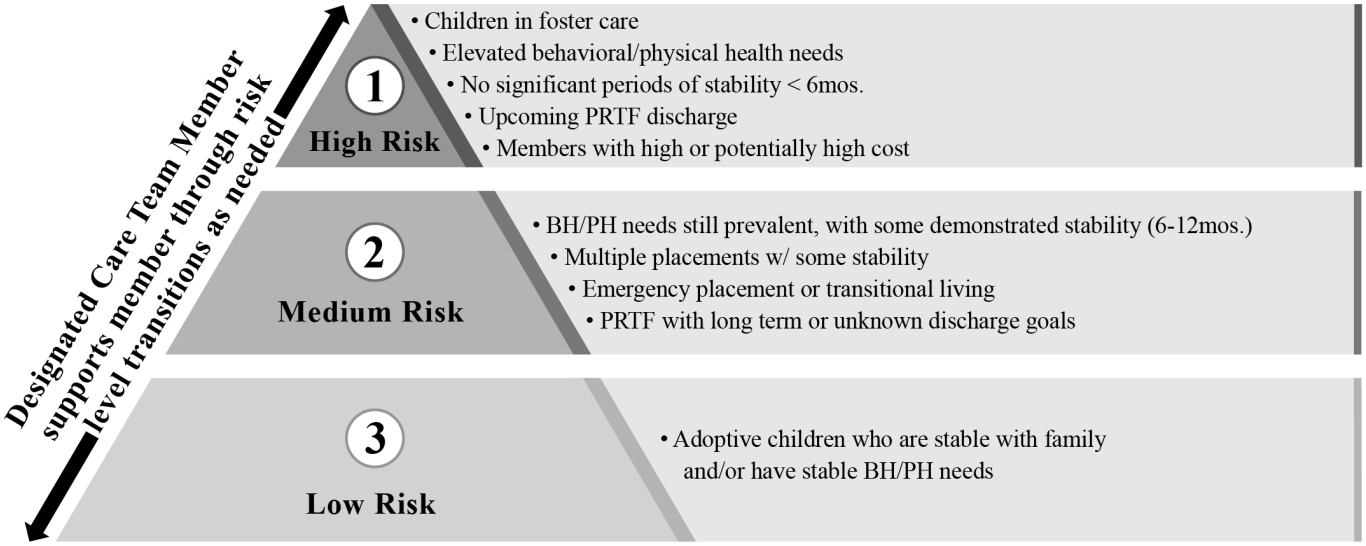


Figure 3. We will tailor interventions based on the child's identified needs.

The care management team will complete assessments on every child; they will use the Health Risk Screening (HRS) to determine immediate needs and the **National Child Traumatic Stress Network Child and Adolescent Needs and Strengths (NCTSN CANS) assessment to** determine ongoing needs of the child. The NCTSN CANS assessment, completed at least annually, will be used in conjunction with the type of placement and symptom stability to further determine a child's ongoing risk level and intervention needs. Care managers will further use the CANS to identify additional medical, behavioral and SDOH needs (i.e., recreational and school needs) to quickly engage the outpatient and community services that best fit their needs before escalation and to enhance resilience. Our specialized foster care team will monitor additional data, such as claims, pharmacy and authorizations, to identify any emerging needs the children may have that require additional interventions.

Our care management staff, care managers and service navigators, will have child welfare experience and specialize in resolving issues related to the system of care. We will train all care management staff in trauma-informed care and Mississippi-specifics of the foster care system. They will help families navigate through and explain the program and benefits of the plan and care management services. Care managers will either be an RN or a licensed behavioral health clinician with expertise in trauma-informed care and integrated physical and behavioral health backgrounds.

Our care team will be located throughout Mississippi in the communities where our foster children live. We will assign children to care team members who understand the child's community and available resources. The assigned care team members will remain constant for the child throughout their enrollment in the foster care program. Our model is sensitive to the need of maintaining strong attachments and continuity of care for our children. We will work with the Mississippi Department of Child Protection Services (MDCPS) and use our

heat mapping technology to identify areas in Mississippi with the highest foster care population, realizing the geographic needs will naturally shift to help determine where we will hire staff.

Comprehensive Care Management and Population Health Approach

The table details our foster care interventions above those required in Section 7.5 of Appendix A, Draft Contract. The following interventions are at a minimum and may vary based on the child's needs.

Risk Level	Interventions	
High	Assigned to a licensed care manager Biannual NTCSN CANS Pregnancy support and management Inclusive of all lower-level tier interventions	Assigned to interdisciplinary treatment team (ITT) Contact at least every 30 days: ▪ Face to face or virtual every 90 days ▪ Telephonic other months
Medium	Assigned to a licensed care manager Annual NCTSN CANS Inclusive of all lower-level tier interventions	Contact every 30 days: ▪ Face to face or virtual every six months ▪ Telephonic other months
Low	Assigned to a navigator Referrals to providers and community-based organizations (includes education and monitoring) Completion of Health Risk Screening Initial NCTSN CANS Assessment Trauma-informed education	Foster/adoptive peer mentoring (upon request) Coordination with MDCPS Transitional living education Tracking and escalation of wellness checks Behavioral and medical education monitoring Contact every six months – telephonic

Care Management Programs for Children in Foster Care

We offer the following specific care management programs rooted in evidence-based practices and targeted for children in foster care.

- **Early and Periodic Screening, Diagnosis and Treatment (EPSDT):** Our comprehensive approach to ensuring access to EPSDT services includes provider education and support; child, family and MDCPS child protection worker outreach and ongoing monitoring of performance. We will provide education early and frequently throughout involvement in our program, including wellness reminders that are aligned with recommendations of the American Academy of Pediatrics (AAP) periodicity schedule for escalated well-child exams for children and youth in foster care. These escalated well-child exams will include physical, developmental, behavioral, trauma screenings and anticipatory guidance for foster and adoptive parents. We will track where every child is regarding each of the indicated preventive care items.

  In a state with a similar population to MississippiCAN, over 92% of our foster care children and youth completed their EPSDT 30 day comprehensive exams in 2020.
- **Behavioral Health Support:** Care managers will support referral of children identified through screenings to community trauma informed clinicians to meet their behavioral health needs, including issues around trauma and attachment occurring during or before being placed in foster care.
- **Adolescent Behavioral Health Support:** We will provide children in foster care a mobile app to help them with behavioral health needs. The app will have features such as daily mood tracking, coping tools, day-by-day guidance built on clinical techniques, guided journeys, weekly check-ins to track progress and a comprehensive toolkit to help them manage stress and find focus.
- **Independent Living Transitions Program:** We will provide an educational platform for transitional age foster youth to learn life skills. This tool will allow social workers to work with youth to customize goals to mirror transitional living plan. It will help children in foster care learn transitional life skills related to employment, health, housing, education and transportation.

- **Psychotropic Program:** Our care management team will work with our pharmacist to conduct a retrospective review of the child's pharmacy claims for potential instances of inappropriate utilization of psychotropic medications. Children will be identified based on utilization of four or more psychotropic medications, two or more psychotropic medications in the same class, or the prescribed use of psychotropic medication "as needed." Our pharmacist will review any child under age three prescribed stimulants, under age four prescribed antidepressants and under age five prescribed antipsychotics. A monthly interdisciplinary meeting will be held consisting of care managers, our chief medical officer, the behavioral health director, and clinical pharmacist, with care manager outreach to providers post-review as needed.
- **Early Intervention Program for Ages 0 to 6:** Our care team will provide referrals to help meet the developmental needs of children by assessing for developmental delays in one or more areas of development, atypical development, or a diagnosed physical or mental condition with a high probability of resulting in a developmental delay. We will provide referrals to First Steps for all children with elevated blood lead levels or who experience developmental delays to Early Head Start and Head Start.

Addressing Immediate Care Coordination for Children Taken into Care: Our process and system will allow MDCPS workers or foster caregivers to contact us on behalf of a child in foster care 24 hours a day, seven days a week through our nurse line. The service navigator team will have extended hours (7am to 8pm CST Monday – Friday) to meet the needs of coordinating care for children in foster care.

b. Describe how you would work collaboratively with the State of Mississippi through the MS Department of ...

We have experience in numerous states working collaboratively with state agencies to make sure kids get the care they need when they need it. When evaluating medical necessity, we will consider the unique circumstances of foster children within the bounds of what is allowable for appropriate continuation of treatment. For instance, if a youth is receiving treatment from a psychiatric residential treatment facility (PRTF) and unable to participate in family therapy due to safety concerns or lack of an available parent, we will either forgo the family therapy requirement or allow the MDCPS social worker or designee to participate. We will provide alternate means of participation such as telehealth so the home county worker can participate if needed. If a foster child changes eligibility groups, we will work with MDCPS on continuity of care. We will coordinate with MDCPS, physical health and behavioral health providers to share the most up-to-date medical records for members in foster care in a variety of ways, including developing working relationships with MDCPS workers and sharing data through our data sharing technology suite, as depicted in the flowchart.

Our systems support electronic data interchange (EDI) that allows for easy integration with state and federal information technology systems and data sources. Securely maintaining and sharing medical records of children is essential to the continuity of their care across varied delivery systems, care settings and placement changes. To that end, we have developed platforms to share data in a secure and user-friendly manner. Our system will require minimal customization and will be configured as needed for Mississippi-specific rules.

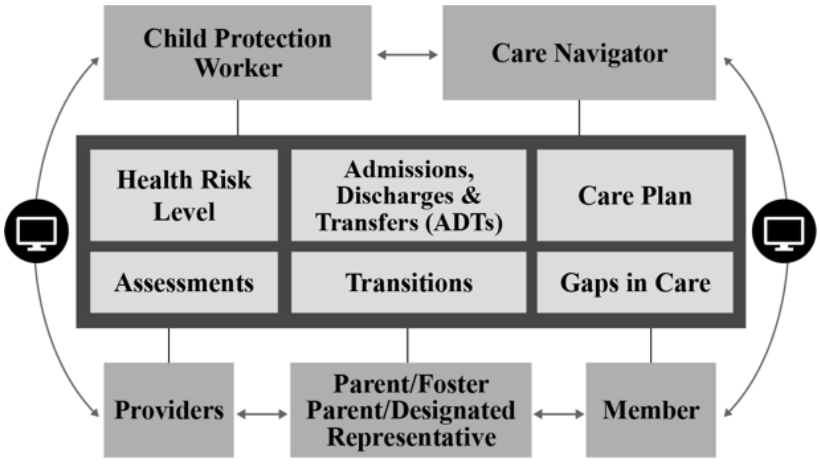


Figure 4. Secure Sharing: We enable collaboration among the child's navigator, MDCPS worker and appropriate state agencies using our secure, cloud-based data sharing technology suite.

Experience and Approach to Partnering with State Agencies

In a state with a similar program to MississippiCAN, we co-locate staff within county agencies. To promote the sharing of real-time information about children in foster care, we will work with MDCPS to co-locate our staff in high-density counties and MDCPS offices, as space and staffing allows. We anticipate the outcomes of having our staff placed in these locations will include creating strong relationships with the agencies; collaboratively completing timely assessments with the agencies; triaging emergent issues efficiently; and providing resources related to claims, network and billing issues.

Our care management team in another state with a foster care population similar to that in the MississippiCAN program piloted a program for children and young adults at high risk for placement disruption. The pilot, done in collaboration with the child welfare division, focused on developing processes to quickly identify children entering care. The immediate notification from child welfare includes detailed information, allowing our care managers to quickly complete the NCTSN CANS assessment and treatment plan and share this with the child welfare case manager. This level of coordination, collaboration and ongoing feedback loop has continued for the children in the pilot. All children were stable at last outreach. We are committed to working with MDCPS to consider this collaboration and a similar program in Mississippi.

Improved Coordination of Care
Within the pilot, 93% of the children were reunified, adoptive or in stable foster care placement. It improved the communication of the child's needs and improved the correct matching of services.

c. Describe your capacity to provide MDCPS access to all data and documentation (withstanding proprietary ...

Providing Health Record Access to MDCPS and Providers

Our care management platform is our electronic health record and will allow the child's integrated care team to develop a treatment plan that meets their needs, goals and desired outcomes; monitor the child's progress; and identify acute events so the care team can coordinate interventions. **The secure care management platform will be accessible to providers and MDCPS workers.** The platform will facilitate the delivery of integrated and coordinated services and supports across systems. The care management platform will include:

- The treatment plan, including care preferences, prioritized goals and interventions needed to achieve them
- Strengths, needs and cultural discovery assessment results, recognizing individualized social, behavioral, medical and functional needs and circumstances
- The child's use of physical and behavioral health and SDOH services
- The names and contact information of the individuals on the child's ITT
- The care team's prioritized health concerns, issues, intervention strategies and self-sufficiency goals
- The child's claims data, pharmacy claims, condition list, medications, service dates, history, immunizations, provider visits, diagnoses, issues, case conference notes and lab results

We can provide reports, such as the 30-day initial comprehensive EPSDT exams, annual well-child visits, visits with specialty providers, services from peer mentors and others at the request of the state.

Providing Health Record Access to Foster and Adoptive Parents

With appropriate permissions from MDCPS, foster parents will be able to access the member's health record. Adoptive parents will access their child's member's health records through the member portal. The member's health record will provide an integrated dashboard of the child's health records, with a detailed view of claims, prescriptions, problems, opportunities and gaps in care, immunizations and more.

Access to Raw Claims Data

In addition to MDCPS workers having access to the member health dashboard, we will share claims data with MDCPS to document the progress of each child's case. We will work with MDCPS on the best way to share this

information. We will coordinate with external partners, such as the Division, to validate data exchanges are complete and valid. Firewalls and physical separation of processing systems will secure access to prevent unwanted entry.

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

Having systems and services in place to address children's specific needs can help improve their overall health and well-being. In addition, these systems and services can increase their chances of reunification, secure a sustainable placement in a loving and supportive family, or achieve a successful transition to adulthood. Following are several examples of innovative approaches we will introduce to children in foster care in Mississippi.

On the Forefront of Training for Staff, Providers and Families in Mississippi

Recognizing the importance of equipping those directly responsible for the care of children in foster care with the appropriate knowledge on how to care for this population, we will offer the following innovative trainings:

- **Staff Training:** Trauma-informed care including secondary trauma and NCTSN CANS administration
- **Caregiver, Transitional Age and Former Foster Youth Training:** Individualized training based on need on transitional living, aspects of trauma-informed care and self- and co-regulation
- **Partnership with National Foster Parent Association:** Training for caregivers, adoptive parents and child protection workers on the needs and development of foster and adoptive children and families.
- **Online Provider Education:** Free accredited education offering continuing medical and professional education units to providers on a variety of subjects related to foster care, physical and behavioral health.

Co-location of Staff

As mentioned, we will co-locate staff within MDCPS offices as an effective and innovative approach to increasing communication and collaboration with individuals supporting our foster children.

Peer Mentors and Targeted Programming

Understanding the importance of supporting transitional age and older youth and the Division's goal of increasing collaboration, in other states with a similar population, we will hire peer mentors to support both caregivers and transitional age and older youth. These specialized peer mentors are former foster youth and current or former foster parents who work with older youth on developing life skills and coping skills. They will use real-life experiences and an Independent Living Transitions Program designed specifically for youth in foster care, which provides education and activities related to transitioning into adulthood to help youth develop life, self-advocacy and coping skills in the area of health care, education, transportation, job skills, housing, money management and other needed areas. **From 2018 through July 2021, in a state with a similar population to Mississippi, 933 transitional age, older and former foster youth have received some type of life skill or foster/adopt peer mentor services from our care management team.**

e. How will the Offeror address racial, ethnic, and geographic disparities in delivery of and outcomes ...

We are committed to addressing health inequity in all aspects of our business and metrics of success. This means bringing intentionality to our work and using additional methods to find root causes of disparities faced by our members. Nationally, 76.1% of children enter foster care due to neglect, which is often unintentional and related to poverty, since poor housing conditions or food insecurity can increase substantiated and unsubstantiated reports for low-income families. Whether engaging in or not engaging in social services because of poverty, the scrutiny involved with lack of resources, often leads to interaction with the child protection system. Poverty increases parental stress, which can trigger family crises including substance use, mental health issues, including depression, intimate partner violence, all of which increase the likelihood of child abuse and neglect. Our health equity approach will include engaging and listening to community voices,

analyzing and understanding barriers (e.g., poverty, LGBTQ+), designing solutions with community partners (e.g., peer mentors) and evaluating effects of our solutions. We will apply an equity lens to our programs and services for children in foster care through:

Educating Providers and Social Service Agencies: We will work toward educating providers and social service agencies about implicit and explicit bias, trauma and trauma-informed care and social determinants of health. We have relationships with the National Foster Parent Association and the National Child Traumatic Stress Network to provide trainings and resource materials to providers, agencies and family members about bias, the effects of trauma, including generational trauma and relevant resources. Our educational platform will offer educational courses on the intersectionality of health disparities and populations who are more at risk.

Using Peer Mentors: Our peer mentors, using their experience with the child welfare system, will help address health disparities by helping families access external and internal resources to feel more confident and successful when engaging with the child protection, social services and health care systems.

Investing in Solutions: Many children in foster care do not have bags or luggage they can carry from placement to placement. To help reduce stigma of not having a way to carry their things, we will provide 17-inch unbranded backpacks in assorted colors to children and young adults in foster care age 3 to 17. Each backpack includes a blanket, socks and assorted toiletries. In addition, we will provide an interactive mobile and web-enabled game to help children in foster care learn about six key areas that have historically prevented transition age youth from achieving stable, independent lives. These areas include money, housing, work, education, health and transportation. Recognizing many young adults in foster care have fragmented documentation, the mobile and web application will allow them to have a repository of their most important documents (e.g., birth certificate, driver's license, individual education plan, insurance card, health record) in a secure, easily accessible location.

6. Dental Services

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

We have more than three decades of experience managing employer-sponsored, government and individual dental programs across the United States, serving more than 20 million members nationwide through a network of more than 405,000 dentist access points. We are currently managing state Medicaid dental programs in more than 15 states and have extensive experience administering programs similar to MississippiCAN and CHIP. Dental care will be fully integrated into our database so that we can effectively include dental services in our person-centered care approach.

We will process dental claims through a highly modular administration system that incorporates benefit/product design, enrollment, provider authorization determinations, claims and reporting. This system will support mandated HIPAA-compliant health care transaction sets to facilitate automated EDI data exchanges and is a thoroughly vetted, integrated platform specifically designed to manage Medicaid dental claims based on each state's mandated dental benefit designs, frequency limitations, benefit exclusions and annual plan maximums. The system is HITRUST CSF certified and accredited by the Utilization Review Accreditation Commission (URAC) for health utilization management and claims processing administration with claims review and appeals. Able to process both paper and electronically submitted claims, the system will accommodate and process all dental claim types and submission modalities regardless of the submitting provider's technology and supports claims management; critical upstream functions, such as enrollment management; and critical downstream functions, such as claims processing accuracy, financial accuracy, coding accuracy, service utilization tracking and encounter data generation.

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

We will offer a comprehensive oral health strategy with unique clinical care programs that will meet the state's request for dental value-adds for preventive care during pregnancy and postpartum, which provides enhanced dental services including coverage for additional exams, minor restorative, and periodontal services. In addition, we will enhance our CHIP coverage by including additional diagnostic and periodontal services. We will focus on appropriate utilization consistent with dental industry standards of care, positive provider relationships, growing and maintaining our Mississippi Medicaid network, and conducting community outreach to promote good oral health habits.

Network Management: Staffing will include Mississippi field-based provider relations support to serve as point of communication for dental providers. Our provider relations representatives will offer training, program support, problem solving, and spot network recruitment to ensure we are 100% compliant with Mississippi access requirements and will actively engage with the Mississippi Dental Association, and its pediatric subgroup. Our Mississippi dental network will include safety net providers, including all FQHCs, Department of Health Consultants, Rural Health Clinics, the UMMC School of Dentistry, and MHS Mobile Dental.

Dental Care Management (DCM): Through our DCM program we will assess and identify the member's risk level through a dental health risk assessment (HRA) and provide DCM services for high risk or special needs members. Our dental care manager will work with members identified as high risk for oral health needs, including pregnancy (perinatal and post-partum) and children who qualify based on social determinants of health (SDOH) with at-risk conditions, including cancer, diabetes, asthma, HIV/AIDS, autoimmune diseases, and children with physical, intellectual, or other disabilities. DCM services will include: monitor and assess adherence to goals; complete a comprehensive review and assess each member's health conditions, oral health habits, and the member's physical, behavioral, cultural, and preferred language needs; coordinate member care with their dental home provider; create and monitor a member dental treatment plan; facilitate the care process by removing access barriers and helping locate resources; engage and educate members or their parents/guardians on the importance of practicing good oral health habits and following their treatment plan.

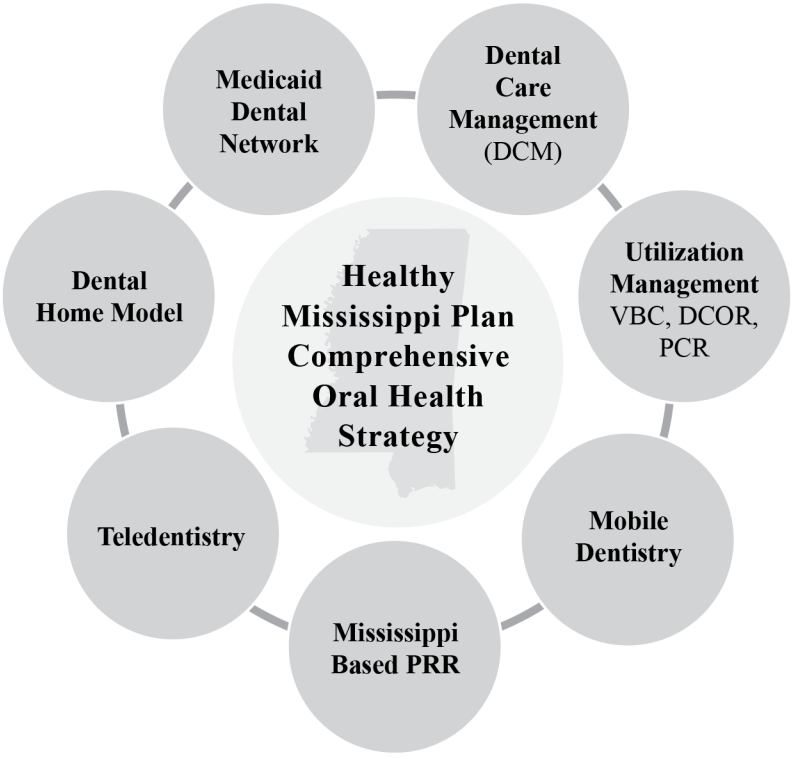


Figure 5. Mississippi Comprehensive Oral Health Strategy

Value-Based Purchasing: We will use our broad experience and infrastructure to engage dental providers in VBP. Our VBP model will provide flexibility and scalability for providers while shifting the focus of the dental delivery system toward preventive care, improved care coordination, and reduction of adverse health outcomes and disparities. Selecting the right performance metrics for a VBP arrangement is critical to driving innovation, action, and alignment of provider performance with state public health priorities. We will offer a new VBP dental compensation model in Mississippi through which providers will be eligible for incentive compensation based on their office utilization for periodic oral evaluations, annual dental visits, sealants for children with elevated caries risk, prophylaxis, and topical fluoride varnish applications for children at elevated caries risk

performance. We will target high volume dental providers for this model and, as appropriate, evolve quality metrics to achieve alignment, streamline administration, and maximize impact among providers.

Dental Home Model: Our first dental home program for children was successfully launched in 2015 in a state similar to Mississippi and was expanded in 2019 to include members age 21+. This program assigns all eligible Medicaid and CHIP members to a dental home to ensure access to oral health care. This dental home coordinates with the member's medical home to support the overall health of the member.

Our Dental Home Model demonstrated proven results in achieving and exceeding state requirements for an ADV metric of 55.5%. We achieved consistent ADV metrics ranging from 62.1% to 63.0% from 2016 through 2019, which is significantly higher than the NCQA national average of 55%.

We will implement our Dental Home Model program to promote network access, Annual Dental Visit (ADV) utilization, continuity of care, and ER diversion, with members assigned to a contracted provider for their dental care. Our approach to dental home assignment will be to align the member with their current dental provider, when possible. The assignment logic will be based on recent dental claims utilization; when claims history is unavailable, we will use geographic assignment based on the member's home ZIP code. Members will have the choice to change their dental home provider assignment at any time.

Teledentistry: We will implement a comprehensive teledentistry solution to provide eligible members with access to at-home phone and video consultations. In addition to covering teledentistry services offered by network dental providers, we will partner with our experienced teledentistry provider to offer 24 hours a day, seven days a week access to virtual visits with licensed dentists, providing guidance on an array of oral health issues and guidance to an appropriate setting for in-person care with their dental home provider or other available network provider. Embedded as a covered benefit or service, our solution can reduce unnecessary ER visits and offer diagnostic services that will reduce overall costs by providing early detection and treatment recommendations.

Utilization Management (UM): We will offer the following UM tools to ensure appropriate utilization and treatment patterns in Mississippi:

- **Dental Care Opportunity Report (DCOR):** A customized provider reporting tool that will reflect practice-level performance data and identifies member engagement and educational opportunities related to key dental quality outcome measures. We will provide the DCOR to our high-volume Mississippi dental providers to help close gaps in care.
- **Peer Comparison Report (PCR):** Will identify providers with aberrant utilization patterns, flagging them when a category or code utilization is twice the network average or more. Will generates real-time profiles for providers identified as outliers and compare their utilization to peers with the same geography and specialty; clinical review will be conducted by our staff dentists to confirm outlier trends.
- **Fraud, Waste and Abuse (FWA) monitoring:** Will ensure members receive cost-effective, quality care by analyzing data patterns and trends of network dental providers. Any suspected fraud or abuse will be referred for investigation. If an error is identified we will counsel providers on program requirements. If the practice continues, we will initiate an investigation and take steps to terminate the provider from the network. In the case of verified fraud, waste or abuse, we will begin recovery efforts for claims paid.
- **Community Education/Outreach and Fluoride Varnish:** Our Community Education and Outreach program is designed to improve overall access, increase member utilization and better manage dental disease. Education materials will address a variety of topics, including oral health for infants, toddlers and children; maternal oral health; early childhood caries; fluoride varnish; and the importance of establishing a dental home. Specific to fluoride varnish, we will reach members and providers through community outreach, mailings, our provider portal and provider emails. We will send a letter to members who receive a

fluoride varnish from their pediatrician or PCP to recommend follow-up with a participating dental provider who can help establish a dental home.

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

We are committed to identifying, addressing, and mitigating health disparities and structural inequities impacting the MississippiCAN and CHIP membership, the health care system, and broader society. We understand and value the diverse needs of the population we serve and work to develop culturally competent services that address these disparities and promote health equity. We will offer our Mississippi providers cultural competency training to reinforce the importance of cultural sensitivity when treating members. Our employees will participate in cultural competency training, and we will host ongoing training sessions and educational opportunities on the importance of inclusion and diversity in the workforce. We will require dental providers to document all languages spoken in their office(s), and we share this information with members via our online provider directory.

We **exceed** NCQA quality compass guidelines of the 50th percentile in states of similar size and geographic makeup. More than 70.9% of our members aged 2 to 20 completed an annual dental visit in 2021.

7. Vision Services

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

We are committed to providing a high-quality, accessible, and equitable network of eye care professionals including ophthalmologists, optometrists, and opticians that offers member access and choice.

With over 20 years of vision care experience, we specialize in administering vision benefits for government-sponsored programs, including benefit management for more than 8 million Medicaid members nationwide. Our Mississippi vision network will include private practices and large retail locations, providing convenient access to care, including weekend and evening hours.

In a Medicaid vision program of similar size and scope to MississippiCAN and CHIP, we have consistently achieved 100% network access, 100% compliance in meeting our required claims turnaround times, and 100% accuracy for claims adjudication.

We actively support our vision members throughout the U.S. with a robust network of highly trained eye care professionals who are dedicated to improving health through the delivery of quality vision care. We will bring this same quality and dedication to MississippiCAN and CHIP and will meet or exceed the network access requirements outlined in the model.

Provider Recruitment and Retention

We understand the importance of fully supporting our vision providers and have a structured program that matches each provider to an assigned network recruiter to answer questions and assist with credentialing and contracting. Our provider phone representatives will assist with questions received via email and call center, and provider relations representatives will help answer complex provider questions and resolve issues. Our provider portal will offer educational and training opportunities, and information on eligibility, benefits, claims, compliance, eyewear, and health and safety.

We will receive vision claims through our provider portal, clearinghouses, or paper, after which claims are adjudicated on our vision platform. We will process all claims according to state guidelines and requirements, and services are paid based on individual provider agreements.

Our commitment to Mississippi members will include providing high quality professional vision services and eyeglasses that are dispensed by local professionals through our frame kits. Our kits will include a large selection of fashionable frame styles, colors, and sizes. Each of our Mississippi network providers will receive a sample selection of frame styles to show members; in addition, providers can visit our website to order from many additional frame options. These kits will offer our members over 2,000 frame/color/size combinations from which to choose, each with a one-year guarantee.

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

Driving Innovation and Value

Our focus is on clinical excellence, and we invest in programs designed to advance vision health in the communities we serve. As an example, we are conducting an innovative Medicaid pilot program that uses an artificial intelligence device to conduct retinal screenings in a primary care setting, with no requirement to have an eye care professional on-site. We will make this pilot program available to our MississippiCAN and CHIP members at select locations. With the high prevalence of diabetes in Mississippi, this will help identify diabetic retinopathy before it becomes disabling.

We will offer an annual eye care benefit for Mississippi adult members that includes an annual eye exam and choice of prescription eyeglasses from our frame kit. Annual eye exams improve vision health and can help uncover many medical issues, including high blood pressure, high cholesterol, and diabetes. Dilated retinal exams (DREs) are a vital component of annual eye exams for adult members with diabetes, aiding in the early identification of diabetic retinopathy and subsequent treatment to prevent vision loss. We will relay all diagnoses from the comprehensive eye exam to the member's PCP, notifying them that the member has seen an eye care provider, outlining services rendered and diagnoses found, and giving the eye care provider's contact information. This will allow the PCP to identify additional opportunities for member education, counseling, specialty referrals, and medication changes.

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

Our approach to addressing racial, ethnic, and geographic disparities in vision services will center on member engagement for prevention and rapid interventions, provider incentives and toolkits for screening and treatment and coordination amongst providers.

Mississippi has a high prevalence of eye diseases that are secondary to chronic conditions that disproportionally impact our Black and rural populations. Most notably, these include diabetic retinopathy (DR), retinopathy of prematurity (ROP), and sickle cell retinopathy & maculopathy. We will have robust chronic disease programs that include aggressive management of diabetes and sickle cell disease, emphasizing vision care. As part of these programs, we will engage members to remind them to seek vision services as a core element of addressing their overall health. We will address vision health by supporting PCMHs and PCPs with tools to address eye health and by incorporating financial incentives in our APM and VBP programs. Most notably, this can be demonstrated by how we have operated in a state of similar size where we purchased eye screening booths and placed these in PCMHs. These booths allow technically-trained paraprofessionals to perform the technical component of the screening and the information is transmitted for a professional interpretation. In one year, this enabled us to perform over 8,000 screenings in the offices of two PCMHs, often catching early signs of chronic eye disease and we will provide this innovation in Mississippi.

In addition to addressing disparities through our core clinical model, we will address them from both the member and provider perspective by:

- Supporting providers with convenient access to educational information and training about diversity and disparities, such as Advancing Health Equity and Caring for Diverse Populations.
- Hosting an ongoing series of training sessions and educational opportunities specific to inclusion and diversity for our company employees.
- Quickly acting upon any provider or member feedback indicating that a network vision provider is not following the nondiscriminatory language set forth in their provider agreement.
- Asking our vision providers to self-report all languages spoken by their staff and sharing this information with members via our online provider locating feature; this feature will allow members to identify providers with wheelchair accessible offices.

- Ensuring all members have access to high quality prescription eyeglass options throughout the state via our frame kits, providing a consistent offering of over 2,000 high quality frame styles to all Mississippi members. Where vision professionals maintain a laboratory, we allow them to craft and dispense their own product if the member chooses that option.

8. Additional Items

a. State whether the Offeror will required any cost-sharing or copayments from MississippiCAN and/or CHIP ...

We will not require cost-sharing or copayments from MississippiCAN members. Cost-sharing will be required of certain CHIP members according to the guidelines outlined in the model contract.

i. If yes, please describe what these cost-sharing/copayment requirements will be.

We will administer CHIP cost-sharing requirements according to the guidelines provided by the state.

b. Describe practices and policies the Offeror would plan to use to ensure that rural MississippiCAN ...

We recognize the importance of identifying and addressing the social, behavioral, medical and functional needs of our members to improve their health outcomes and reduce health disparities. Key to addressing all health needs is adequate transportation. The transportation vendor we will use is familiar with the rurality of Mississippi and has drivers who can accommodate long-distance trips. They have experience facilitating member reimbursement when members use their own vehicle for non-emergency transportation (NET).

Transportation Vendor Experience

Our transportation vendor reports that nationwide, approximately 20% of their total trip volume consists of rural or remote rural locations with limited transportation resources and they are capable of supporting those areas. The vendor provides NET services in extremely rural areas across the country. Because they have operated in sparsely populated settings since their inception, they know providers may drive considerable distances for one trip. We use the following methods to deliver safe and prompt transportation to rural members and can bring this experience to Mississippi:

- **Innovative Provider Rate Structures:** We have been successful establishing mileage bands and out-of-service area rates that incentivize transportation providers to fulfill trips in rural areas.
- **Sole Source Providers:** We work with medical facilities with fleets to set up sole source arrangements where they transport members to and from appointments or programs at their facility.
- **Non-Professional Community Drivers:** To provide cost-effective service, our transportation vendor successfully integrates volunteers into our NET programs, specifically in areas where public transportation and traditional transportation providers are unavailable.
- **Gas Mileage Reimbursement:** If a member has access to a personal vehicle, wishes to drive or arranges transportation with a relative or friend using a personal vehicle, we assign gas mileage reimbursement. We make reimbursement convenient for members through reloadable debit cards.

Value-Added Benefits for Non-Emergency Transportation

In addition to standard NET services provided to MississippiCAN members, we will offer value-added benefits to CHIP members and expand benefits available to MississippiCAN pregnant members as outlined below.

- **Pregnant Members:** As a value-added benefit for MississippiCAN members, we will offer NET to help pregnant members access critical care and community resources. This benefit will improve access to care, particularly in rural areas where transportation needs affect members' ability to pursue a healthier lifestyle.
- **CHIP Members:** This benefit will be comprised of unlimited rides to and from Medicaid covered services, gas mileage reimbursement, meals and lodging and commercial flights.

Rural Vendor Advisory Council

We will establish a Rural Vendor Advisory Council, with the goal of understanding how we can better collaborate with rural-based transportation providers to deliver higher quality service in rural communities. Comprised of vendors from throughout the country and transportation vendor logistics staff, the Council will meet quarterly to discuss challenges specific to providers in rural communities and identify new processes and technology solutions to solve for those challenges. So far, these challenges include issues like locating rural addresses, GPS taking drivers to incorrect locations, inability to navigate backroads due to flooding, and ineffective communication between transportation providers and members. We look forward to working with our Council members to improve the service we deliver in rural communities nationwide.

Member Alert Reports

The Member Care Alert will notify our care management team when critical care members cancel transportation or do not show for transportation to their critical care appointment. As a result of the early notification, care managers will immediately intervene to ensure members are attending critical care appointments. This early intervention can potentially avoid future high cost of care. These reports can reduce ER visits, surgeries, and annual spending, and close gaps in care to improve overall quality scores.

Alternative Approach

Our care managers will be aware of the challenges our members living in rural areas face when accessing care. We will ensure our care managers are fully trained in remote care capabilities to assist members with accessing virtual care options, including scheduling virtual appointments when transportation services are unavailable.

c. Describe any additional proposed innovations for delivery of Member services or benefits that the Offeror ...

Geographic Analytic System

We have developed a platform for creating, interacting and sharing real-time maps and location data within a secure environment. We will use this technology to access advanced mapping and spatial analysis tools to create heat maps and overlay various data points to get a full picture of what affects our members most. We will use this technology for public health emergencies and emergency preparedness to understand which members will be affected the most by disease spread and natural disasters. This will allow us to direct resources to accommodate local needs more precisely. For instance, should members be displaced by a natural disaster, we can help them find the closest, most appropriate community resource. In addition, should a care manager be displaced, we can divert resources to make sure those members under the care manager’s care are taken care of.

Sickle Cell Disease Partnership in the Delta

We will work with the University of Mississippi Medical Center (UMMC) to fund a medical home centrally located for members in the Mississippi Delta who have sickle cell disease through the Delta Family Medicine Residency Program. Through this program, family medicine residents will learn, from a UMMC hematologist, how to provide culturally competent care for members with sickle cell disease. This initiative will support the need for more physicians and to provide better access to high-quality care for a highly prevalent chronic disease in Mississippi.

Member Services Model

First and foremost, our member services model offers members a person – someone whose name they know and whose phone number they have – who is there when they need it most and who serves as a trusted advisor through the complexities of health care. Service navigators will assist with health system navigation unique to the member’s circumstances. They will partner with care managers, clinicians and providers to support coordination of care and resolve concerns. They will assist with issues related to covered services, eligibility, written materials, alternative formats, provider selection, making appointments, rights and responsibilities, grievances and appeals, referrals and authorizations, community services, transportation and more. In addition,

Spiritual Support staff will be available to provide clinical spiritual care and chaplaincy services and inform members about our spiritual care program, acknowledging this important component of overall well-being. The program will use telephonic outreach and focuses on members and their family who are in spiritual distress with the goal of reducing unnecessary hospitalizations and ER visits by addressing their spiritual needs.

Doulas

Doulas are shown to improve outcomes for pregnant Black members by elevating their voices in their care journey and providing trusted educational, emotional, and social support. We will **invest $130,000 to launch doula pilots** in collaboration with local doula organizations in the Jackson/Metro area and Delta region. Doula support is an evidence-based intervention shown to improve outcomes including cesarean section and preterm birth rates, enhanced experience, and reduced disparities in perinatal care.

In-Home Health and Wellness Service

We will provide annual in-home health and wellness services to members, including in rural areas with limited access to health care. During the 45-60-minute visit, an advanced practice clinician (APC) will review the member's health history and medications, perform health screenings, and develop member-specific treatment plan and goals. They will evaluate members' home and social environment for potential risks and other social and behavioral needs. Our APCs will help close gaps, such as for transportation or food services. Information gathered during visits will be shared with PCPs and used to connect members to appropriate follow-up care. While COVID-19 presented challenges for in-home visits, we quickly set up telehealth to continue much-needed care, going from zero virtual visits before the pandemic to nearly 120,000 in 2020.

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

Foundational to our company's operating philosophy are our policies on equal opportunity, equity, and inclusion, which we apply to our employees and those we serve. Our three-tiered approach encompasses breaking down barriers to care and building health equity for members we serve, the health systems in which we operate, and the communities in which our members live. Roughly half of Mississippians live in rural areas, with higher levels of unemployment, poverty, racial disparities, lower levels of educational attainment and access to care. We will use a multipronged approach to address these disparities, including:

Public Health Emergency Response: Recognizing the impact that COVID-19 has had on the community and health system in the last few years, we will implement a campaign alongside community-based organizations in Mississippi to support communities that are vulnerable and at a higher risk of contracting COVID-19. The Black population has been disproportionately impacted by vaccine hesitancy**,** and we will commit to targeted outreach that includes member education and funding providers to administer vaccines and testing in the community. In another state with similar characteristics we used our experience in supporting the public health emergency to deploy a mobile unit that provided screening and treatment for various needs after severe storms. In addition to health needs, our team supports the community by offering assistance with utilities, housing, food and even legal advice.

Data Analytics: Our ability to collect, analyze and integrate person-specific data, including race and ethnicity, has helped us identify and measure utilization metrics to target health disparities and gaps in care. These important insights strengthen the use of telehealth among our high-needs and under-resourced populations. We will use insights obtained during the pandemic to inform our long-term strategy, guiding partnerships, investments, and solutions to address individual barriers.

Disparities Dashboard: Our Disparities Dashboard is a newly created dashboard, that stratifies race, ethnicity, language, and disability status by HEDIS measure allowing identification of focus areas and development of targeted strategies to address nonmedical risk factors. We will use this tool to further understand the barriers to

care for these measures and work with CBOs, provider partners, MississippiCAN and CHIP, and the other CCOs to address known disparities.

For example, we will implement our **Health Equity Incentive**. While all our alternative payment models will address health equity by identifying members with care opportunities, we know improving health equity and reducing disparities in outcomes requires focused intentional strategies. We will stratify key HEDIS measures important to MississippiCAN and CHIP members, by member characteristics (e.g., race/ethnicity) to identify disparities within the provider's patient panel. Providers will earn higher incentives for improving care for all and for reducing an identified gap often experienced by historically marginalized groups.

HEDIS®: We will use HEDIS as a source key measurement that reflects performance of quality of care from a clinical perspective and allows us to identify and resolve disparities in health care. We will integrate data into operational areas as appropriate. Internal workgroups and quality committees will analyze the results to review trends, identify opportunities and develop an action plan.

B. Member Services Call Center

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

Our member services call center, staffed by Mississippians, will enhance the member and family experience in Mississippi using a person-centered approach, and by delivering accurate, timely first call resolution to member inquiries and concerns. We will deliver quality and seamless support for members in compliance with the requirements in Section 5.1 of Appendix A, Draft Contract.

Convenient and Simple
Members can request a callback during regular call center hours through our secure member website. The member simply clicks the icon titled, "We'll Call You," selects a topic that describes their inquiry and enters their phone number. This connection provides a convenient and simple way to receive assistance.

Primary Point of Contact. We will assign a single service navigator to the member and their family who will remain as the single point of contact for future interactions. When the member or their family calls our member services call center, they will be automatically routed to their assigned service navigator for ongoing assistance with medical, behavioral health, dental, community-based supports and transportation. This will provide consistent support through their knowledge and understanding of the member's history and circumstances. While typical member services consist of multiple transfers, our service navigation approach will reduce the time spent by having a single point of contact — the service navigator — support for the duration of their issue. Our service navigators quickly become someone whose name our members know and whose phone number they have — who is there when they need it most and who serves as a trusted advisor through the complexities of health care. Service navigation is at its core a personal experience. We believe that by removing the confusion of the health care system and addressing basic needs of our members, we will free our members to focus on their health, which can contribute to improved health outcomes and cost of care. In addition, service navigators will be trained and well versed in the member handbook, offerings on the member portal and mobile application and will help guide the member to these resources.

Member-Focused Member Services Model. Our service navigation model is an innovative best practice service model, especially for members and their families that truly need high-touch, single point of contact interactions. Our goal with service navigation is to improve the health plan experience of our members through a person-centered design. We want to reduce the amount of effort members and families exert within the health care system, build a relationship with the whole family, ease their anxiety through social and community supports and drive member satisfaction and better health outcomes. Service navigators will assist with health system navigation unique to the member's circumstances and partner with care managers, clinicians and providers to support coordination of care and resolve concerns. They will assist with issues related to covered services (including medical, behavioral health, vision and dental), eligibility, written materials, alternative

formats, provider selection, making appointments, rights and responsibilities, grievances and appeals, referrals and authorizations, community services, transportation and more.

a. Confirming that the location of the proposed operations will be within the State of Mississippi ...

Yes, we confirm that the location of the proposed operations will be in Mississippi. Our call center will comply with hours listed in Section 5.1.3.2 of Appendix A, Draft Contract.

b. Specific standards for rates of response (e.g., live answer, incomplete calls, speed of answer, average ...

We will work diligently to meet and exceed performance service levels to make sure MississippiCAN and CHIP members receive efficient handling of their issues and concerns. Our experience and work management tools will facilitate accurate estimations of expected call volume and appropriate staffing. To support continued appropriate staffing, our local Mississippi workforce management team will use a series of applications, including scheduling software, to aid in monitoring our call response rate daily, and generate specialized reports to identify peak call times while measuring service navigator productivity. We will report compliance metrics to the Division upon request and in compliance with contract requirements. In states with a similar population to MississippiCAN and CHIP programs, we consistently exceed similar performance standards and have demonstrated performance metrics for 2021 as shown in the table. We will adhere to the performance standards as outlined in Appendix A, Draft Contract.

Year	Live Answer	Average Hold Time	Speed of Answer	Average Length of Call	Abandoned (Incomplete Calls)	Service Level
Standard	N/A	Less than 120 seconds	30 seconds	N/A	< 4%	80% answered in 30 seconds (CHIP metric is 90%)
2021	46,326	90	8.30	482 seconds	0.4%	96.30%
2020	48,453	45	14.49	440 seconds	1.1%	90.20%

On a regular basis, quality analysts will perform call-monitoring activities to make sure service navigators are providing members with accurate information and adhering to established policies and procedures. We will capture and measure call data via our call distribution system, and will record all inbound member services calls to assist in random sample monitoring. In addition to the formal monitoring the quality analysts will perform, supervisors will replay recorded calls at least one day a week, allowing timely quality reviews and recorded feedback to be provided to our staff. Our member services manager will list selected recorded calls every two weeks with local supervisors and review performance metrics daily to monitor quality and compliance. We will randomly select and record calls and monitor no less than 3% of calls for compliance with customer care guidelines, reporting these findings to the Division through a quarterly report in compliance with Section 5.1.6.7 of Appendix A, Draft Contract. We will make the recording available to the Division upon request within five business days and maintain recordings for at least six months.

c. Accommodations for non-English speaking, hearing impaired, and visually impaired callers, including ...

Our approach to providing health care is person-centric and considers the member's needs including language, hearing or visual requirements. We will provide our members with resources and support to promote communication and foster an inclusive environment, including staff fluent in Spanish (the second most common language spoken by members in Mississippi) and free interpretive services in more than 240 languages. Service navigators, nurse line RNs and crisis line behavioral health clinicians will be trained in handling calls that require an interpreter. We will monitor the languages most requested through our interpretive services line (e.g., number of callers and languages requested) to assess additional needs (e.g., translated member materials).

We will use the 711 National Telecommunications Relay Service (TRS) TTY line to facilitate communication with our hearing-impaired members. Service navigators and our care management teams will receive training on handling calls from TRS operators. We will offer to read important communications to visually impaired members and provide member materials in large print, Braille and voice recorded audio formats upon request.

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

The service navigators will be comprehensively trained to recognize and respond effectively when a member calls with an urgent need, situation or health crisis and may warm transfer members to behavioral health clinicians who are available 24 hours a day, seven days a week to assist. If the call is a life-threatening emergency, our staff will be trained to contact 911 and remain engaged to support the response. Local crisis services may be engaged to assess, triage and follow up with members during and after a crisis. We will provide members with access to our nurse line, available 24 hours a day, seven days a week, staffed with RNs available to address member questions and triage immediate health concerns. Trained and experienced RNs on staff will triage callers with life-threatening emergencies to 911 and warm transfer callers to a licensed behavioral health clinician when the RN presumes the member is experiencing a non-life-threatening emergency or urgent behavioral health crisis. Staff will remain engaged until confirmation of appropriate emergency assistance.

Our member services center will have an option for pharmacy services, where members will be directed to dedicated pharmacy team to assist with escalated issues. Our pharmacy team has national experience working within a carved-out pharmacy benefit collaborating with states' pharmacy benefits administrators (PBA) to ensure our members have timely access to pharmacy services. For example, through collaboration with another state Medicaid agency and their PBA, we were able to make enhancements to our processes, ensuring our call centers can coordinate with external entities including the state's PBA, providing a warm transfer for members or providers who are mis-directed. This ability provides a quick and seamless process to resolve pharmacy services related calls. In addition, some states with pharmacy carveouts permit our staff to access claims platforms so that we may assist members by viewing pharmacy transactions.

If a member assigned to a care manager calls with an urgent need during regular business hours, they will be warm transferred to their care manager or another available member of their care team. The service navigators will contact subject matter experts for assistance with complex issues as needed. This interdisciplinary team approach will provide urgent assistance to members who need additional support to resolve an issue. Service navigators will have access to contact lists for common types of urgent issues, such as respiratory durable medical equipment providers to help identify the member's oxygen provider. Another resource contact list will describe urgent situations and who to contact for assistance (e.g., phone numbers of care managers).

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

Our local staff within our call center will be experienced with the MississippiCAN and CHIP programs and will receive ongoing training, at least quarterly, to confirm they effectively respond to a broad range of inquiries with sensitivity to members with disabilities, language differences, need for assistive technology and various cultural backgrounds. We will submit quarterly reports to the Division that detail the trainings, topics covered and the staff who complete the training.

Education for our local service navigators will begin with 11 weeks of rigorous training on subjects including, but not limited to, Medicaid, the MississippiCAN and CHIP programs, benefits and eligibility, searching for providers, handling urgent calls and our core customer care philosophy. Service navigators will receive training on referrals, escalations and warm transfers to care management for clinical staff assistance for members with complex needs. They will receive training on the enhanced capabilities of our member services model, including the Community Services Referral Module, to refer members to food banks, job placement and other local resources; Prevention and Wellness Module to resolve barriers from closing gaps in care; and Provider

Processes Module that trains the service navigator to offer to schedule appointments. We will assess all service navigators on their training to ensure comprehension and retention.

We will provide service navigators with ongoing training inclusive of the very latest in Medicaid changes and requirements that include "Late Breaking News" articles, Provider Bulletins, State Plan Amendments, Administrative Code Filings, the Division's Provider Reference Guide and MississippiCAN and CHIP program updates. We will deliver ongoing multimodal training, including ad hoc training sessions led by supervisors, team meetings, one-on-one coaching and web-based training. Other ongoing trainings will include general refresher courses on important topics such as member experience, ethics and confidentiality; quality analyst monitoring and formal feedback; supervisor monitoring of calls followed by one-on-one coaching; and weekly newsletters to all service navigators that include reminders regarding policy and procedures.

Our service navigators will be local residents who understand the cultural elements of Mississippi. We will provide ongoing cultural competency training on the cultural, linguistic characteristics and special health care needs of the members they serve. Training will focus on awareness-building activities, including:

- Communication protocols for members with limited English proficiency
- Cultural awareness and understanding of health disparities among different cultural groups
- Cultural beliefs related to health, illness, medical care and end-of-life issues
- The need to treat each person with dignity and respect
- Barriers facing individuals with special health care needs
- Overcoming barriers to communicating with individuals with disabilities
- Cultural sensitivity training via role-play and teaching modules
- Social determinants of health and effect on member care needs

We will provide ongoing training for handling urgent calls. Service navigators will be trained to recognize the symptoms of a medical crisis (such as slurred speech, shallow breathing) and symptoms of a behavioral health or substance use disorder (SUD) crisis.

The service navigators will be comprehensively trained to recognize when a member calls with an urgent need, situation or behavioral health crisis. Trained and experienced RNs on staff will triage callers with life-threatening emergencies to 911 and warm transfer callers to a licensed behavioral health clinician when the RN presumes the member is experiencing a non-life-threatening emergency or urgent behavioral health crisis. All service navigators will complete training on long-term services and support, including the role of care managers and will review supporting standard operating procedures and job aids for Mississippi.

Forming Bonds with Our Members

Our member, Pat, who we serve in a similar state, was overwhelmed with the benefits available to her and needed help addressing her medical and behavioral health needs. Pat's service navigator, Nikki, was ready to support Pat with dedicated assistance. As a service navigator, Nikki is empowered to reach out and proactively assist members by coordinating resources, addressing claims issues, providing social support and assisting with other needs. Nikki explained to Pat options to remove barriers to needed medical, behavioral, dental, pharmacy, and community services. Pat and Nikki's bond grew throughout the COVID-19 pandemic. Nikki helped Pat schedule her COVID-19 vaccines and a bone scan. The scan identified that Pat had osteoporosis and Nikki supported Pat in scheduling follow-up care. Nikki even helped Pat get a cellphone for the first time.

f. How the Offeror will address service interruption through fail-over to an alternative site, redundant ...

We have a comprehensive business continuity plan to support communications if service interruption occurs and will comply with requirements in Section 5.1.6 of Appendix A, Draft Contract. We will engage our business continuity plan in times of unexpectedly high call volume, such as natural disasters. Our plan will restore critical business processes and resume normal business operations in a prioritized manner. For any

downtime event, all our call centers across the country are prepared with procedures to communicate with members, track and record calls, and respond to requests during and after the event.

If local operations are compromised, the first-line backup for our member services center will be a team from a state north of Mississippi. We will provide staff with the equipment and secure connections they need to perform job duties from home. Thus, if coming into the office is not possible, service navigators can login securely from home and serve members with the same service levels as they would from the office. Our work force management team will create and manage staffing plans based on call volume forecasts, allowing call queues to be adequately staffed throughout the day. These will be tenured advocates who have been trained in Mississippi-specific content.

Workforce Management Overview
▪ Monitors call volumes, talk times, staffing, speed of answer ▪ Real time monitoring of call queues to ensure service level goals are met and adjust quickly to unanticipated volume increases ▪ Alerts operations to unanticipated spikes in call volume ▪ Plans and schedules staff accordingly to account for anticipated known high volume days
Call Management Technology
▪ IEX Scheduler: Creates navigator schedules based on call volume forecast, occupancy goals, service level metrics and average handle time projections ▪ All operations are proactively monitored by the Network Operations Center (NOC) 24 hours a day, seven days a week for business continuity planning. The NOC monitors weather for additional pre-planning.
Contingency Playbook
▪ Tenured contingency staff – virtual staff working from home spanning multiple states ▪ Backup teams are available in times of higher-than-expected call volumes and during emergencies ▪ Training curriculums are available to deploy in the situation that call volumes need to be rerouted ▪ Skill-based routing and call forecasting allow us to easily overflow calls with the same level of service

g. For behavioral health/substance use disorder, how the Offeror will provide crisis intervention and other ...

We will streamline the members experience of accessing medical and behavioral health services by providing one phone number by which they can reach the member services team or the behavioral health crisis line. Members will have direct access to our behavioral health crisis line and our member services team will accept these calls and quickly connect the member to the resources they need. For callers who may be in a non-life-threatening behavioral health/SUD crisis, the service navigator will warm transfer the call to our independently licensed, master's level behavioral health crisis staff trained in de-escalation techniques, who will be available 24 hours a day, seven days a week. For life-threatening emergencies (such as any call involving an in-progress act of violence toward another, suicide attempt, or the caller or service navigator feels there is an imminent danger to self or others), they will triage the call to 911 while our staff remains on the line. Service navigators will never place a caller on hold if the service navigator believes the caller is experiencing a life-threatening crisis. Should a caller search for a mental health or substance-use treatment provider or facility, or ask questions about behavioral health benefits, our service navigators will ask a screening question if they perceive the member to be in crisis, including behavioral emergencies. If a caller responds "Yes" to the risk question, the service navigator will warm transfer the call to a behavioral health clinician. If the responses do not indicate a crisis and there are no outstanding concerns, the service navigator will answer the member's inquiry. We will employ an integrated care model liaison with behavioral health experience who will be a dedicated call center resource in our Mississippi call center, providing training to service navigators to address behavioral health calls, including screening for a possible behavioral health crisis. Service navigators will receive training to react swiftly and calmly in the presence of a caller who is experiencing an emergency or crisis and to assist and triage callers appropriately.

Our toll-free member services staff will respond to routine, urgent and emergent issues for physical, behavioral, pharmacy and social support inquiries and conduct triage for crisis behavioral health services during normal business hours. For after-hours assistance, MississippiCAN and CHIP members will connect with a nurse line 24 hours a day, seven days a week, where licensed RNs will address their questions and triage immediate health concerns, whether routine or nonroutine. Trained and experienced nurse line RNs will triage callers with life-threatening emergencies to 911 and warm transfer callers to a licensed behavioral health clinician for immediate assistance when sensing that a member has a non-life-threatening behavioral health emergency or urgent need. Our care management staff will follow up on all crisis contacts by members to assist with crisis prevention (e.g., development of a crisis plan) and coordination with the provider(s) who provided treatment services during the crisis episode, such as crisis respite or psychiatric inpatient providers.

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

To manage call volume, we will use a combination of analysis and technology, making sure our call metrics remain stable and meet performance requirements. Our Network Operations Center (NOC) will support all call centers with real-time operational monitoring and reviews results and trends to verify adequate capacity for routing calls to trained staff.

Proposed Automatic Call Distribution System

We will use an automatic call distribution (ACD) system organized by skill (call type, program type). The system monitors volume, performance metric targets and service navigator availability and status.

Capabilities and Capacities

After assessing the potential membership of the MississippiCAN and CHIP programs, we are confident our call center will have more than sufficient capacity to meet the demands of the call volume demands from MississippiCAN and CHIP programs. Our workforce management staff and call center operations leadership will review performance results real time, hourly and daily. They will meet every morning with call center management to review the previous day's results. Workforce management will report monthly results on business segment scorecards, use load-balancing analytics to equalize workload and employ variable staffing techniques to accommodate anticipated volume.

We will use the ACD system to enable the service navigator to address member calls and use teleconferencing. The ACD will capture and measure call data, allowing us to produce weekly, monthly or ad hoc reports for the Division. We will provide the following information to the Division in a monthly report:

- Number of incoming calls
- Number of calls answered
- Average time to answer a call
- Average abandonment time
- Identity of the call center staff member taking the call and authorizing the request
- Number of abandoned calls during the wait in queue for interaction with call center staff
- Average talk time
- Highest abandonment calls time
- The top three drivers of the month, such as:
  - Address change
  - Benefits
  - PCP Inquiry
  - Provider Inquiry
  - Transportation
  - Coordination of Benefits Information
  - Member Record - Eligibility

Call routing/interactive voice response (IVR). Our call center technologies will manage the flow of all incoming calls to provide timely responses to member inquiries. Intelligent routing and IVR systems will provide skill-based and priority call routing to link members with the appropriate service navigator. The system

will be available 24 hours a day, seven days a week; if a member calls for nonurgent needs, outside of staffed hours, they will be prompted to leave a message and these will be returned within one business day by our member services team. Our IVR system will request that the caller enters or speaks their unique identifier such as member ID, to populate the service navigator's desktop system and provide member-specific information at the service navigator's fingertips. Each service navigator will be accountable for resolving the issue that prompted the member's call and anticipating future issues. We will equip service navigators to solve issues across all benefits, including medical, pharmacy, behavioral health, provider research and appointment scheduling.

Operational readiness: To confirm operational readiness before implementation, we will test our systems, validate scripts, make test calls and confirm appropriate staffing ratios, conduct mock readiness reviews and other preparedness that leads to positive caller experiences. We will confirm that each service navigator is fully trained and has access to all of the necessary systems.

Operational monitoring: Our call center technologies will manage the flow of all incoming calls to provide timely responses to member inquiries. The member services model is our standard for delivering integrated, outcome-based services, using intelligent routing and natural language technology.

C. Member Handbook

1. Describe how the Offeror's Member Handbook will inform Members about the process for accessing ...

Our member handbook and all supporting materials will be written at no higher than a third-grade reading level and conform to all standards outlined in the Americans with Disabilities Act (ADA) to meet the needs of our members with visual/hearing impairments and physical/mental disabilities. Ongoing, we will update our member handbook, upon feedback received from member focus groups and organize the content according to actual member preferences. The member handbook will continually evolve as we enhance features and content. Our member handbook will contain all required information in Section 5.4.2 of Appendix A, Model Contract and will include information on obtaining local behavioral health/substance use disorder services, as well as all other clinical services offered by us, or in partnership by the Division.

An interdisciplinary team comprised of our member services director, quality director, ESPDT coordinator, health services director, health equity director, compliance officer, population health director, network strategy director and representatives from pharmacy, behavioral health, dental and vision benefits will review the member handbook as needed and more formally annually. They will review for ease of use and updated content. We will obtain Division approval before distribution and posting it on our website. We will comply with all of the Division's requirements in the model contract to make sure we continue delivering a complete and easily understood member handbook to our MississippiCAN and CHIP members.

Member Handbook Information on Accessing Services

Our MississippiCAN and CHIP member handbook will contain information on accessing physical health and behavioral health/substance use disorder (behavioral health/SUD) services, including, but not limited to:

Member Welcome Guide: To deliver a high-level overview of how to begin using their health plan and access services, we will provide a welcome guide section that reinforces the member's need to make an appointment with their PCP. This guide will offer basic information to help members learn how to access care, including behavioral health care and SUD treatment, and the benefits and services covered under their health plan.

Benefits at a Glance: Our MississippiCAN and CHIP member handbooks will provide the member with an overview of the health care benefits and services available to them in a section titled, "Benefits at a Glance." Information will be provided for:

- Primary care services
- Medicines
- Nurse line
- Vision care
- Well-child visits
- Hospital services
- Dental
- Maternity and pregnancy care
- Large provider network
- Laboratory services
- Substance Use Disorder
- Behavioral health
- Family planning
- Specialist services

Member Support Section: Our "Member Support" section will help members learn how to obtain assistance. Providing this information will enable members to contact us for help with accessing services, questions about benefits or other needs. It will provide contact information for member services for help accessing medical, behavioral health/SUD services. This section will provide steps to register for secure access to our member website, details on our care management program, how to obtain transportation services, how to obtain translated printed member materials and interpreter services, what to do during emergencies and a list of important numbers, including the Division, our nurse line and more.

Health Plan Highlights: The "Health Plan Highlights" section of the member handbook will include a sub-section to prepare members for doctors' appointments. It will include information on the primary care medical home (PCMH) and the PCP's role and accessing care through network providers and out-of-network providers. This section will emphasize the importance of annual checkups and include a list of important screenings for women, men and children. It will inform members what to do if they need care while they are out of town. It will notify members how to obtain transportation if needed, so they can attend their appointments. This section of the member handbook will address how our members can access behavioral health /SUD services, and provide information on outpatient services, crisis intervention and access to inpatient services.

Hospitals and Emergencies: The section titled "Hospitals and Emergencies" will advise the member on how to seek emergency care, explains inpatient and outpatient hospital services and the benefits available. This section will provide examples of emergencies and non-emergencies, information about urgent care and how to access services at urgent care clinics. Prior authorization will be covered in this section and it will inform members that certain services require approval, and how these services are authorized.

MississippiCAN and CHIP Benefits: The "MississippiCAN and CHIP Benefits" section will provide a comprehensive list of covered services, any limitations and whether prior authorization is required to help members understand all available services and how they can be accessed. For ease of use, this section will be set up as a table with an alphabetized list of benefits, including physical and behavioral health, any limitation and any need for prior authorization. The differences between MississippiCAN and CHIP will be separated and noted. We will not combine member handbooks for the MississippiCAN and CHIP programs; we will offer separate manuals to provide members with information most applicable to their care.

2. Describe how the Offeror's Member Handbook will inform Members about the Offeror's Care ...

The sections of the member handbook discussed in our response above to 4.2.2.1.C.1 will inform members about our care management system. Specifically, the following sections will speak directly to our care management system.

The "Member Support" and "Disease and Care Management" sections in the member handbook will explain the functions of the care management program, how members can refer into a program and how to access other health, education and social services programs. The "Disease and Care Management" section will outline the care management team and how they will work with the member.

The “MississippiCAN and CHIP Benefits” section will provide a comprehensive list of covered services; any limitations and prior authorization requirements and disease and care management. There will be additional, standalone sections on wellness; maternity; disease and care management; and behavioral health programs that will provide details on these offerings, list the member services number for more information and explain how to self-refer into one of our programs.

Our field-based care management team, community health workers, outreach staff and transformation consultants will have copies of the member handbook with them. As they speak with members, they will highlight the parts of the handbook that are of most relevance to that member. The print versions will be sent to members upon request and will be delivered to local community organizations and state Medicaid offices.

D. Website and Mobile Application

1. Describe how the Offeror will ensure that Members are well-informed about the existence and functions of ...

We will promote our secure member portal and mobile application in our member materials, including the welcome letter, member handbook and member welcome guide. Our public website will link members to our secure member portal, where members will find more information on the mobile application and links to download the app. Further, we will train our service navigators to promote the member portal and train our member-facing staff (e.g., service navigator, care manager, nurse line) to talk with members about the tools available online to help them learn about their benefits, conduct provider searches, view covered services, medications and more. We will provide site demonstrations, educational materials, email notices, online help and customer care to educate and assist members. In addition, we will provide information on our member portal and mobile app to community partners so they can direct members to these resources as appropriate.

2. Describe any functions beyond those required in Appendix A, Draft Contract, that the Offeror will make ...

Our member website design will meet the unique needs and challenges of our members, including appropriate reading levels, vital plan information in English and Spanish, and translations into multiple languages, including Vietnamese, Chinese, Tagalog and Somali. This site will support our Hispanic and Latino community by providing navigation in Spanish and facilitating access to interactive programs and educational materials. Our Accessibility Program will meet the requirements of Section 508 of the Rehabilitation Act in Section 1557 of the Affordable Care Act. We will enhance website accessibility for individuals with disabilities as technology standards evolve and customize content on our website to align with Mississippi-specific requirements.

Our members will have access to multiple resources on the member portal. These resources will include assessments (e.g., alcohol and tobacco); financial resources; searchable provider database and links to expert resources. It will contain 62 libraries focused on relevant behavioral health topics, such as resilience, addiction, recovery and stress. It is our standard practice to regularly review and update the member website to maintain consistency and accuracy of information, and to verify compliance with state requirements. We will make regular enhancements to the member website to better serve our members. For example, we will add the Health Risk Screening to the secure portal for members to easily access and complete them. Another enhancement will be our “we’ll call you” feature, which will allow members to receive a call back from member services. When requesting the call, the member will select a topic for the inquiry and enter their phone number. The member will then receive a call for assistance. Our digital marketing team will use a change log tracking system to document all website changes and updates.

E. Member Education and Communication

1. Describe what methods the Offeror will use to inform Members of the functions of the Member services ...

We will inform members about and encourage use of our member services call center during the welcome call and in our member materials, member handbook and member welcome guide, which we will provide to members within 14 days of receiving notice of the member’s enrollment. Our public website, secure member

portal and mobile application will have information on the member services call center. We will train our member-facing staff to talk with members about how the member services call center can help them learn about their benefits, conduct provider searches, schedule appointments, connect them with medical and behavioral health resources and more. We will provide collateral materials, emails, online help, customer care and technical support to educate and assist users.

2. Describe what methods the Offeror will use to inform Member of the functions of Care Management ...

We will inform members of the functions of care management during the welcome call, our member handbook and member welcome guide. Our public website, secure member portal and mobile application will have information on care management functions, educational resources and information on how to self-refer. We will train our member-facing staff (e.g., service navigators, care managers, community engagement team) to help members learn about care management, maternity and wellness programs such as quitting tobacco or diabetes management. Service navigators at our call center will encourage the use of care management and handle member calls to self-refer to care management. When care managers contact members for the first time, the care manager will explain the purpose and importance of care management. In addition, providers will have many opportunities to learn about our care management functions, through interactions with provider-facing staff, workshops and events. They can they pass along this information to members who may benefit from care management.

3. Describe how the Offeror will develop and maintain a comprehensive, evidence-based health education ...

We will maintain a comprehensive health education program to serve our MississippiCAN and CHIP members in compliance with all requirements in Section 5.2 of Appendix A, Draft Contract. We will tailor our well-established health education program to the needs of MississippiCAN and CHIP members, employing sustainable best practices and tools. Our evidence-based program focuses on disease prevention, healthy lifestyles and health care decision-making skills. Our care teams will use HEDIS outcome indicators, national preventive care guidelines, state population health goals, evidence-based practices and contractual requirements to develop our health education program. Integrating evidence-based practices into our health education program enhances the member's experience and will improve long-term health care outcomes to effectively reduce morbidity and mortality related rates in Mississippi. We will emphasize the use of evidence-based health education and clinical guidelines based on clinical literature and expert medical experience to help members make choices about the best health care activities that empower them to manage their condition.

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

Our comprehensive education program will integrate health education and tools that help our members achieve and maintain a healthy lifestyle. These resources will help members improve their health knowledge and their overall health status. Our program framework will be structured to educate members in all ranges of the health care continuum, including prevention (e.g., receiving immunizations), getting healthy (e.g., exercise, tobacco cessation) or living with chronic diseases (e.g., learning about asthma and applying the knowledge toward self-management).

Accountabilities

Accountable ownership for our MississippiCAN and CHIP education program will fall under the direction of our medical director, who will develop and refine our health education program with support from national and local health education staff, health equity director, care managers, clinical teams, community health workers, quality teams, the Division, other CCOs and key community stakeholders. This interdisciplinary team will use evidence-based, disease-specific programming, clinical priorities, national recommendations and national and local resources. Our national health educator will be accountable for making sure each evidence-based component is applicable to our MississippiCAN and CHIP population. Locally, our medical director will handle education program monitoring and work with our utilization management (UM) coordinator to oversee the

health education program. Our medical director and accountable partners will use clinical analytics reports, compiled from business intelligence and HEDIS metrics, to analyze the effectiveness of the health education program and recommend changes.

Health Education Activities

Our ongoing health education activities will include programs that are appropriate to the member population and can effect behavioral change for improved health outcomes. Our educational activities will align with our programmatic focus of prevention, getting healthy and living with chronic illness. We will use community-based partnerships to identify additional relevant health education activities. We will partner with these organizations to plan and deliver services that address these health education needs. We will combine low, medium and high-touch opportunities for members to engage in the modality of their choice (e.g., telephonic, email, text or in person). Each activity will provide a unique opportunity for us to maximize promotion of health education and personally inform members how to close their individual care gaps. Our educational activities will focus on the following topics and include:

Prevention	Getting Healthy	Living with Chronic Illness
▪ Immunization outreach ▪ Telephonic outreach-gaps in care ▪ EPSDT outreach ▪ Women's health ▪ Checkup reminder mailings ▪ Flu immunization campaign ▪ Question, Persuade, Refer ▪ Mental Health First Aid	▪ Community Health Fairs ▪ Clinic Days ▪ Head Start to Health ▪ Member workshops ▪ Seeking Safety ▪ Community Baby Showers ▪ Mindfulness Exercises ▪ Weight Loss	▪ Diabetic education ▪ Sickle cell program ▪ Disease management ▪ Care management ▪ Member newsletter ▪ Behavioral Health Self-Care and Peer Support App ▪ Medication adherence program

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

Our primary rationale for selecting areas of focus in our comprehensive health education program is to address the health conditions prevalent in Mississippi and contractually required by the Division, including asthma, prediabetes, diabetes, hypertension, obesity, attention deficit disorder, congestive heart disease, behavioral health, substance use disorder, sickle cell and organ transplants. To confirm that our areas of focus are relevant to our members, we will use internal qualitative and quantitative data from a variety of sources. This will include our internal resources such as our databases, member risk assessments and claims analysis. We will use our member and provider advisory councils and goals and objectives set by the Division of Medicaid.

Through additional local and national statistical data, we have already identified areas that represent health care challenges and offer significant quality improvement opportunities for Mississippians. We will target opportunities for improvement in areas of clinical care that reflect the demographic characteristics, prevalence of disease and the potential consequences of the disease for members. Our areas of focus will be selected through an internal assessment of disparities in delivery of health services and in health outcomes that are related to remediable cultural barriers and community limitations.

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

We will write all MississippiCAN and CHIP member materials at or below a third-grade reading level and will obtain Division approval prior to use. All of our teams will collaborate to create consistent and retainable materials for our members. We will use an evidence-based Flesch-Kincaid tool to assure that our member documents are at a 3rd grade reading level. This resource will make compliance with state reading level requirements simple with detailed descriptions, guidance and examples for alternative grammar. Our system

will enforce clarity of our member materials to ensure that members understand our information. In addition, it will monitor several different criteria and make suggestions in "real-time" and help with:

- Writing style (capitalization, punctuation)
- Word replacement suggestions
- Spelling and grammar
- Clarity
- Voice and tone
- Inclusivity and sensitivity (gender, age, disability)

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

We support the use of Culturally and Linguistically Appropriate Services (CLAS) standards and will comply with the requirements outlined in Section 5.2 of Appendix A, Draft Contract. Our customized materials will be approved by the Division, available in English and Spanish and can be made available, upon approval of the Division, in other languages as required. Our standard will be to make written materials, including health education materials, available in alternative languages when approximately 5% or more of the total population speaks the alternative language. Before printing and use, we will submit all member materials to the Division for review and approval, and we will follow state and federal regulations, and MississippiCAN and CHIP contract requirements. For non-English speakers, we will provide free interpretive services that offer access to more than 240 languages. Our member website will be available in 11 languages.

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

Our member website and PDFs of member educational materials, including our member handbook will comply with the Web Content Accessibility Guidelines. This will make our digital content accessible for people with disabilities and a diverse range of hearing, movement, sight, and cognitive ability. We will create written member materials in a minimum 12-point font (except ID cards). We are sensitive to the needs of individuals with disabilities and special health care needs. We will make alternative formats available for members who have developmental, visual, hearing, speech or physical disabilities. We will make translations into large print, Braille and digital audio formats upon request.

4. Describe how the Offeror will employ creative solutions to encourage participation in Member outreach ...

To increase participation in our education and incentive activities, we will provide information to providers, community partners and our Community Partnership Advisory Committee (CPAC) to be shared with our members. We will use in person outreach, written, telephonic, email, text, digital platforms and incentive programs to deliver education to our members. We will partner with local organizations who have standing events so that we can take advantage of a group of our members.

In-Person Outreach

Since many Medicaid members rely on community- and faith-based organizations to meet a variety of needs, we find these organizations provide a valuable perspective on both potential members' needs and on effective outreach methods. We will proactively work with organizations that serve Medicaid populations to conduct specialized events, such as health fairs, where we provide education and information about healthy lifestyles, in addition to our care management and wellness programs.

Health Literacy Campaigns

As a best practice, we will deliver health literacy campaigns through multiple channels, such as mailers, outbound calls, emails, social media and information provided by member facing staff so that we can learn which touchpoints resonate with our target audience's needs and habits. Our health literacy campaigns will include information for such health and disease states such as maternity health, behavioral health, well-child visits, immunizations and social needs.

Printed and Telephonic Resources

We will use printed and telephonic outreach to encourage participation in health education and help close gaps in care. We will use a layering approach from low to high touchpoints to make sure we are engaging with members in the way in which they are most apt to respond. For instance, we will send disease management education to members with chronic conditions such as asthma and diabetes, and preventive care mailings to all members. We will distribute educational brochures at community and outreach events, schools and provider offices. For those members who do not live in a region near an upcoming community wellness event and are not up to date with their recommended preventive screenings, we will use live outreach calls to reach them. We will use a manual pre-event phone call to encourage participation to community events and send out an event mailer to increase attendance at community events.

Virtual Meetings

We will work with community partners such as sheriff's offices, community-based organizations and churches to provide education to our members. These virtual meetings will occur biweekly and provide information on benefits; enrollments and engagements; health education, COVID-19 resources and more.

Omnichannel Gap in Care Reminders

Our omnichannel clinical outreach program will aim to improve member engagement by sending important health screening reminders to members in a channel of their choice. The program will use a combination of IVR, text and email follow-up to remind members to get needed care.

Incentive Programs

We will use innovative incentive programs that comply with state and federal guidelines, to educate our members about preventive care and to close gaps in care. These programs will offer rewards to members for completing important screenings, tests and immunizations that improve health outcomes.

5. Describe the Offeror's proposed process for maintaining both online and print Provider Directories that ...

We will comply with all requirements of Appendix A, Draft Contract, Section 5.5. We will maintain an online searchable provider directory that gives members the ability to search by specialty, facility type, geographic location, provider name, provider gender, language spoken, hospital/group affiliation and whether the provider accepts new patients. We will accept photographs of participating providers. We will maintain a PDF version of the directory on the member website that can be formatted for print production and distribute it to members, potential members, network providers, our staff members and others upon request. We will make hardcopy directories available in State Medicaid Regional Offices, our office, libraries and other areas as directed by the Division.

Provider Data Requirements

Our provider directory will include demographic and practice information for all types of providers in our network, including, but not limited to, PCPs, hospitals, specialists, FQHCs, rural health clinics, ancillary providers, behavioral health and SUD providers, and pharmacies. This will include all the necessary information to populate our provider directory, including facility names, individual practitioner names, practice locations, hours of operation, telephone numbers, fax numbers, email addresses, board certifications, handicap accessibility, patient age ranges accepted and languages spoken. We have the ability to note high-performing providers who may excel in clinical outcomes and be designated as a patient centered medical home. Finally, we will encourage providers to supply current professional photographs so that they can be included in our directory. We will extract and publish all required provider directory elements from the database to maintain compliance with Division requirements.

Production Process for Accurate and Up-to-Date Provider Directories

We will update our online provider directory five times a week and we will update printed directories monthly, based on federal guidance. We will extract data for all participating providers, including subcontracted vendor data, into a defined file layout for both paper and online directory production. We will print our provider directory on demand to make sure it is a current paper directory.

Maintaining Provider Directory Network Information

We will conduct our provider directory reviews and make necessary edits at least monthly. Our proactive provider directory maintenance approach will include the following designated teams and resources:

- **Provider Verification Outreach (PVO) Team:** Our PVO team will contact network providers to update information, with PVO activity initiated by specific triggers (e.g., analytics pointing to potential discrepant data, regulatory requirements, referrals from call centers).
- **Field-Based Representatives:** Our field-based representatives, including provider advocates and field-based registered nurse consultants, will routinely meet with providers to share and discuss our processes and maintain ongoing collaborative relationships.
- **Network Account Management Team:** This outward-facing team will handle the contracting process and work directly with providers to establish, maintain and correct provider data elements.
- **Routine Reviews:** An ongoing provider demographic review and validation effort will be performed in collaboration with the network account management team. We will prioritize and target physician practice groups and other provider types based on member impact and date of last update.

We will extend autonomy and responsibility to the providers to review and update their information. This will include a requirement to notify us of any changes to their participation status and demographic information that may affect member access. Providers can initiate updates to their demographics through the provider portal or our provider services center.

Identifying PCPs and Specialists Who Are Not Accepting New Patients

We will permit providers to close and re-open their panel at their discretion with no interruption in provider relations advocate support and care management support for clinical needs. We will allow providers to set limits on their panel size. Our care managers and provider relations advocates will maintain communication with these providers and alert us if their panel status preference changes. We will provide physician availability information through our member portal, provider directory, care managers and service navigators. The provider directory will show which providers are accepting new patients, and those who are not.

6. Describe the Offeror’s proposed policies, procedures, and processes regarding the Member’s rights ...

We will strongly support our membership in exercising their legal rights, which we demonstrate by incorporating the principles of dignity of risk and self-determination in our policies, procedures and trainings. We will have policies and procedures for MississippiCAN and CHIP, such as the Notification of Rights document, which will cover purpose, definitions and policy and process for members to access and receive their Rights and Responsibilities. We will comply with all requirements in Section 5.10 of Appendix A, Model Contract and maintain policies and procedures in compliance with state, regulatory and federal regulations.

To raise awareness among our membership, we will include information on rights and responsibilities in our member handbook, member newsletter, the member website and other direct communications. We will provide information to individuals with disabilities during their planning meetings to confirm that they can make informed choices about their lives. To protect the rights of individuals with intellectual or developmental disabilities, we will participate in Human Rights Committee meetings if requested by the individual or family and execute on specific actions determined within the meetings. We will communicate members’ rights to

practitioners via our provider manual, the provider portal and in our provider contracts. Designated staff, including our compliance officer, will monitor compliance with MississippiCAN and CHIP program requirements regarding member rights. In compliance with MississippiCAN and CHIP program requirements, our Member Rights policy will guarantee the following rights to members:

- Receive information in a manner that is easily understood in accordance with 42 C.F.R. § 438.10
- Be treated with respect and with due consideration for their dignity and privacy
- Receive information on available treatment options and alternatives presented in a manner appropriate to the member's condition and ability to understand
- Participate in decisions regarding their health care, including the right to refuse treatment
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation, as specified in other federal regulations on the use of restraints and seclusion
- Request and receive a copy of their medical records and request that they be amended or corrected, as specified in 45 C.F.R. §§ 164.524 and 164.526
- Free exercise of rights and the exercise of those rights do not adversely affect the way we and providers treat the member
- Be furnished health care services in accordance with 42 C.F.R. § 438.206 through 438.210

Beyond the MississippiCAN and CHIP member rights requirements, we will include the rights to:

- Receive culturally sensitive assistance, and receive courteous and prompt treatment
- Receive information about the benefit program and which services are covered
- Know the qualifications of our health care providers

We will maintain and follow policies and procedures to confirm that members' rights are communicated clearly and are respected in every aspect of our services, and member concerns regarding violations of these rights are addressed and resolved appropriately through our grievance and appeals process.

7. Describe the Offeror's proposed policies, procedures, and processes to ensure Marketing requirements are ...

We understand the importance and sensitivity regarding permissible marketing activities and prohibited practices. We will comply with all requirements outlined by the Division in Section 5.9 of Appendix A, Draft Contract. We will comply with requirements specified by 42 C.F.R. § 438.104 and not directly market to individual Medicaid members or potential members.

Our Policies, Procedures and Processes to Meet Marketing Requirements

We will follow multiple written internal policies and procedures (P&Ps) that specifically address compliance with MississippiCAN and CHIP program contractual requirements related to marketing materials and activities. Our P&Ps will enforce compliance with Division approval of all membership materials and community events and confirm material distribution to members who are enrolled with us.

We will follow Mississippi-specific P&Ps to make sure all marketing plans, schedules and informational materials for community outreach, networking and outreach programs are compliant, submitted to the Division for review according to contract requirements and receive Division approval before use. We will submit new and revised marketing and informational materials no fewer than 30 days before distribution to facilitate approval. We will report on marketing activities to the Division weekly, quarterly and annually according to requirements. In addition, we will provide an annual marketing work plan to the Division and quarterly updates.

Compliance with Prohibited Marketing Activity Requirements

We will use a marketing complaint log to make sure any issues are addressed. We will support all marketing team members through leadership oversight and comprehensive training on marketing activities.

Leadership Oversight

We will fully comply with the requirements in Section 5.9 of Appendix A, Draft Contract as we partner with the Division. Our member services manager will oversee all marketing materials, outreach activities and events to confirm efficacy and maintain compliance with state and federal marketing guidelines. Our member services manager's role is to verify that members have the tools they need to understand the MississippiCAN and CHIP programs and how to access care. Our member services manager will oversee all required training, including education for all our affiliates that includes state guidelines, restrictions, approval process and timelines. This training will include a presentation of our written P&Ps and an agreement form to be signed as an attestation of understanding. As needed, our member services manager will consult with our compliance officer to review questionable marketing activities and determine the appropriate course of action (e.g., corrective action).

Required Staff Training

Our marketing and compliance teams will develop a system of cross-functional checks and balances, working collaboratively to comply with marketing policies and procedures governing submission and approval of marketing materials and compliance to marketing policies and procedures. Annually, our marketing and outreach staff will receive compliance training related to the program’s marketing guidelines and federal regulations regarding Medicaid marketing. We will include this training in our onboarding process and require all new employees to complete the program. Staff will attest to their understanding and attendance.

Member Marketing Materials

We will produce printed marketing materials, including brochures, in our efforts to raise awareness of the MississippiCAN and CHIP programs and extend the reach of health care services to individuals living in all areas of Mississippi. Division-approved written materials will provide members with information about benefits, our provider network and contact information where members and potential members can obtain the information to make informed decisions. All our member materials, if appropriate, will include the updated Non-Discriminatory 1557 Notice. Printed materials will contain website information for individuals who wish to view our online provider directory and obtain more information about benefits. Member materials developed for the MississippiCAN and CHIP programs will be:

- Created with sensitivity to culture and literacy level, with member materials written at or below a third grade reading level
- Available in prevalent languages spoken in the service area, including English and Spanish
- Available in large print and other alternative formats upon request
- Compliant with all applicable laws and regulations regarding marketing by health insurance issuers and approved by the Division within required time frames before distribution.

Potential members, families and caregivers can access our public website to learn about the MississippiCAN and CHIP program. This website will provide information about health plans available by ZIP code, specific health plan benefits, pharmacy and drug lists, the member handbook, and a listing of network providers — the same information included in other marketing channels/brochures and posters. The website will provide contact information for assistance with Medicaid questions and enrollment and will undergo yearly usability testing.

We will have P&Ps in place to confirm accuracy of materials in content and translation, in language and alternate formats, and that our materials do not defraud, mislead or confuse potential members. All public communications will be subject to corporate communication policies and procedures, to include auditing of the

material and content. Subject matter experts will conduct formal interdepartmental reviews of marketing materials before dissemination and provide ongoing monitoring to confirm accurate representation.

Sample Materials

Our sample materials follow this section and include our educational materials sent to members after enrollment. We have included our PrevCare Child Email, which is preventive information for children and our new member insert as marketing material examples in **Att. 4.2.2.1-1 PrevCare Child Email** and **Att. 4.2.2.1-2 New Member Insert**.

8. Describe the Offeror's proposed approach to inform Members about covered health services including:

We will use multiple methods to provide members with the knowledge and resources they need to understand their covered health services and access health care and community resources. Our approach will use staff interactions, easily understood member materials, person-centered planning processes, technology and innovative programs. These will include quarterly newsletters, welcome calls, care management, community events in partnership with local organizations, digital technologies and an enrollment packet. We will comply with the Division's requirements in Section 5 of Appendix A, Draft Contract and deliver innovative capabilities to meet our members where they are in relation to understanding their health care services.

Using Staff Interactions to Inform Members about Covered Health Services

Our service navigators will make welcome calls to new members to provide education about covered health services. The welcome call will educate members about the MississippiCAN program and CHIP and provide them with an opportunity to ask questions. Service navigators will use Division-approved tools and scripting to provide validated health plan information and answer any immediate questions and concerns.

Members can contact our member services call center for answers about covered health services. As part of our standard training activities, our service navigators will know how to communicate benefits and coverage. We will train these staff members because they are usually first contact for members and we understand that new members are often unsure of their benefits and how to use them.

Our community health workers (CHWs) and care managers will support member education, using their knowledge of the community and its resources to locate and engage members, establish relationships, identify and access local community resources, connect members to a PCP, escalate members to a behavioral health clinician and provide education. Our CHWs will work with community committees, providers and organizations to become an integral part of the community. The service navigators and CHWs will provide information regarding covered health services at various community events and activities across Mississippi. **In a state of similar size, our CHWs average more than 6,000 interactions of this kind each year**.

Using Member Materials to Inform Members about Covered Health Services

We will use easy-to-understand member materials to advance member knowledge of benefits, improvement of health, pharmacy services and more. Education will begin with new member onboarding materials, including the member ID card, welcome card carrier letter and welcome packet, which will provide information and contact numbers for member assistance. Accompanying the member ID card will be our welcome letter, which will provide step-by-step instructions for how to register on our secure member portal, where members can find covered health service information. Our member handbook will deliver education that includes a description of covered services and appropriate utilization; use of emergency services, facilities and transportation; PCP roles and responsibilities; how to prepare for a doctor's visit; access information and more.

Using Technology to Inform Members about Covered Health Services

On our secure member portal members will have access to customized MississippiCAN and CHIP benefit information, extensive health and wellness information, provider searches and more. We will offer up-to-date information on benefits and coverage to help members make informed choices. Our member portal will serve

all demographic groups, simplify the user experience, be personalized (e.g., focused on specific member interests and behaviors) and help members navigate the health care system and close gaps in care. Site design will be user-intuitive and include demonstration videos. We will enhance website accessibility for individuals with disabilities as technology standards and industry requirements continue to evolve.

9. Describe the timely process by which media release, public announcement or public disclosure of any ...

When we are notified of a service change requiring mass communication, we will: 1) determine the most effective method to convey the message to the public, providers or members, including, but not limited to, direct member or provider outreach, website announcement or media release, depending on the nature of the change; 2) craft the language in accordance with the organizational and state requirements, depending on the audience, with support from the organization's marketing and communications teams; and 3) route the communication and anticipated go-live to the Division for an expedited review. Our internal processes can be completed in a matter of days, but distribution will hinge on the Division's capacity to review and approve the outreach. No announcements will be made without going through the Division's established review process.

F. Member Satisfaction

1. Describe the Offeror's proposed approach to assess Member satisfaction including tools the Offeror plans ...

Member feedback is vital to the success of our programs. We will take every opportunity to gain insight to how members receive information and services to ensure we continuously improve our interactions. We will measure our members' satisfaction by complying with all Division requirements for assessing member satisfaction, including the tools we use for assessments, the frequency of assessments and the parties responsible for assessments. We will use the following assessment tools to provide our members with opportunities to communicate feedback.

Consistently High NPS Scores
In a state with a similar population to MississippiCAN and CHIP, we averaged a Net Promoter Score (NPS) of over 73 in 2021. A score of 73 shows a high degree of satisfaction; according to Forbes, any score above 50 is considered excellent.

Assessment Tools	Frequency of Assessment and Responsible Parties
CAHPS®	An independent, third-party company will conduct the CAHPS® survey annually, measuring our members' experiences, such as their satisfaction with customer care and their ability to understand our materials. The CAHPS® results are a key indicator of our members' experiences and satisfaction with their PCP, specialty care practitioners and other health care components, such as transportation and written member materials. We will create a local task force to address areas for improvement. This task force, which will consist of the member services manager, chief operating officer, network strategy director, quality management director, health services director and other key personnel, will review our scores, address any deficiencies and create an improvement action plan to remediate items that may result in improved scores. We will implement the action plan throughout the year and monitor its impact quarterly. In compliance with Section 8.6 of Appendix A, Draft Contract, we will file with the Division the survey results and action plans at least 90 calendar days following receipt of the findings from our certified survey vendor.
The KMIs and NPS:	The Key Member Indicator (KMI) program is a monthly tracking survey conducted among members, families and caregivers by a live telephone representative. KMIs will enable us to measure key performance metrics and identify drivers of satisfaction to inform decisions and improvements. Analysis of the data will help us determine the percentage of people highly likely to recommend us and unlikely to recommend us (NPS). We will track this data against demographic data (e.g., age, sexual orientation) to help identify trends in health inequities.
Member Services Post Call Survey	We will offer members the option of a post call survey after a member calls our member services department to assess our members' experiences, evaluate the performance of member services staff and identify opportunities for training. Member services quality staff will monitor call survey results on an ongoing basis, checking for trends and opportunities for improvement, and provide feedback and training. If a member indicates they are dissatisfied with their experience, a supervisor will follow up to confirm resolution.

Assessment Tools	Frequency of Assessment and Responsible Parties
Member Website Survey	Members can click "Feedback" on our website to provide input on their website experiences, allowing us to have a continuous feedback mechanism for site enhancements. We will review survey data quarterly to initiate improvement opportunities. We will use site analytics to identify opportunities for improvement. For example, our analytics identified the member benefits site as one of the most frequently visited. We made significant improvements to the site to make it easier to use, such as allowing members to search for benefits by key word.
Grievance Tracking:	We will complete an annual qualitative analysis, including identification of barriers, opportunities, interventions and effectiveness of interventions implemented.
Community Partnership Advisory Council	Our CPAC will allow members to voice their input in a collaborative environment. The CPAC objectives include assessing member satisfaction and maintaining responsiveness to our members' ongoing and emerging needs. This feedback is part of continuous member satisfaction tracking and will be used, in conjunction with other measurements, to facilitate improvements.

G. Member Appeals

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

We avoid grievances and appeals (G&A) by delivering high-quality, responsive and culturally competent services and communications to our members. However, we have multiple ways in which we will encourage and facilitate members to file grievances/appeals when they are dissatisfied. We have experience implementing a reliable member grievance, appeal and state fair hearing program that verifies the appropriate and timely processing and resolution of member G&A when a member does not agree with a decision we have made.

Our member G&A program will use Mississippi-specific policies and procedures that comply with 42 C.F.R., Part 438, Subpart F, all applicable federal and state laws, regulations and policies and the requirements in Appendix A, Draft Contract, Section 5.11. Our Mississippi-based G&A coordinator, knowledgeable of the G&A requirements for Mississippi, will be supported by an on-site appeals supervisor and appeals representative. Our G&A coordinator will be responsible for tracking and trending member grievances to monitor for needed operational actions, understands our systems and interacts with our G&A clinical team. Our national G&A market engagement lead will be responsible for reports that assist with tracking, identifying trends and root causes that contribute to member G&A. These reports will be reviewed monthly for recommendations and interventions.

a. Compliance with State requirements as described on the Division's Website and, Section 5.11, Member ...

Our G&A policies will comply with Section 5.11, Member G&A Process of Appendix A, Draft Contract. In each of the Medicaid programs we serve, we have developed systems, processes and an organizational structure (e.g., collaboration between G&A, compliance and quality management) that allow us to track our handling and resolution of member and provider G&A. This allows us to confirm compliance with contract requirements and provide high-quality services to our members and providers. Our Mississippi program will incorporate these established systems, processes and organizational structure to evaluate G&A data and act on issues we identify. We actively employ lessons learned from other states and will apply these lessons to work in Mississippi.

Process Summary	State similar to MississippiCAN and CHIP (2021)
Grievances submitted per 1,000 members	0.21
Appeals submitted per 1,000 members	0.23
Member grievance acknowledgement letter compliance rate	100%
Member grievance resolution compliance rate	99.88%
Member appeal acknowledgement letter compliance rate	99.84%

Process Summary	State similar to MississippiCAN and CHIP (2021)
Member appeal resolution compliance rate	99.25%
Average standard member appeal turnaround time	21.7 days

b. Process for expedited review;

Expedited review will occur when the time frames for a standard resolution may seriously jeopardize a member's life, health or ability to attain, maintain or regain maximum function. Our expedited review and resolution of appeals process will comply with the contract requirements, including resolving the request within 72 hours of receipt, unless this time frame is extended pursuant to 42 C.F.R. 438.408(c). Our expedited appeal review process will include the following steps:

Exceeding Expedited Review TAT
In 2021, in a state with a similar population to MississippiCAN and CHIP, the average expedited member turnaround time was 1.9 days.

- A member, the member's authorized representative or provider acting on the member's behalf, requests an expedited appeal review verbally or in writing
- We forward the expedited appeal request to a medical director to determine if the request meets the criteria for expedited review
- If it does not meet the criteria for expedited review:
  - We make every effort to contact the member and provide prompt verbal notice of our decision.
  - We follow up with a written notice of denial of expedited resolution within two days that explains that we will transfer the appeal to our standard appeal process.
- If our medical director determines the expedited review request does meet the criteria:
  - The expedited appeal is queued to our resolution analyst (RA) for investigation and resolution. The RA adjudicates the appeal following our expedited appeal resolution processes and procedures.
  - We provide verbal notice of our decision within 72 hours and issue a written Notice of Disposition. The Notice of Disposition contains the results of the resolution process, including the legal citations or authorities supporting the determination along with the date it was completed.

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

We will encourage members and their families who have questions or concerns to call our member services center if they need assistance completing forms or other procedural steps. Our service navigators can serve members in their choice of primary language. Our service navigators will assist the member and their family with G&A processes, including preparing and submitting a written grievance or appeal. In addition, care managers, community health workers (CHWs) and our quality team will help members write and file G&A, provide each member a reasonable opportunity to present evidence and allegations of fact or law, inform the member of the limited time available in cases involving expedited resolution and continue monitoring the member's issue through to resolution. This commitment will create an environment where members view us as a resource and affords us the opportunity to resolve member issues with as little dissatisfaction as possible.

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

Each grievance is an opportunity to improve the care and services we provide not only to the members who file them, but to all members. Grievances represent a means of understanding trends that allow us to make continual improvements to the way we provide care and services, thereby reducing the number of G&A filed. We will conduct quality investigations and analyses related to G&A monthly to identify trends that necessitate further evaluation and education. We will analyze grievances to identify opportunities to improve member satisfaction

and to remedy potential service gaps. We will complete quantitative analyses providing a narrative discussion of results compared year over year, including any relevant results from specific subcategories, or any relevant issues negatively affecting reliability or validity of data. We can drill down to provide additional detail to help explain trends. We will complete qualitative analysis, including identification of barriers, opportunities, interventions and effectiveness of interventions implemented. Our quantitative analyses will track top drivers month over month and year over year for grievances by various fields such as specific member, specific provider, type of care, type of grievance and regional factors compared. We will interpret this information to update the G&A process, determine if new implementations are yielding expected results and identify issues that have global reach.

For example, in a state with a similar population to MississippiCAN and CHIP, we trended a significant increase in provider appeals related to two claims codes beginning in 2018. We noticed an increase in the state's overturn rate of our appeals related to these claims codes. We conducted a root cause analysis and determined that our claims processing system was incorrectly denying these claims. Through a redesign of the auto pay list, a restructuring of the appeal versus claims review process and improving the process to review appeals, we reduced the appeal volume for issues related to these claims codes by 94% from approximately 2,000 per month to 115 per month.

In addition to our monthly G&A analysis meeting, the Quality Management Committee and our quality, provider and utilization management subcommittees will review the analyses of G&A data each quarter to:

- Establish goals and performance thresholds and compare results to previous measurements
- Conduct root cause analysis and barrier assessments to provide insight into issues that may have contributed to the causes and performance gaps in achieving established goals
- Develop and implement corrective action plans, considering member dissatisfaction and any disruption to the access of appropriate health services
- Incorporate the data analyses in decision-making activities to refine our operational process
- Benefit from national subject matter experts to review the analyses, identify contributing factors and drive policy and procedure changes and interventions to address systemic issues, barriers or other opportunities to improve processes, outcomes and member satisfaction
- Conduct a post-implementation review of our G&A tracking system if any operational changes are put in place to confirm it lowers the number of G&A filed

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

Our grievance processing procedures and policies will comply with Section 42 C.F.R. 438.402. Grievance cases will be routed to a RA for investigation and resolution. Individuals who participate in rendering grievance decisions will not be involved in any previous level of the review or decision-making process. These individuals will have the requisite clinical expertise to address a member's condition or disease, particularly when the grievance focuses on denial based on a lack of medical necessity, denials of expedited resolution of an appeal, or grievances related to specific clinical issues. Unless the grievance involves a denial based on lack of medical necessity or involves clinical issues, the RA will research and resolve the grievance. The RA may enlist the help of other internal departments if subject matter expertise is needed. The RA may contact the member or the member's treating provider to obtain information to resolve the grievance. We will send a written Notice of Disposition that includes the actions we took to investigate and resolve the grievance.

f. Process to review decisions overturned in external reviews and State Fair Hearings and the Offeror's ...

We will address overturned external reviews and fair hearings via our quality subcommittees, where we will perform an analysis to identify any barriers, opportunities to overcome barriers and to recommend interventions to prevent reoccurrences. [END OF RESPONSE]

Att. 4.2.2.1-1 PrevCare Child Email

It's time to schedule a checkup. Take steps to keep your family healthy. An annual wellness visit can help keep your family healthy. What you need to know about annual wellness visits.

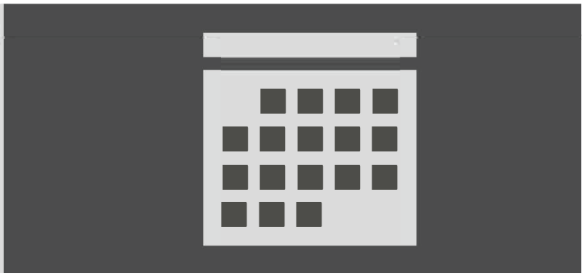
Instant access to your online account. **Sign in now**

Readability
Flesch Reading Ease: 90
Flesch-Kincaid Grade Level: 2.9

En Español

Company Logo
Company Information

It may be time to schedule your child's checkup



We care about your family's health

We are committed to helping you and your family stay healthy. That is why we encourage regular checkups. Even if you and your family members don't feel sick.

All kids ages 3 and older should see their primary care provider (PCP) once a year. These annual wellness visits are a way to help make sure your child stays healthy.

Learn more

Stay up-to-date on shots.

Talk with your child's PCP about what shots they need and when they are needed. Once your child completes their childhood shot schedule, their PCP may recommend the COVID-19 vaccine if they are between ages 12-18.

Questions? We're here to help.

Call Member Services at the number on the back of your member ID card. We can help you find a doctor. We can help make an appointment for you. We can help you if you need help getting a ride to the doctor.

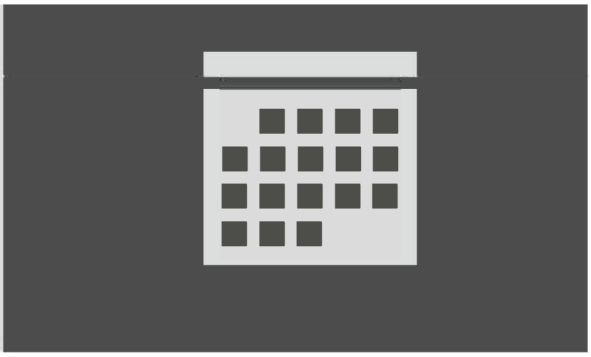
Get updates about your health plan benefits sent to your mobile phone. Once you have provided consent, you can even choose the kind of information you'd like to receive. Sign up now.

Acceso inmediato a su cuenta en línea. Inicie sesión ahora.

Company Logo
Company Information

Readability
Flesch Reading Ease: 90
Flesch-Kincaid Grade Level: 2.9

Puede ser el momento de programar el chequeo de su hijo



Nos preocupamos por la salud de su familia

Nos comprometemos a ayudar a cuidar su salud y la de su familia. Es por eso que recomendamos los chequeos regulares, incluso si usted y los miembros de su familia no se sienten enfermos.

Todos los nifios de 3 años en adelante deben visitar a su medico de cabecera (PCP) una vez al año. Estas visitas anuales de bienestar son una manera de cuidar la salud de su hijo.

Obtenga más información

Mantengase al dia con las vacunas.

Hable con el PCP de su hijo sabre que vacunas necesita y cuando debe aplicarselas. Una vez que su hijo complete el cronograma de vacunaci6n infantil, el PCP puede recomendar la vacuna contra la COVID-19 si tiene entre <12> y 18 afios.

¿Tiene preguntas? Estamos aquí para ayudarle.

Llame a Servicios para Miembros al numero que aparece en el dorso de su tarjeta de identificaci6n de miembro si necesita ayuda para encontrar un proveedor, programar una cita u obtener transporte para asistir a esta.

Reciba actualizaciones sobre los beneficios del plan de salud en su teléfono móvil. Una vez que haya otorgado su consentimiento, incluso puede elegir el tipo de información que le gustaría recibir. Inscríbase ahora mismo.

Att. 4.2.2.1-2 New Member Insert

Company Logo
Company Information

Your benefits start:
<DATE>

>000001 0000000 003115
NEW ENGLISH
124 ANY STREET
ANYTOWN LA 99999-9999

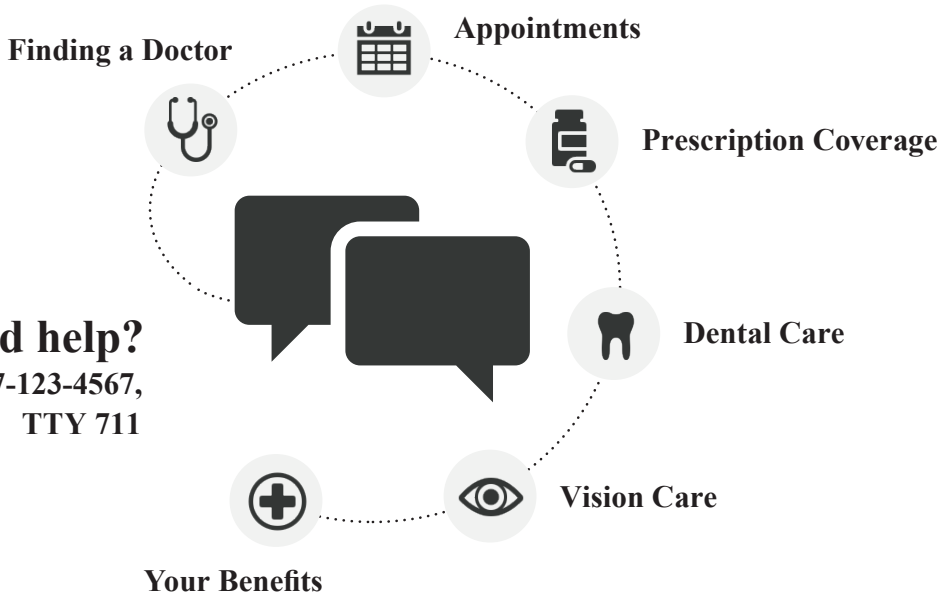
Readability
Flesch Reading Ease: 91.1
Flesch-Kincaid Grade Level: 2.7

Welcome.

We're proud to have you as a member of We look forward to making your health care experience as easy as possible, starting today.

Call us. We're here for you.

Call one of our member advocates when you have a question or need help. For example, an advocate can help you pick your own personal doctor, called a Primary Care Provider (PCP).



Need help?
Call 1-877-123-4567, TTY 711

Turn this page over for more helpful information.

Your member ID card is enclosed.

Always carry it with you. It includes important health plan information on the front. It also has helpful phone numbers on the back.

- You will also receive an ID card from the State of
- Be sure to show both your and ID cards when you get health care services.

Get connected.

We make it easy to get the information you want and need.

- **Register at** This is your secure member website. See your covered benefits, search for providers, view your member handbook and much more.
- **Download the mobile app.** It's designed for people on the go, and includes many of the same features as the member website. Find it at the App Store or Google Play.
- **View short, helpful videos.** Watch them at .
- **Follow us on Facebook at .** Keep up-to-date on local events and health plan news.

What's next.

We'll call to welcome you to our plan. As part of the call, we'll learn more about you and your health, and answer questions about your coverage.

Simple for you. That's our promise.

Health care isn't always easy. But we'll make it as simple as possible for you. So, let us know if you need help with anything. And thank you for joining .

Company Logo

Company Information

does not treat members differently because of sex, age, race, color, disability or national origin.

If you think you were treated unfairly because of your sex, age, race, color, disability or national origin, you can send a complaint to:

Civil Rights Coordinator

You must submit the complaint in writing within 30 days of when you found out about it. If your complaint cannot be resolved in 1 day it will be treated as a grievance. We will send you an acknowledgement of the grievance within 5 days of receipt of the grievance. A decision will be sent to you within 30 days.

If you need help with your complaint, please call the toll-free member phone number at **1-877-123-4567, TTY 711**, Monday through Friday, 7:30 a.m. to 8:00 p.m. CT.

You can also file a complaint with the U.S. Dept. of Health and Human Services.

Online:
https://ocrportal.hhs.gov/ocr/portal/lobby.jsf

Complaint forms are available at
http://www.hhs.gov/ocr/office/file/index.html

Phone:
Toll-free1-800-368-1019, 1-800-537-7697 (TDD)

Mail:
U.S. Dept. of Health and Human Services
200 Independence Avenue SW
Room 509F, HHH Building
Washington, D.C. 20201

We provide free services to help you communicate with us. Such as, letters in other languages or large print. Or, you can ask for an interpreter. To ask for help, please call the toll-free member phone number at **1-877-123-4567, TTY 711**, Monday through Friday, 7:30 a.m. to 8:00 p.m. CT.

English
ATTENTION: If you do not speak English, language assistance services, free of charge, are available to you. Call **TTY 711.**

Spanish
ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **TTY 711.**

Vietnamese
LƯU Ý: Nếu quý vị nói Tiếng Việt, chúng tôi có các dịch vụ hỗ trợ ngôn ngữ miễn phí cho quý vị. Vui lòng gọi số **TTY 711.**

Traditional Chinese
注意：如果您說中文，您可獲得免費語言協助服務。請致電 或聽障專線 **TTY 711**。

French
ATTENTION : Si vous parlez français, vous pouvez obtenir une assistance linguistique gratuite. Appelez le **TTY 711**.

Arabic
تنبيه: إذا كنت تتحدث العربية، تتوفر لك خدمات المساعدة اللغوية مجانًا. اتصل على الرقم الهاتف النصي **711**.

Choctaw
Pisa: Chahta anumpa ish anumpuli hokma, anumpa tohsholi yvt peh pilla ho chi apela hinla. I paya **TTY 711**.

Tagalog
ATENSYON: Kung nagsasalita ka ng Tagalog, may magagamit kang mga serbisyo ng pantulong sa wika, nang walang bayad. Tumawag sa **TTY 711**.

German
HINWEIS: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachendienste zur Verfügung. Wählen Sie: **TTY 711**.

Korean
참고: 한국어를 하시는 경우, 통역 서비스를 무료로 이용하실 수 있습니다. **TTY 711** 로 전화하십시오.

Gujarati
ધ્યાન આપો: જો તમે ગુજરાતી બોલતા હો, તો તમારા માટે વિના મૂલ્યે ભાષાકીય સહાયતા સેવાઓ ઉપલબ્ધ છે. કોલ કરો **TTY 711**.

Japanese
ご注意：日本語 をお話しになる場合は、言語支援サービスを無料でご利用いただけます。電話番号 または**TTY 711**。

Russian
ВНИМАНИЕ: Если вы говорите по-русски, вы можете воспользоваться бесплатными услугами переводчика. Звоните по тел **TTY 711**.

Panjabi
ਸਾਵਧਾਨ: ਜੇਕਰ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਤੁਹਾਡੇ ਲਈ, ਮੁਫ਼ਤ ਵਿੱਚ ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਸੇਵਾਵਾਂ ਉਪਲਬਧ ਹਨ। ਕਿਰਪਾ ਕਰਕੇ ਆਪਣੀ ਹੈਲਥ ਪਲਾਨ ਟੀਮ ਨੂੰ ਸੰਪਰਕ ਕਰੋ। **TTY 711** ਤੇ ਕਾਲ ਕਰੋ।

Italian
ATTENZIONE: se parla italiano, Le vengono messi gratuitamente a disposizione servizi di assistenza linguistica. Chiami il numero **TTY 711**.

Hindi
ध्यान दें: यदि आप हिन्दी भाषा बोलते हैं तो भाषा सहाय ता सेवाएं आपके लिए निःशुल्क उपलब्ध हैं। कॉल करें **TTY 711**.

4.2.2.2 Provider Network and Services (Unmarked)

A. Provider Network

1. Explain the Offeror's plan to develop a comprehensive Provider Network to ensure it meets the Division's ...

We will provide access to a robust, diverse, fully credentialed and contracted statewide provider network for all covered benefits that meets the requirements outlined in RFQ Appendix A, Draft Contract, Section 6.2. Provider Network Requirements.

a. The Offeror's recruitment strategy, including processes for identifying network gaps, developing ...

Our Provider Recruitment Strategy

Increasing Access to High Quality Care

Under the direction of the health plan's network director, the network management contracting team will complete initial and ongoing assessments and pursue recruitment and network enhancement activities. Our provider recruitment and retention strategy is anchored on serving the needs of our members by developing a strong network foundation of geographically distributed, value-driven medical homes and the specialists, hospitals and ancillary providers to support them. We will include a large core set of PCPs, all Mississippi hospitals and willing behavioral health providers. We will have an open network while making sure all providers are aligned on our value-driven approach. We will retain providers by establishing productive relationships aimed at supporting their needs and improving clinical and financial outcomes. Upon securing partnerships, we will quickly offer, execute and load contracts of all credentialed providers.

Our medical home foundation will center on a comprehensive statewide panel of culturally responsive PCPs. These providers will include FQHCs and RHCs and over 6,000 other primary PCPs, including nurse practitioners. We will work diligently with these PCPs to establish and meet goals such as NCQA-PCMH certification, ACO shared savings, HEDIS®-based incentives and elimination of unnecessary hospital visits. To support these PCPs, we will have and maintain a comprehensive network of value-driven, in-state specialists and ancillary providers to serve the physical and behavioral health needs of our shared members. This will include a keen focus on those who are equipped and competent to care for children and the chronically ill.

We are aware of the medical workforce shortage in Mississippi, and the disproportionate impact on behavioral health providers. We will aggressively engage and contract with providers in Mississippi to provide the full array of behavioral health services to meet the needs of our members. We will contract qualified providers from inpatient, residential and community-based services. To have services that meet the needs of members in the community, we will contract with community mental health centers (CMHCs), private mental health centers and independently licensed clinicians. We will target providers who provide a full array of services, such as day treatment, crisis services, intensive in-home services, intensive outpatient services and other services that promote community integration.

Supporting the dental benefits defined in the MississippiCAN program and CHIP, we will have a geographically distributed network of high-quality dentists, orthodontists, oral surgeons and periodontists. A central focus of our recruitment strategy will be securing providers who are committed to preventive oral care in the adult and pediatric populations — essentially serving as a "dental home." We will support these dental homes with a dental care management staff aimed at helping overall oral health, contributing to our person-centered care model.

Securing and retaining providers to MississippiCAN and CHIP-covered vision benefits is important. Our vision and eyecare network will be geographically distributed across the state, and we will engage providers to serve all optometric and ophthalmologic needs. We will not require professionals to have a dispensary. Rather, we will contract with providers to perform professional services only and providers who have frame and lens

crafting capabilities. By contracting with smaller providers who may not have lens and frame-crafting capability, we believe we can have a broader reach. In these cases, we will supply providers with a frame kit that offers hundreds of stylish options.

Finally, our strategy includes securing ancillary providers to best support the needs of our adult and pediatric members. This includes aggressive recruitment of physical and occupational therapists, speech-language pathologists, chiropractors and durable medical equipment companies.

Reducing barriers to care is a major factor in ensuring members receive needed services. To reduce barriers and achieve access, we must address the cultural and geographic needs of all members. To meet the expectations of our Native American population, we will make sure we properly engage with Mississippi's only Indian Health Services center and support them in their clinical and administrative needs. We will support all school-based providers, including the school-based nurses and make certain these providers are properly equipped to provide and bill for EPSDT and child-wellness services, since schools provide an unmatched opportunity to meet the needs of our pediatric population.

Identifying Network Gaps

We will use data-driven cloud reporting tools and formal and informal feedback from members and providers to make sure we exceed the standards identified in Appendix A, Draft Contract. The cloud reporting tools will allow us to assess our provider network adequacy and identify gaps in compliance with the model contract. Our member surveys and interactions will provide insight into whether we are delivering on our members' expectations, while our provider satisfaction surveys will assess their approval of our specialty and referral options. In addition to assessing access standards, we will ensure appointments are available with the providers in our network. To assess this, we will employ telephonic appointment availability surveys and periodic site visits. We will use the results of these assessments to further refine our network strategy to make sure our network accommodates members' needs and preferences.

- **Early Identification and Intervention:** We will research network geographic and quality gaps, identify key providers for further network contracting efforts and identify other solutions such as virtual visits and telehealth when local providers are unavailable. Our **network management system proactively notifies us 90 days before a provider contract expires or recredentialing is due.** We send outreach emails and make outbound telephone calls reminding providers of the upcoming deadlines. In cases of high-need providers, we will perform site visits to remind providers. These actions allow us to engage and assist providers before there is risk of network disruption. Our interdisciplinary team of care managers, network managers, subcontractors, and provider services and representative teams will hold monthly roundtable meetings to identify potential network gaps and opportunities for improvement. Our health plan's network director will lead this forum, and actionable items will be escalated to the chief operations officer and chief executive officer.
- **Ongoing Review:** Our network development, care management and compliance teams will perform ongoing reviews of our provider network to confirm continued compliance with the state's access standards, and to make sure we are meeting the needs of our members. Monthly, we will formally monitor the provider network to identify any changes that occurred or are needed. During weekly interdisciplinary rounds, we will discuss any unmet needs of our members. If a network deficiency is identified, we will initiate a single case agreement to secure services and follow that with a recruitment outreach to bring the provider into our network.
- **Community Engagement:** We will develop a **Provider Advisory Committee** of local community physicians and nurse practitioners from across the state, which will meet quarterly and will be involved in providing ongoing feedback into the performance of our network. This multidisciplinary group, bound by confidentiality, will be representative of our network and will advise on its quality and size. This group will have insight into sanctioned providers that may present risk to the integrity of the network. Finally, our local

member advisory group will be asked to provide ongoing input on access and availability of providers. This group will be composed of consumers representing a cross section of our MississippiCAN and CHIP members and families.

- **Provider and Member Feedback:** We will use formal satisfaction surveys and complaints, grievances and appeals data to identify network gaps reported by members or providers. We will survey both our members and providers annually to assess their perception of our provider network and availability. To conduct the surveys, we use statistically-validated tools that measure satisfaction and include items specific to the availability and quality of our primary and specialty care providers. Results from these surveys will lead to formal action planning around network development and contracting strategies. Informal feedback from members and providers will be ongoing through our field-based and call center staff members. Both our provider and member call centers are equipped with technology that actively monitors calls and detects key words. These allow our call center managers to track and trend key topics such as "finding a provider." If there is a trend in calls that leads us to believe we need to further assess our network, then we will undertake these actions quickly. Our field-based representatives are constantly seeking feedback on the perception of our members and providers and they will pass any feedback gathered in the field to our network director to take immediate action.

Developing Recruitment Work Plans

We have established network work plans that consider member demographics, population distribution, barriers, and cultural and linguistic preferences. The county-by-county work plan for MississippiCAN and CHIP will include a timetable that identifies the individual(s) accountable for each task; target dates for start and finishing tasks and the status of each activity. The workplan will include a process to identify alternative solutions for any access gaps that are identified. The network management team will meet weekly to confirm recruitment and retention plans are on track. We describe our tools and approach below.

Tools

- **Network Analysis:** Using our network analysis tool that searches for and identifies available providers by geographic area, we will identify providers to target for recruitment, allowing us to strategically recruit providers by type, specialty and geography. This analysis will begin with a comprehensive database of all providers available. That database will be compared against the list of providers currently registered with Mississippi Medicaid. If we identify providers who are not in network but accept Medicaid, we will invite these providers to participate with us in MississippiCAN and CHIP.
- **GeoAccess Analysis:** We will run GeoAccess analyses quarterly, and on demand, to identify gaps in the targeted provider network, statewide by provider type. The GeoAccess report overlays members' residences with the location of providers giving us a validated method to ensure we are addressing geographic barriers to care. The basis of member and provider data is at the ZIP code and county levels and we can apply radius requirements that are outlined in the Model Contract and NCQA standards. This tool will allow us to predict impact if a provider does not renew a contract with us.
- **Practitioner Database:** In addition to our direct network analysis tools, we will indirectly assess our network by identifying if a physician is in our network but does not have privileges at a facility within our network. We will use physician privilege data to ensure that providers have all of the tools they need to properly care for our members. If we identify a "Physician Without Privileges," we will use this information to address any gap in our hospital and facility network and take immediate action.
- **Satisfaction Surveys:** As previously noted, we use statistically validated surveys as part of our recruitment strategy. We will administer these tools at least annually as required in the model contract, aimed at assessing member and provider perception of our network access and availability. We will use information gathered from these annual satisfaction surveys to develop formal work plans to strengthen our network.

Approach

We will document our approach based on the information collected using the tools described above. Our approach will include:

- **Rural Approach**: Recognizing that Mississippi has a large rural geographic area, using the tools and strategies mentioned above, we will target the available providers within those rural service areas. To best serve the needs of our members, we will include adjoining counties and states. Securing all available providers in these areas is critical, so we will place a high priority on our rural focus. To support rural providers, we plan to leverage physician-to-physician telemedicine consult capabilities. This will bring specialty care into the PCP office to maximize the clinical value of the encounter. In rural areas, we aim to deploy member-facing telemedicine while not disrupting the provider-patient relationship. We will do this by deploying technology and assisting local providers in adopting such technology and commit to data sharing with the medical home. Critical to our rural strategy is leveraging trade organizations that represent key provider types. Examples include health care trade associations that represent FQHCs, RHCs, CMHCs, etc. These organizations can serve as "aggregators" to assist us with delivering value-based agreements that are more attractive to providers.
- **Urban Approach:** We will target providers in urban areas to meet access and availability standards that promote member choice. Urban areas allow us to contract with many providers and quickly align on value-driven care. Using the same tools mentioned above, we will aim to contract all Medicaid enrolled professionals and facilities. Once we have verified that we have a compliant network that exceeds contract standards and the requests of our members, we will quickly move toward a retention strategy that is centered on value-based care that incentivizes providers who support our integrated total-person approach.
- **Cultural Sensitivity:** We will integrate an awareness of diversity, cultural sensitivity, and health equity into our provider recruitment efforts. This includes statewide assessments to determine specific needs that to be met. To improve the likelihood that members will actively participate in their care, we aim to have a network of providers who demographically align with our membership, including a priority to secure Mississippi's only Indian Health Services center. In areas where Mississippi does not have a culturally diverse group of providers, we will have provider resources aimed at instilling cultural competency and promoting health literacy among their patients. When a language barrier exists, we will facilitate access to real-time interpreter services, including oral translation in over 240 language, American Sign Language and relay services, for both members and providers.

Processing and Executing Provider Contracts

Our contracting processes are largely electronic, which promotes speed and accuracy of loading providers. Prior to initiating a contract, we will verify that a provider is qualified to perform the services being requested for our network. This is done through a credentialing process and we are equipped to accept industry-recognized credentialing processes, such as those performed by a formal committee following the Council for Affordable Quality Healthcare (CAQH), or a local centralized credentialing verification organization (CVO) process as suggested by the Division below.

Following successful credentialing, and verification that a provider is enrolled with Mississippi Medicaid, a member of our local network management contracting team will contact the provider and invite their participation in our network. We will email contracts to the provider for review and e-signature. After the contract is e-signed and countersigned, the provider information team will load the provider's information into the claims system. This signifies they are ready to see members and claims can be processed. The process from provider signature to load will surpass contract standards of occurring within 21 calendar days as required in Appendix A, Draft Contract. When a contract has not been received within seven calendar days, we will send a system-generated reminder email to the provider. If the provider does not respond or has a question, we will contact the provider telephonically to reassess their participation intent or to answer any questions.

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

Our strategy is to create a supportive provider experience, focusing on **service, simplicity, and collaboration.**

Service

Nurturing Local Partnerships

We will have a team of clinical and nonclinical support services across the state that regularly engage providers. Specialty nurses, such as our field-based RN consultants, practice care managers and behavioral health consultants, will engage with providers to share clinical data, performance metrics, and align joint initiatives. Our care managers will engage PCP and specialty providers to help coordinate care. We will assign provider relations representatives to contracted providers based on geography and provider type. These representatives will be equipped to address administrative and financial needs of providers. To optimally serve the specific needs of providers, we will maintain staff who have expertise in certain provider types. To best support our medical homes, we will have provider representatives familiar with FQHCs and RHCs. Similarly, hospital-focused representatives will be used to support acute care facilities and representatives familiar with dentistry, durable medical equipment (DME), and BH/SUD will be deployed in the field. Our large medical homes will have dedicated one-to-one clinical representatives to support care transformation efforts and VBP initiatives. As evidenced in states similar to Mississippi, this level of support leads to increased provider satisfaction, which increases retention.

Simplicity

Providers will have access to our provider portal, 24 hours a day, seven days a week to conduct business anytime it is convenient for them. Through a single secure portal, providers will be able to access solutions aimed at streamlining and simplifying clinical and administrative interactions. Their professional or support staff will be able to complete administrative interactions, with quick solutions to manage prior authorizations (PAs), make demographic changes, eligibility and benefit verification, appeals, claims management and reconsiderations. Clinical tools will include on-demand trainings, evidence-based criteria for medications and procedures, and care gaps. These clinical tools will assist providers in maintaining an accurate and real-time roster of their patient panel and identifying missed preventive services — both of which improve earning potential for providers enrolled in our incentive arrangements.

Collaboration

Timely communication, provider-friendly tools and education are essential to helping providers learn about MississippiCAN and CHIP and how we can comanage these populations. We will listen to and collaborate with providers to identify and work together on ways to streamline our processes. Providers will have access to their field-based provider relations representatives, virtual trainings, and our provider portal We will have a full suite of alternate payment models and clinical support models to allow providers to earn more for improving patient outcomes and reducing health disparities. We will commit to hosting in-person open forums for providers, and actively participate in professional organizations' conferences and events. We will work alongside the Division and the other CCOs to engage with providers to promote collaboration and advancement of MississippiCAN and CHIP. In a state similar to Mississippi, our **child wellness team presents to newly contracted pediatricians on the importance of, and resources for, EPSDT and child wellness.** This is especially important to achieving early partnerships so we will commit to doing this for MississippiCAN and CHIP participating providers serving children.

Member Access to Out-of-Network Specialists

We commit to providing a comprehensive network designed to serve the full MississippiCAN and CHIP membership. Occasionally, a specific provider type may not be available timely in a rural or remote area, or if a need is so specific that a provider type does not exist in the State. In these rare instances we will use our care managers, in collaboration with our medical director and the referring provider, to evaluate options to best suit

the member. Whether working with local out-of-network providers or providers outside the member's geographic area, we will ensure timely access to care by:

- **Short-Term Intervention:** If a contracted provider is unavailable to meet member access and availability needs, we may enter into a single case agreement (SCA) with the out-of-network provider to ensure the member is able to receive needed care. We will confirm the provider is enrolled with Mississippi Medicaid and facilitate a care plan between the out-of-network provider and the member's PCMH or referring provider. If the provider is not enrolled with Mississippi Medicaid, we will work with the Division and the provider to assist with enrollment activities. The SCA will be quickly executed to meet the member's needs. We will ask the out-of-network provider to create a care plan that can be followed closer to home and employ telehealth for follow up care when possible.
- **Long-Term Intervention:** Continuity of care is important clinically and emotionally for members. We will support the continuation of existing relationships with out-of-network providers when it is in the member's best interest. For example, if a new member previously received oncology services from an out-of-network provider, we would continue to authorize services and reimburse the provider. In addition, we believe that certain services such as maternal-child health represent patient-provider bonds that should be protected for the health and safety of the mom and child.
- **Urgent and Emergency Services:** We will not require prior authorization for any emergency services, regardless of a provider's network status. Members have the right to access care at any hospital, trauma center or licensed emergency facility of their choice and should not expect any barriers.
- **Telehealth:** The medical home is the foundation for care delivery. If our care manager, medical director, or referring provider is unable to secure an SCA or contract we will explore the opportunities offered by telehealth. We will maintain active relationships with telehealth providers across the country and ensure they are enrolled with Mississippi Medicaid. We will work with the member and PCP to ensure that the option meets the needs of the member.

Monitoring Quality of Out-of-Network Providers

Our Mississippi-based medical director will review all requests for the use of out-of-network services for clinical determination. Prior to the medical director's review, members or physicians on behalf of members, may request a referral with an out-of-network provider if:

- The member is diagnosed with a condition or disease that requires specialized medical or behavioral health care; and
- We do not have a participating specialist with the professional training and expertise to treat the condition or disease; or
- We cannot provide reasonable access to a specialist with the professional training and expertise to treat the condition or disease without unreasonable delay or travel.

A decision by our medical director to deny access to the out-of-network provider will meet the qualifications of an adverse determination, which is appealable.

All approved out-of-network encounters will be reviewed after services are performed. This review will include clinical outcomes and member and provider satisfaction.

c. If Subcontractors will be used for certain service areas (e.g., dental, behavioral health/substance use ...

Nearly all of our proposed subcontracted services will be performed by wholly owned affiliates. This allows us to coordinate our network recruitment and retention efforts to best support our person-centered care model and to provide advanced data sharing capabilities and care coordination that links multiple provider types. For

example, in states where we administer dental benefits alongside medical services, we are able to incentivize pediatric providers who promote fluoride varnish through dental referrals or within their own offices.

Our network analysis tool and GeoAccess system are fed by data reported by our subcontractors so analyzing network gaps and implementing access enhancement strategies will be seamless for all provider types.

When we delegate functions to subcontractors, we maintain complete accountability for performance and systematically oversee all delegated relationships through our Mississippi leadership team. All vendors and subcontractors will be held to the same standards outlined in the model contract and they will provide monthly reports to the health plan chief operating officer and compliance officer. This includes all provider access and availability standards and the overall expectation that we will exceed the needs of our members and referring PCPs.

To ensure appropriate monitoring and oversight, at least quarterly, our subcontractors will be required to meet with us to review their development activities and performance metrics at Delegated Vendor Joint Operating Committees (DVJOC). Here they will share their performance indicators and discuss any deficiencies and action plans that are in place, including changes in the network. Our manager of delegated and subcontracted entities will lead the DVJOC meeting composed of clinical and operational health plan staff to ensure accountability from all delegated services, drive operational performance, and ensure we consistently meet or exceed network adequacy standards. If we observe any gaps in the network or access deficiencies, we will report the findings to the Division and place the subcontractor on a corrective action plan.

d. Proposed method to assess and ensure the network standards outlined in Appendix A, Draft Contract, are ...

Our Mississippi provider network will meet network standards as detailed in Appendix A, Draft Contract, and NCQA standards. To ensure all medically necessary covered services are accessible and available, our network strategy team will monitor network performance, address opportunities for improvement, and communicate follow-up actions to the Quality Management Committee.

Using GeoAccess to Ensure Network Adequacy

Our proposed method to assess our network and ensure standards are met includes GeoAccess, which maps the travel time and distance between the member's residence and the primary care providers' service location(s). Next, we will do the same for our network of hospitals, specialty care providers, dental providers, dialysis centers, vision services, behavioral health locations and urgent care centers, and compare access and availability performance to state requirements and our expectations. Our proposed method will display the GeoAccess data as follows:

- Pictorially using maps with member distribution overlayed by provider types. Each provider type will be displayed separately so that we can assess each provider type independent of the others. This will allow a quick overview to ensure our members have options close to home.
- Lists by counties that separate each provider type and how many members have access to each provider type. This method will allow us to analyze each county and see what percent of the county's residents do not have access to a certain provider type. This is especially helpful when we need to see which specialists will need to be targeted within a certain county.
- Flexibility to look at pediatric providers independent of adult-focused providers. This will support the need to be able to monitor access to care for our CHIP and MississippiCAN children.
- Ability to look at providers who have closed panels or are no longer accepting new patients. Our systems have indicators that will allow us to visualize our provider distribution and see which ones are still accepting new patients. This will allow us to be absolutely certain of our network's full potential.

Using Our Provider Data to Ensure Network Adequacy

Upon credentialing and contracting, we will verify where our physicians have admitting privileges. We will store this data in our provider database so we can ensure that we have all needed facilities (hospitals, surgical centers, inpatient residential, etc.) to support providers and members. If we identify that a provider holds privileges at a hospital that is out-of-network, we will use this information to identify a potential gap.

Using Appointment Availability to Ensure Network Adequacy

Merely having providers is not always sufficient to meet the needs of members. To ensure that care is available when it is needed, we propose routine and random appointment availability calls to providers to check appointment availability.

Ultimate accountability of provider access and availability will be overseen through our Service Quality Improvement Subcommittee, which will report to our board of directors. The network strategy team will monitor network performance and the network director will formally report all activity to the subcommittee and to the Division. The team will share the adequacy of our provider network with our provider and member advisory groups, which will serve to align performance and perception. Access and availability activities will include:

- Reviewing network performance against access standards
- Monitoring, evaluating and implementing improvement plans for network access and availability
- Monitoring network provider linguistic competencies as compared to languages spoken by members, and providing access to interpretive services
- Monitoring member and provider calls and feedback to identify potential network concerns
- Reviewing member and provider satisfaction survey results
- Conducting member surveys on appointment availability, after-hours availability and open scheduling
- Receiving, evaluating and acting upon feedback from Member and Provider Advisory Committees
- Obtaining feedback from clinical and quality operations staff
- Implementing any necessary action plans

e. The Offeror’s process for continuous network improvement, including the approach for monitoring and ...

Our Approach to Continuous Network Improvement

We will consistently look for ways to improve our network. Continuous network improvement relies on a multifaceted process that includes:

- Analyzing data to identify network improvement areas
- Performing state assessments to determine clinical demands and current provider performance
- Using provider services and support to help us retain contracted providers
- Incentivizing providers above-and-beyond traditional reimbursement methods
- Developing strategies to increase access
- Planning for growth via proactive provider contracting and credentialing
- Incorporating community and stakeholder feedback
- Engaging high-impact provider types that can satisfy multiple needs
- Using innovative strategies and technologies to achieve network improvement

The ongoing use of the previously mentioned tools and assessments will be critical to carrying out our network strategy. To further refine our network, we will collaborate with the other CCOs in an effort to closely align our

approaches with providers. This will allow for seamless transitions when members choose to move into another CCO. We will use our field-based teams and advisory groups to help us identify new providers more quickly.

Finally, to help combat the barriers that geography places, we will partner with providers who can meet the members where they are. This includes maximizing the scope of clinical pharmacists. Most members visit their pharmacy more frequently than any other provider type. Many of these pharmacies employ pharmacists trained in vaccines and venipuncture, so engaging these providers to augment the services will support medical homes. In addition, we will actively search for providers who can provide enhanced telehealth and mobile units and we will develop creative partnerships with emergency medical responders — all of whom are capable of providing services in the home.

Monitoring and Evaluating Appointment Availability

Network providers will be contractually obligated to comply with the appointment standards detailed in RFQ Appendix A, Draft Contract Section 6.2.2. We will inform providers of our appointment standards through new provider orientation, ongoing training, and educational materials, including our quarterly newsletter and our provider manual, which are available online. We will conduct routine phone surveys and annual audits, which will include a random sampling of PCPs, behavioral health providers, and key specialty types to solicit information about appointment availability. We will compare the appointment availability results against the Division's requirements and our accessibility and availability standards. Our quality management team will engage and monitor nonadherent providers and take action to improve the provider's performance including corrective action plans. Participation in our VBP and incentive programs will require providers to allow unhindered access to their practice.

Enabling Member Access to Care

As described in our response to Question b, above, specific provider types may be unavailable in specific areas, such as rural or remote areas. Our care managers will work with members to identify providers who can meet the member's needs.

Expanding Access Through Telehealth

Driving Innovation and Value

Our virtual visits program will allow members to initiate a telehealth visit from home through video conferencing or smartphone application with a qualified provider. Our virtual visits program will enable direct access to care through web, mobile web or the mobile app and will be available 24 hours a day, seven days a week throughout the contract term. **On average, our virtual visits program has shown that it can resolve 77% of health issues** without having to refer the individual to in-person care. In two states similar to Mississippi, since the program's inception in 2019, **ER visits decreased by 46% and 38% for individuals engaged in our virtual visits program.**

Telehealth OUD/SUD/MAT Support: We recognize the need for OUD/SUD/MAT services exceeds the capacity of providers in Mississippi, as coverage for these services is fairly new and substance abuse continues to rise. Our telehealth OUD/SUD/MAT support program is a virtual opioid use disorder (OUD) and substance use disorder (SUD) clinic that offers telehealth services. This offering helps close the gap in a manner that is convenient for our members to access. We will offer our telehealth OUD/SUD/MAT support program to MississippiCAN and CHIP members.

Behavioral Health Virtual Visits and Telemental Health: We will incorporate behavioral health virtual visits into our standard offering for members and providers as an alternative method to seek and provide care.

We will offer our behavioral health self-care and peer support app, a self-help digital application that uses clinically validated techniques, such as cognitive behavioral therapy (CBT) and mindfulness to reduce the effects of toxic stress, depression and anxiety.

f. How the Offeror will ensure appointment access standards are met when Members cannot access care ...

Our care managers will provide hands-on assistance and a closed-loop referral process in arranging both network and out-of-network care as member needs dictate. Care managers will tailor assistance to meet member needs and schedule these appointments in compliance with our appointment standards. Out-of-network providers operating under an SCA will be required to provide care in compliance with our policies, including appointment access standards. To ensure appointment access standards are met, we will require providers who engage in ACO arrangements to have extended hours and to contract with urgent care centers for care on weekends and holidays.

g. Describe the role of the Contractor's Provider Representatives, how the Offeror will recruit and maintain ...

We will have a fully staffed provider relations team, including 30 full-time, Mississippi-based provider relations representatives across the state. Depending on their functions, our provider services representatives will have strong clinical or administrative backgrounds so that they will be knowledgeable of provider needs. Providers will be served according to their specialty type and geographic location. This will include provider relations representatives hired across the state of Mississippi who have working knowledge of MississippiCAN and CHIP and the provider type they will be serving. Our provider relations team will contribute to the design and implementation of all MississippiCAN and CHIP education programs and will be expected to build and nurturing positive relationships with Mississippi's network of health care professionals. The provider relations role will be a trusted advisor to providers, and they will approach each provider engagement as an opportunity to positively impact care delivery.

Our Provider Relations Representatives Role

The provider relations representatives will be accountable for the full range of provider relations and service interactions with clinicians, hospitals, specialists, FQHC, RHC, PCMH and practice managers. They will work on end-to-end provider claim and call quality, provide feedback and guidance, assist in efforts to enhance ease of use of physician portal and future services enhancements and assist network contracting and development teams by identifying gaps in network composition and services. Our provider relations representatives will take a hands-on approach to identify issues early, communicate proactively and foster strong, positive provider relationships.

Our Efforts to Recruit and Retain Provider Relations Representatives

We will conduct rigorous workforce planning activities that ensure contract compliance is consistently maintained. We will use community-based resources to ensure a diverse staff that reflects the communities we serve. Our provider relations representative recruitment efforts will include representation from all areas of Mississippi.

We recognize that our most competitive advantage will be retaining a tenured staff of the best and brightest employees, who represent the Mississippi communities we serve. We will retain experienced and qualified key personnel by rewarding and recognizing performance in a challenging environment and providing clear direction to achieve success. Our practices, policies and procedures will guide employees as they evolve in their role. By offering resources to help employees develop, we will preserve and attract the highest-quality employees. In a state similar to Mississippi, **80% of our provider relations representatives have a tenure of five years and rate their job satisfaction as "high."**

Ensuring Provider Representatives are Current in Medicaid Policy

We will provide initial and ongoing MississippiCAN and CHIP training to our provider relations representatives including training on the laws, regulations and codes governing these programs. We will train provider relations representatives to understand common provider concerns, and our systems will support providers through modules that are self-taught, instructor-led classroom training and field shadowing. Initial training will include over 60 curriculum modules and last approximately two months before assignment to a provider territory.

Throughout the two-month training process, provider relations representatives will shadow a senior representative at on-site provider visits and meetings. Representatives will attend a week-long intense training class with other new-hires from around the region where they will be immersed in coaching and instruction that prepares them for their role in providing the highest level of service so that their providers, in turn, can provide the highest-level of care for our members. Representatives will engage in ongoing training throughout the year to keep them abreast of the most recent topics and changes in the industry.

In order to make sure representatives remain current on the latest changes such as State Plan Amendments and program changes, we will distribute MississippiCAN and CHIP materials through an internal SharePoint site that includes timely and specific updates on new or revised policies. This will include the latest member and provider information, all of which will be shared throughout the year and formally socialized by our provider services manager and supervisors. These resources will be available to both field-based and telephonic representatives to ensure that providers are receiving consistent and accurate information at all points of contact.

2. Describe how the Offeror will develop and maintain collaborative relationships with low, medium, and ...

Relationships are important and are the foundation of our work with providers and members. We have established relationships with low, medium, and high intensity residential treatment facilities and those who offer medically monitored inpatient treatment services nationally. We will support those facilities through our clinical relationships and our provider relations staff. Our clinicians will work directly with facilities to provide utilization management, care coordination and discharge planning support. Our care managers will collaborate with facilities to assist with discharge planning and make recommendations regarding services available in the community and supports for members as they transition from a higher level of care to the community. When new services, such as opioid treatment programs, have been approved by the state in similar states, we have expanded our service array to include new provider types to provide those services. We will do the same in Mississippi.

In addition to our provider relations outreach, our care management and utilization management teams will be in frequent communication with providers through their work on behalf of our members. Through these relationships, collaborations will emerge to include things such as daily case management calls with facilities, care management staff placement within facilities to assist members with discharge and provider trainings responsive to providers' identified needs. Much of our American Society of Addiction Medicine (ASAM) engagement will occur through our teams — helping providers identify the correct level of care, clarify the goals of treatment, identify any specific activities of daily living needs and move toward treatment success. We will use these decisions from ASAM guidelines to guide and support providers and members in making decisions that lead to better outcomes and potentially reduce utilization that is not therapeutically beneficial.

In other states, we provide educational materials and updates regarding ASAM, including information regarding the guidelines, frequently asked questions and other key information to support these providers in service delivery. Most recently, in 2021, we provided education to providers regarding expanded coverage of ASAM level 3.5 in states that support that level of care. We provided information on how this expanded coverage would impact provider contracting and invited additional providers to apply for network participation.

Developing and Maintaining Collaborative Relationships

To promote strong relationships with these facilities and other Mississippi providers, we will have designated Mississippi behavioral health provider and care management staff who have experience at the behavioral health/substance use disorder service delivery level in Mississippi. This team will work closely with Mississippi providers to:

- Bridge coordination between the physical and behavioral health/substance use disorder providers
- Support the delivery of high-quality, cost-effective health care services for members

- Resolve any operational issues
- Coordinate meetings with our clinical team and providers to provide feedback regarding performance
- Share and disseminate best practices, such as our clinical practice guidelines, available through our provider manual, covering both physical and behavioral health/substance use disorder conditions
- Promote mutual values and goals such as increasing Mississippians' access to behavioral health/substance use disorder care through program development and telemental health services
- Connect PCPs and/or PCMHs with behavioral health professionals to assure members are screened and appropriately referred
- Promote value-based purchasing with qualified providers
- Participate in external, state-supported interdisciplinary teams to problem solve difficult cases with members and facilitate a smooth transition between levels of care

3. Describe the Offeror's process for working with Providers and the Credentialing Verification Organization ...

Our Approach to Working with Providers and Centralized Verification Organizations

We understand the Division is in the process of implementing a centralized Credentialing Verification Organization (CVO), and our company has experience implementing such an approach. As Mississippi works through the transition to its new model, we will be actively engaged and share our experiences in other states with the Division, other CCOs, and the chosen CVO. In addition to supporting the Division, we will begin working with our provider network to assist them in this transition and explain how this process will precede our contracting activity. Once the CVO is live and the uniform credentialing process is implemented, we will integrate the CVO activities into our processes. This will include connecting technology and systems for file transfers and updating websites with links to the CVO. Below are two examples of states (State A and State B) in which we have worked with CVOs under a Medicaid arrangement:

State	Date Started	Experience
A	2012	We participated in the development and deployment of a statewide credentialing CVO alliance. The alignment of credentialing cycles across all CCOs reduced duplication of efforts and provided for administrative simplification. The state's plan included a uniform initial credentialing requirement, use of CAQH for collection of all credentialing applications, a single CVO to perform credentialing and sharing of results among the participating plans.
B	2018	Our credentialing team implemented processes in conjunction with the state to implement the CVO for the credentialing and recredentialing for state Medicaid providers. Given our experience working with the chosen vendor, we experienced a seamless implementation of this new CVO process.

State Credentialing Verification Organization Lessons Learned

Through our experience co-implementing CVO processes, we have found that it is critical to have active participation and input into data exchange file layouts for data and file exchanges between the CVO and CCOs. We learned to anticipate provider challenges with credentialing during the transition to the CVO and prepare our staff for intervention and issue resolution.

In addition, some providers are accustomed to serving under delegated credentialing arrangements with CCOs. We have experience serving to facilitate discussions between those providers and CVOs. In some situations, the CVO and the state may choose to continue allowing these arrangements, while in other instances the delegated relationship will be dissolved in favor of the single CVO as overseen by the state. In both scenarios, we have seen better outcomes if those expectations are established early and can be communicated by all parties including our staff.

Educating and Assisting Providers in Completing Credentialing and Recredentialing

We will collaborate with the Division, CVO, and providers to execute on developing training materials, strong processes, and procedures along with sharing best practices and lessons learned. We will update all training materials and reference tools and our provider relations representatives will provide on-site and telephonic support to ensure providers are up to date on new processes and changes to existing processes. We will develop self-paced training on the portal allowing providers and their staff the ability to take trainings or refresher courses to accommodate their schedule as needed. This training will have an attestation at the end indicating the provider has successfully completed the course. In addition, we will have topic-related town halls, education sessions and instructor-led trainings. This approach will extend to vendor relationships. We will maintain policies and procedures designed to support the CVO credentialing and recredentialing process.

The goal of credentialing is to make sure providers meet quality-driven standards. We will maintain a comprehensive network quality strategy that monitors outcomes and practices to make sure members are safely cared for. When providers fall short of our expectation, we will work with the Division and CVO to report quality concerns so that credentialed status can be reviewed as necessary.

4. Describe the Offeror's approach for timely contracting of Providers upon receipt of information from the ...

Timely Contracting After Receipt of Credentialing Information

We will ensure timely contracting of providers upon receipt of information from the CVO. We understand and will comply with all requirements in RFQ Appendix A, Draft Contract related to required contracting events through strong connectivity, effective processes and electronic delivery systems, as outlined by our approach in the figure.

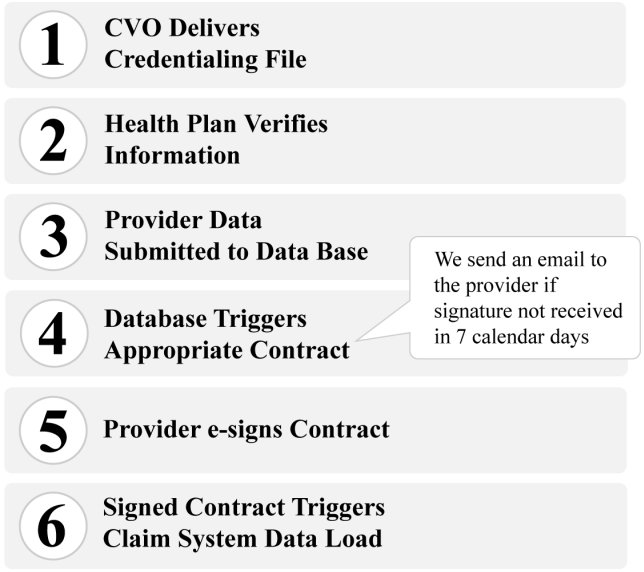


Figure 1: Post CVO Credentialing Provider Contracting Approach

Once we receive the file of providers approved through the CVO, we will ensure all required data is present to submit to our contract database triggering the contract to be sent to the provider. Upon receipt of the contract, the provider will e-sign and the contract will automatically be returned to the health plan for counter signature. Once the contract is fully executed by both parties the provider will be loaded into the claim platform and the process is complete. We will perform the process outlined above within 21 calendar days as required per Appendix A, Draft Contract. When a contract has not been received within seven calendar days; a reminder email will be generated to the provider. **In a state similar to Mississippi, we are currently loading 100% of newly credentialed providers into the claims payment system within 21 days from credentialing approval date.**

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

Please see **Att**. **4.2.2.2-1 Standard Provider Contract Templates.**

6. Describe the Offeror's proposed policies and procedures for addressing the loss of a large Provider group ...

We will establish policies and procedures to ensure regulatory compliance with Sections 6.4 Provider Terminations. Our systems will actively monitor contract effective dates and alert us to upcoming expirations. This is a safeguard to prevent providers from going out-of-network, and a tool our network management team uses to engage providers well before they are at risk of losing network status. If we and a provider are unable to resecure network status, we will offer the provider an emergency contract extension. If this is unsuccessful and

we experience a facility or large network provider termination, we will make extensive efforts to prioritize a return-to-network plan while minimizing member disruption.

Our Proposed Policies and Procedures

If we lose a large provider group or health system, our first responsibility is to provide our members with access to, and choices of providers and services through intensive care management and established referral activities. We understand and will comply with all requirements in Appendix A, Draft Contract, Section 6.4 Provider Terminations to include member and provider notification requirements, submission of termination work plans, care management, continuity of care and reporting requirements. Our detailed Policy and Procedure *Potential and Actual Provider Terminations* ensures all members continue to receive care and regulatory requirements are met.

The ability to recognize and promptly respond to potential and actual gaps in service occurs through coordination among provider services, care management and our provider network. Our policies and procedures will govern provider terminations activities in compliance with RFQ Appendix A, Draft Contract Section 6.4, including all subsections and ensure required member and provider notifications are timely and member transitions are smoothly completed with no disruption in member care. These policies and procedures include:

- Constant monitoring of potential network disruptions
- Making sure members receive adequate and timely notification and care during periods of actual or impending temporary network disruption
- Implementing post-disruption processes, which include, but are not limited to, ongoing member care coordination, enhanced communication among stakeholders and focused efforts on new agreements as the network normalizes

a. System used to identify and notify Members affected by Provider loss;

We will use member assignment data and claims data to identify and notify members affected by the potential termination at least 30 days prior to the effective date of the provider's termination date (if adequate notification was received) or within 15 days after receipt of the termination.

Step 1	**Receipt of Provider Termination**	▪ Provider notification of a termination is received ▪ Provider demographic data is updated in the system ▪ Gap analysis report is generated
Step 2	**Identify Affected Members**	▪ Identify members who received care or are assigned to the provider through utilizing provider demographic and claim data ▪ Confirm care management team is current on the term status and impacted members ▪ Develop continuity of care plan and potential transition of care plans ▪ Notify Call centers of the termination w/detail talking points
Step 3	**Generate Member Letters within Required Time Frames**	▪ Notifying member of the date their current PCP will be out of network ▪ Notifying the member on the process of how to choose a new PCP ▪ How a member can continue using services during a transition period

In accordance with RFQ Appendix A, Draft Contract, we agree to notify the Division in writing of a provider termination at least 60 calendar days prior to the effective date of the termination. If the provider initiates a termination, and we receive less than 60 days' notice, or if there is a significant safety concern that dictates quick action, we will notify the Division within two business days after receiving notice from the provider or initiating the termination.

The member assignment data and claims data are both integrated into our provider database, which will generate a report that identifies the members who will be affected by the termination. This will support our care management and member enrollment platforms to assist us in accurate and timely member outreach.

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

Assisting Members Affected by Provider Loss

Our member assignment and claims data systems feed into our provider database, which will allow us to auto generate and mail a letter to each affected member (in English or in Spanish by member preference) thirty (30) calendar days prior to the effective date of the termination, or fifteen (15) calendar days after receipt or issuance of the termination notice. The letter includes:

- The name of the terminating provider
- The termination effective date
- Information about how to choose a new provider or locate an alternative hospital. The letter will offer other options
- If the provider is a PCP, the letter provides instructions for the member to call our member services center for assistance in selecting a new PCP
- And information about how a member can continue using services during a transition period
- Alternate providers that the member can consider
- Rights to continue seeing a provider if continuity of care is needed

If the member does not select an available PCP within 30 calendar days of the notice, our auto-assignment process will select an open-panel PCP based on known factors as current provider relationships, language needs (to the extent they are known), age and sex, enrollment of family members (e.g., siblings) and area of residence. Our policies and procedures will include a documented process for ensuring that the PCP is willing to accept assignment of a member before we assign the member to the PCP.

Our director of network management will inform service navigators of any large group termination and are available and willing to assist members who want to select a different PCP. We will mail members a new membership card, which notes the new PCP. If the member is in care management, or requires care coordination, we will use the following process:

Notification to Care Manager: Our automated system will generate a notification immediately to the care team to allow sufficient time to coordinate services for the member through another provider.

Review of Transition Options: Our care manager will assist the member with selection of an alternate provider, which will support the member's right to choose.

Continuity of Care (COC): The care manager will verify that services offered by the previous provider are not terminated until arrangements to start services are complete with the new provider. If we determine a member should continue care with the terminating provider; the SCA process will be initiated ensuring the member has continuity of care.

Transition Assistance: When a new provider starts services, after termination of another, the care manager will contact the member or representative on the first day of services to verify the member has started receiving services. During this outreach, the care manager will verify whether all additional required assistance was provided such as translator or disability assistance. If this does not occur, the care manager will intervene to ensure COC.

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

Systems and Policies We Will Use to Maintain Continuity of Care

Upon termination, our care management team in coordination with our network management team will immediately assess provider availability within the community. The preferred strategy will be to refer the member to another qualified, contracted provider near the member. If a contracted provider is unavailable, we will take the following steps: refer to a non-contracted provider with whom we attempt to initiate an SCA; recruit a new provider; or transport the member to a provider outside of the member's community. For members in active treatment, we will make certain their care is not disrupted during this transition. Our comprehensive COC policies will reinforce our position that members' needs come first.

Our transition of care and continuity of care policy will allow current members a transition period when a treating provider leaves our network. During this transition interval, the member will be eligible for in-network benefits and covered services rendered by an out-of-network provider for continued treatment through the current period of active treatment or for up to 90 calendar days, whichever is less.

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

Members will be assigned to a new provider to avoid disruption in care or services. We will analyze the GeoAccess and network analysis reports for the remaining providers to confirm we are meeting members' access to care needs and, when necessary, we will follow the "any willing provider" standard to identify available providers for network participation. At all times, we will provide transportation to and from providers who are no longer in our network.

Our Approach to Using Existing Network Providers to Ensure Continuity of Care

We will implement a short-term intervention such as continuing services with the current provider until the treatment period ends to avoid disruption in the member's care. We may refer the member to a nonparticipating provider, recruit a new provider or arrange for the member to see a provider outside the member's immediate community, if needed, with appropriate transportation support. Members who live near bordering states may be able to receive care across state lines. Using our existing networks along with our technical and operational support to include leveraging telemedicine and mobile health solutions, we will be able to meet the health care needs of our members.

7. Describe any Provider incentive programs the Offeror plans to implement to improve access and ...

Our Approach to Provider Incentive Programs

Driving improvements in access and the quality of care is our priority. One way to do this will be by incentivizing providers to facilitate practice transformation and enable them to provide the right care, at the right time in the right place. Under the current restrictions of Mississippi's Medicaid Technical Bill, incentives we propose to use to improve access and the quality of care include quality pay for performance and shared savings programs. Our planned incentives target PCPs, including FQHCs, RHCs and patient-centered medical homes (PCMHs), and specialists. We will offer incentive programs to behavioral health providers, dentists, pharmacists, hospitals and specialty care providers.

We will match providers with incentives aligned with their capabilities, organizational culture, populations served, and help them progress along the Health Care Payment Learning and Action Network (HCP-LAN) alternative payment model (APM) risk continuum while promoting and enabling success. Our incentive programs will all come with support from our staff and will align quality measures with HEDIS and Division quality and outcomes priorities. We will propose the following incentive programs to drive improvements in both access (getting members in for care) and quality of care (closing care opportunities). We are confident that all selected CCOs could implement any of our incentive programs through a program-wide aligned approach, and we recommend the Division allow each CCO some flexibility to deploy their unique and innovative

incentive models. At the same time, we recognize the importance of creating administrative simplification and ease for providers working across multiple vendors and welcome the opportunity to work with the Division and the other CCOs to implement the strongest possible program**.**

Incentive Program	Program Description	Targeted Providers	Expected Outcomes
Quality Gap Closure Incentive Program	This program will focus on closing gaps in care and improving quality outcomes critical to the Division and MississippiCAN and CHIP members. This model will include key HEDIS® and CMS Core Set metrics aligned with state quality objectives, such as asthma, diabetes care, cancer screening, and well-child visits. Participating providers will receive standard reimbursement and opportunities to earn incentives for closing gaps in care. This program will serve as an aligned step into other APM models. *In a similar-sized state in 2020, providers in this program closed over 68,000 gaps in care and earned over $500,000.00.*	PCPs, including FQHCs, RHCs, PCMHs, Pediatricians	Improve HEDIS measures such as comprehensive diabetes care HbA1c test (CDC), Breast Cancer Screening (BCS), Well-Child Visits (W30), and other priority measures monitored by the state.
Health Equity Incentive Program	All our VBP programs will address health equity by identifying members with care opportunities and our Health Equity Incentive Program will aim to address disparities seen between populations for key HEDIS metrics important to MississippiCAN and CHIP members, tiering incentives to reward providers for bringing members in for needed care. For example, we know that for the breast cancer screening HEDIS measure there is a larger disparity between Black and white members, especially in Harrison and Forrest. To help address this disparity, we propose using this measure in our HEP program and creating higher incentives to reward providers for bringing members in for needed care and decreasing the disparity seen between the two populations.	PCPs, including FQHCs, RHCs, PCHMs, Pediatricians	Improvements in health equity between populations by decreasing disparities seen in key HEDIS quality measures between populations of people, such as comprehensive diabetes care HbA1c test (CDC).
Pediatric Patient Centered Medical Home ACO	This incentive model will be exclusively for NCQA Patient-Centered Medical Homes (PCMHs) with greater than 80% pediatric populations. This model will focus on driving improvements in access as practices in this model must have open panels and extended hours. For providers to earn incentives in this program, at least two quality performance goals must be met to receive a per-member-per-month (PMPM) bonus, paid annually. Providers in this program may be eligible for additional PMPM funding if additional quality performance and efficiency measures are met.	PCMHs with greater than 80% pediatric members	Improvements in HEDIS quality measures such as well-child visits (W30) and immunizations for adolescents (IMA). Improvements in access to care as providers need to have extended office hours.
Shared Savings	This model will recognize that most member care is directed by PCPs, including PCMHs, which have the greatest opportunity for affecting the overall health and total cost of care for MississippiCAN/CHIP members. In this program, participating providers will be eligible to share in savings they achieve against total cost of care or clinical efficiency metrics. Practices must maintain open panels for new patients and offer extended evening and/or weekend hours for expanded accessibility. *We have implemented over 191 shared savings programs in 17 states for Medicaid managed care programs. Nationally, providers in these*	PCMHs, Medical Groups, PCPs with greater than 1,000 assigned members.	Improvements in HEDIS quality measures such diabetes (HbA1c) testing and well-child exam for the first 30 months of life (W30). Improvements in access to care as providers must offer extended office hours. Reductions in unnecessary emergency room visits.

Incentive Program	Program Description	Targeted Providers	Expected Outcomes
	agreements show 9% lower admission rates and 2% fewer ER visits compared to members whose providers are not in shared savings.		Reductions in unnecessary inpatient hospital stays.
Integrated Shared Savings	Similar to our Shared Savings described above, our Integrated Shared Savings model will support providers who have an integrated medical and behavioral clinical model within their practice. Providers will be eligible to share in savings they achieve against a blended total cost of care (TCOC) metric that includes both medical and behavioral health utilization. Practices must meet a quality gate of physical and behavioral health measures aligned with the Division's quality and performance measures to share in savings.	PCMHs, Medical Groups, PCPs with greater than 1000 assigned members who have behavioral health providers co-located.	Improvements in HEDIS quality measures such diabetes (HbA1c) testing and follow up after hospitalization Improvements in access to care as providers must offer extended office hours. Reductions in unnecessary emergency room visits. Reductions in unnecessary inpatient hospital stays.
Obstetrics Provider Quality Gap Closure Program	This program will reward qualifying OB practices through annual bonus payments for achieving or exceeding target scores related to certain HEDIS prenatal and postpartum measures and improving birth outcomes. *Using this incentive in a similar state, targeted providers' prenatal and postpartum visit rates increased 39% year-over-year.*	OBs	Improvements in prenatal and postpartum (PPC) HEDIS quality measures.
Behavioral Health Community-Based Provider Shared Savings	To improve outcomes for members with mental health conditions, our program will focus on reducing unnecessary hospital costs through the provision of high-quality outpatient care. Since members cannot be assigned to an outpatient behavioral health provider, we developed an attribution model whereby members who have two or more outpatient visits with the same provider are attributed to them during the measurement period. Providers must meet quality metrics such as follow-up after hospital discharge and medication adherence. This model can be deployed using a flexible, aggregated approach enabling lower volume providers who would not otherwise qualify for an incentive program to participate without requiring clinical integration.	Behavioral Health Community-Based Providers	Improvement in seven and 30-day follow-up after hospital discharge (FUH 7/30) HEDIS quality measures. Improvement in medication adherence. Reduction in unnecessary inpatient behavioral health hospital stays.
Behavioral Health Facility Shared Savings	This program will focus on lowering behavioral health episode cost of care while driving improvements in quality outcomes such as follow-up after hospital discharge and readmission rates. A Provider Enablement Consultant (PEC) will be assigned to each provider who participates in a behavioral health value-based program. The PEC will deliver data, analytics, and clinical insights to providers to help them enhance their person-centered care. Most importantly, provider enablement will monitor, measure and drive population- and member-centric outcome improvements.	Behavioral Health Facility (Inpatient, Partial Inpatient, Residential)	Improvement in seven-day follow-up after hospital discharge HEDIS quality measures (FUH 7). Clinically appropriate reduction in readmissions rates for behavioral health facility services.
Pharmacist Incentive	To take advantage of the accessibility of pharmacists within the community to complement and bolster the role of the physician, we will partner with Mississippi independent pharmacists to recognize and reimburse	Independent Pharmacists	Improvements in HEDIS quality measures such as Statin Therapy for Patients

Incentive Program	Program Description	Targeted Providers	Expected Outcomes
	pharmacists for their clinical value beyond medication dispensing. Focusing on HEDIS measures, including Comprehensive Diabetes Care and Statin Therapy for Patients with Diabetes, Mississippi pharmacists will contribute to our team-based and multipronged approach to target hard to reach members in rural areas of the state. In a state with a similar size and member population, pharmacists were able to close 13% of identified gaps in care for members identified as hard to reach or non-responsive to traditional methods of outreach.		with Diabetes – Statin Therapy (SPD).
Dentist Incentive	Upon contract start, we will offer a new VBP incentive program for dental providers through which providers will be eligible for incentive compensation based on their office utilization for periodic oral evaluations, annual dental visits, sealants for children with elevated caries risk, prophylaxis, and topical fluoride varnish applications for children at elevated caries risk performance.	High-volume dental providers, including FQHCs and large dental practices	Increased preventive and diagnostic procedures performed, which will contribute to improved HEDIS Annual Dental Visit (ADV) metrics

8. Explain the Offeror's proposed process to maintain the Offeror's Provider file with information about each ...

Our Proposed Process for Maintaining the Provider File

Achieving Operational Excellence

We will collect data at several points throughout our interactions with Mississippi providers, from their initial application to join the network, to ongoing communications and outreach. We collect data and information about providers through national registries and databases. We will use our comprehensive set of established processes to continually review and update our provider data. We will collect and display captured information, including cultural competency trainings, languages spoken, facility and equipment accommodations and panel status, including whether providers are accepting new patients, in our provider directory to make sure members in MississippiCAN and CHIP can locate providers who meet their needs and preferences. These processes are adaptable and, through collaboration with the state, we can augment them to reflect Mississippi and population-specific needs.

The daily provider file will be used to ensure we are maintaining files of providers who are enrolled with the state, and we are recognizing only eligible providers and maintaining consistent and current provider payment data. We will initiate cessation of payment immediately to any providers who are sanctioned by the Division. If we detect a sanction before being alerted, we will notify the Division and seek advice on our next steps.

a. Issue IRS 1099 forms,

All provider files submitted for loading into the claim processing system will be required to have a valid W-9 tax form on file at the time of loading. If a W-9 is not on file the provider will be required to submit before their data can be loaded into the claim processing system. The W-9 forms will be stored in our system as part of the provider file. This process will be applicable to network and out-of-network providers and will facilitate our issuance of IRS 1099 forms as required.

b. Meet all federal and Division reporting requirements, and

Provider information will be collected through multiple avenues and will be stored and accessible for all reporting requirements. The data will be readily available to meet business, state, or federal reporting requirements. We will produce provider files as necessary in support of our encounter process, state partners, auditors, and as outlined in state and federal regulatory requirements. In addition, all provider data will be collected in support of the Federal Managed Care rule around our directories.

We will monitor data quality by using an internal error report to identify provider records not in the appropriate format. Our provider file information will then be reconciled with the Division's provider file to ensure data accuracy and alignment with the Division. Our provider data systems are flexible enough to accommodate changes as we receive feedback.

c. Cross-reference to state and federal identification numbers to identify and report excluded Providers.

We will routinely cross refence to state and federal exclusion reports as part of our approach to support our data and data integrity. We will comply with all federal and state requirements to make certain all providers are screened for excluded persons. We will communicate this obligation to any subcontractors. Further, we will search the following sources upon enrollment, re-enrollment and at least monthly thereafter to capture exclusions and reinstatements: HHS-Office of Inspector General's (OIG)'s List of Excluded Individual and Entities (LEIE), General Services Administration (GSA) Excluded Parties List Service (EPLS), the CMS Medicare Exclusion Databank (MED), the State Board of Examiners and the System for Award Management (SAM). The process will include routine checks of the following databases: Social Security Administration's Death Master File, the National Plan and Provider Enumeration System (NPPES), National Practitioner Data Bank (NPDB) and Health Integrity and Protection Databank (HIPDB).

B. Provider Services Call Center

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

Our toll-free Mississippi-based provider services call center will operate in compliance with the requirements of the RFQ, including those in Appendix A, Draft Contract Section 6.9.

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

Overview of Our Provider Services Call Center Operations

Operating under the direction of our provider services director, our provider services center will be staffed by provider phone representatives who will be extensively trained on the MississippiCAN and CHIP contract requirements. Our provider phone representatives will help on covered services, fee schedules, enrollment, member eligibility verification, procedures for prior authorization and referrals, claims payment, disputes, grievances, benefit exclusions and limitations, coordination of benefits, coordination of out-of-network services, referrals to the fraud and abuse hotline, provider demographic updates and PCP assignments. We will facilitate the transfer of member medical records among providers and provide PCPs a monthly list of members under their care, (including identification of new and deleted members) and a guide detailing the use of the list. Throughout the upcoming contract term, our provider phone representatives will receive intensive training on the details of MississippiCAN and CHIP and will have access to each provider's file, credentialing status and claims/payment data.

Our provider services center will have an option for pharmacy services, where providers will be directed to dedicated pharmacy team to assist with escalated issues. Our pharmacy team will have national experience working with a carved-out pharmacy benefit, collaborating with the state's pharmacy benefit administrator (PBA) to make sure our members have timely access to pharmacy services. Upon designation of the state's PBA, we will enact processes so that our call center can coordinate with internal and external entities, including the state's PBA, to provide a warm transfer for providers. This ability will provide a quick and seamless process to resolve pharmacy services-related calls, or to help with any misdirected calls.

a. Hours of operation;

Our provider phone representatives will live answer provider calls Monday through Friday from 7:30 a.m. to 5:30 p.m. Central Time, or as directed by contract changes. Providers can leave a message at our provider services center at any time outside these staffed hours and calls will be returned the next business day. We will use intelligent call routing that recognizes a provider's phone number or TIN and preferred language to connect

the caller quickly and accurately with an appropriate Mississippi provider phone representative. The system will offer a menu of automated and live options, allowing providers to speak with a representative at any point during the call.

b. Describe how the Offeror will ensure call center employees will have cultural competency.

Standardized cultural competency training will be required of all employees, including our call center employees. Our local leadership team will be accountable for creating and maintaining our cultural competency plan that supports cultural humility in delivering high-quality service to support a positive provider experience and member outcomes.

Our cultural competency training will bring awareness and sensitivity to individuals that come from varied economic, social, religious or ethnic backgrounds. We will apply voice-activated behavioral analytics to record and analyze 100% of provider calls, enabling us to identify opportunities unique to each representative and provide one-on-one coaching.

c. Specific standards for rates of response (e.g., live answer, incomplete calls, speed of answer, ...

To ensure compliance with call performance standards, our management team will monitor activity in real-time and generate specialized reports to identify peak call times and quantify individual provider phone representative productivity. To confirm the accuracy of our responses, we will use a call-monitoring system to perform evaluations, make and play recordings, and perform live monitoring. Supervisors will access the call monitoring system to review their team's quality evaluation details and scores. We will record at least 99% of calls and randomly select provider phone representatives for monthly quality reviews. We will routinely monitor no less than 3% of calls for compliance with customer care guidelines and will have procedures to increase if indicated. Our provider phone representative call system will detect changes in voice tone, volume, inflection, and the use of key words to alert the on-call supervisor for quick intervention and redirection as necessary to ensure a satisfactory outcome.

We will provide the Division with call recordings upon request and file reports as required in the Appendix A, Draft Contract. We will retain the recorded calls for seven years. Our provider services management will meet weekly to address metrics, staffing, training needs, and to document updates or operational issues. The management team will measure wait times, the number of calls holding in queue, average speed of answer, reasons for calls, and offers a transfer to a satisfaction survey after the call.

d. Training program for call center employees including local and statewide cultural competency; and,

Our commitment to comprehensive staffing and training initiatives will be key factors in our success in meeting Mississippi requirements for responsiveness and quality control.

Provider Phone Representatives Training

We will facilitate initial and ongoing training to foster high provider satisfaction as our provider services call center provider phone representatives. Provider phone representatives will receive extensive MississippiCAN- and CHIP-specific training to handle a broad range of complex topics. We will conduct on-site trainings for our provider services call center team and their backup counterpart teams. Claims supervisors, call center supervisors and provider relations representatives will participate in monthly and ad hoc calls to discuss updates, issues, concerns and network changes that may affect how we respond and resolve provider inquiries.

In concert with our standard new employee training and onboarding activities, initial provider phone representative training will include segments that align with our member services call center training, plus a six-week provider services session covering benefits, eligibility, claims and two weeks of on-the-job training. Our methods will include facilitated lectures, role-playing/simulation, question-and-answer sessions and computer-

based training. Seasoned staff will receive ongoing monitoring and training. Training topics and educational information will cover all aspects of MississippiCAN and CHIP, including:

Provider Phone Representative Training	Onboarding to Mississippi Plan	Functional Onboarding	Annual Compliance Training
Course Title	▪ MississippiCAN and CHIP Contract Training ▪ Company Required Courses ▪ Fraud, Waste and Abuse ▪ Privacy and Security ▪ Cultural Competency ▪ Code of Conduct	▪ Intro to Medicaid and Medicaid Calls ▪ Call Handling ▪ Handling Complex Provider Inquiries ▪ Introduction to MississippiCAN and CHIP ▪ Net Promoter System ▪ Pharmacy and Prior Authorization Systems	▪ Privacy and Security: Safe and Secure with Me ▪ Annual Compliance Training (includes Fraud, Waste and Abuse and Code of Conduct)

Before placement in the provider services call center occurs, provider phone representatives must demonstrate their ability to respond to provider inquiries, including complaints, grievances and appeals, and claims questions during their training period. Provider services staff will receive annual refresher and ad hoc training. Once provider phone representatives work independently, we will continue to monitor their performance and provide feedback for continuous quality improvement.

Cultural Competency Training

Our cultural competency training will bring awareness and sensitivity to individuals that come from varied economic, social, religious, or ethnic backgrounds. In the training, we will present an overview of several major cultural groups and explore the cultural dimensions of each group to increase staff understanding and appreciation of differences and similarities. Before placement in the provider phone queue, provider phone representatives must demonstrate their ability to respond to provider inquiries and complete all required training sessions with a passing score. Ongoing training will address the cultural competency and special health care management needs of our MississippiCAN and CHIP population, including use of our members' first language; cultural awareness and understanding of health disparities among cultural groups; treating each person with dignity and respect; communication protocols for members with limited English proficiency; and characteristics of and barriers facing individuals with special health care needs.

e. A description of any plans to use electronic communication to respond to Provider inquiries.

We will give providers live attention from Mississippi-based call center representatives. We will handle basic inquiries, such as eligibility and claim status using interactive voice response (IVR), but the providers will always have the option of securing a live representative.

During calls to the provider services call center, our provider phone representatives will provide technical support to help providers find information on our website or portal. However, most of our electronic correspondence with providers will be through our field-based provider relations representatives. Our provider relations representatives will communicate with providers via phone and secure email and text.

2. Describe how the Offeror will assess the quality and efficiency of the Call Center.

First Call Resolution

Our technology will enable us to track first call resolution measures and monitor provider call quality. The technology will offer 99% call recording and screen capture capabilities, enables quick identification of provider dissatisfaction, and facilitates root cause analysis of any repeat phone call. Call recording capability

will allow resolution specialists to receive immediate feedback on how they can improve their communication and resolution skills.

Internal Monitoring to Ensure Performance Standard Compliance

Our network team and local health plan staff will continuously examine our provider service components to certify compliance with Mississippi requirements, and all state and federal requirements. Examples of compliance monitoring we will perform include:

- **Provider services call center:** To confirm compliance with call performance standards, such as requirements for average answer speed, average length of call and blocked calls, we will use the following:
  - The provider services center management team will monitor our call response rate using scheduling software, generates specialized reports to identify peak call times and quantifies individual resolution specialist productivity. The management team will measure the longest wait time for any caller by monitoring the number of calls holding in queue and makes adjustments as needed.
  - To confirm the accuracy of our responses, we will use a call monitoring system to perform evaluations, make and play recordings and perform live monitoring. Supervisors will access the call monitoring system to review their team's quality evaluation details and scores.
  - We will record at least 99% of calls and randomly select provider phone representatives for monthly quality reviews. We will monitor no less than 3% of calls for compliance with customer care guidelines.
  - We will monitor calls daily and have supervisors provide immediate coaching and feedback.

We will track and trend the results of the call monitoring for all staff to highlight areas of improvement. The director of operations within the provider services center will review the trended results and adjusts the training curriculum as necessary. After training, provider services center managers will continually monitor performance. A coach will be responsible for monitoring, scoring, tracking and trending provider calls. The coach will provide immediate feedback to individual staff to improve the quality of their calls, acknowledge positive behavior and provide feedback for building their communication skills.

Measuring and Monitoring Response Accuracy and Caller Satisfaction

The following describes the methods we will use to measure provider phone representative performance.

- **Phone Technique:** Use a professional greeting with the provider, apply hold courtesy skills, apply call control skills, follow redirection procedures, and use a professional closing at call end.
- **Building Trust:** Identify provider's inquiry or issue, demonstrate full attention, deliver response with confidence, communicate clearly and connect with the provider.
- **Accuracy and Completeness:** Provide accurate, complete information to the provider.
- **First-Call Resolution:** Verify that call documentation matches the call content, route or close documentation correctly, make outbound call if necessary, to resolve issue and send out requested information.
- **Call Calibration Meetings:** Call center management meets monthly with our Mississippi leadership teams and health plans to listen to recorded calls and provide input regarding call conduct.
- **Post-Call Surveys:** We will invite each caller to participate in a brief post-call satisfaction survey. We will ask providers opting to complete the survey to provide ratings on three questions and provide informal feedback about the provider phone representative service. As appropriate, we will report out individual issues and concerns, and use aggregated survey information gathered during these surveys to trend provider services center satisfaction and to formulate topics for ongoing provider phone representative training.

C. Provider Education and Communication

1. Describe how the Offeror will educate network PCPs/PCMHs about Care Management services, how to ...

Educating Providers About Care Management Services

Our provider relations representatives will develop and deploy provider education materials to help providers know how to engage with our care management (CM) team including local field-based care managers. Our joint clinical meetings with providers will include a liaison from our care management leadership who will offer their contact information to facilitate referrals.

We will educate providers about our care management programs and services during new provider orientation and providers will continue to have access to online self-paced training modules, training materials and regularly scheduled in person education sessions. Educational opportunities will include:

- Our provider manual
- Face-to-face visits from our field-based staff
- Dedicated training sessions
- Monthly provider education sessions
- Town Halls and in person Provider Events
- Joint Operating Committees with our larger health systems
- Provider bulletins and newsletters
- Provider Advisory Committee

Educating Providers about How to Connect with Care Management

Our provider relations representatives will educate providers about how to connect with care management by phone, email, virtually, on-site and in partnership with our health care professional associations providing program materials. Our nurse consultants will be actively engaged with our care management teams and the PCP/PCMH through on site visits and scheduling workdays in the practice.

Practice-Based Care Managers

In a state of similar size and demographic makeup, we embed RN nurse consultants inside high-volume primary care medical homes across the state. The feedback we have received from members/families, PCPs, specialists, hospital care managers and our provider advisory committee affirms this is the right approach to help our high risk and complex members have improved health and utilization.

Measuring Provider Care Management Engagement

The best measure of provider care management engagement is quantifiable data that shows improvements in care or missed opportunities. Our standardized reports at the group and practitioner levels will show when care is being delivered and when impactful care is being neglected. We will use these opportunity reports to measure provider effectiveness and drill down to the member-level to see who needs more intense engagement. Where opportunities are missed, we will use the reports to demonstrate care management opportunities.

We will create a care management partnership and referral report detailing partner state, local and community and community-based organizations for both input on care management strategies and referring members for services.

For our CM referral partners, we will implement a partnership agreement that details 1) data sharing and data protection; 2) implementing health promotion and disease prevention initiatives; 3) coordinating service delivery with the member's PCMH or PCP, as appropriate; 4) tracking member outcomes and measuring success; and 5) making and tracking of closed-loop referrals.

Our Approach to Addressing Provider Care Management Underutilization

Provider relations representatives will connect with individual providers or groups who have been identified as underutilizing the care management program. We will determine the appropriate intervention by addressing current issues and trends, reenforcing the benefits of care management to the provider and the member.

2. Describe how the Offeror will educate network PCPs/PCMHs regarding how and when to refer a member ...

All provider agreements will require providers to perform a comprehensive mental health assessment and coordinate with other treating providers. We will reinforce this approach through ongoing training, communications, and resources to support initiatives that either the Division or we identify. We will work closely with the PCPs, PCMHs and BH/SUD providers co-managing members through joint clinical meetings, care coordination, relevant reporting, jointly developed care plans and active information sharing.

Educating Network PCPs Regarding Behavioral Health Referrals

We will promote our person-centered care approach to all providers and provide education specific to behavioral health (BH) and substance use disorder (SUD) screenings and referrals. We will reinforce this concept through various education opportunities, including:

New Provider Orientation

Within 30 calendar days of joining our network, PCPs and behavioral health professionals will participate in an orientation introducing themselves to our comprehensive supports, including our network of providers, subspecialty areas, our local-based network staff, provider services center, provider manual and provider portal. During orientation, we will explain the importance of screening, collaborating, and referring members to appropriate services — including behavioral health and substance use disorder. We will emphasize the importance of collaborating with other providers to make sure members receive quality care coordination.

Behavioral Health Tools for Health Care Professionals

Our tools will be available on our website to assist providers in understanding how to identify behavioral health conditions and how to refer members for more specialized treatment. Providers will have direct access to behavioral health clinical practice guidelines and evidence-based screening tools (e.g., Patient Health Questionnaire-9, a validated screening tool for depression) and information on how to contact our behavioral health staff for assistance in referring members. We will provide information on Screening, Brief Intervention and Referral to Treatment (SBIRT), an evidence-based Substance Abuse and Mental Health Services Administration (SAMHSA) practice adopted by Mississippi to identify substance use disorders (SUD) early. The SBIRT allows PCPs to identify and treat SUD in their practices with brief, evidence-based interventions.

Intellectual and Developmental Disability Tools

We will offer a series of training modules that provide practitioners with valuable content on providing care to people with intellectual and developmental disabilities. Hosted on our education site, these free courses provide CME credits and are easily accessible to PCPs, psychiatrists, primary care and psychiatric nurse practitioners, medical office staff, residents and students. Our goal is to increase the number of providers who have a willingness to, and express confidence in, treating individuals with intellectual and developmental disabilities.

3. Describe how the Offeror will develop the Provider Manual, including brief descriptions of major sections.

Our Approach to Developing our Provider Manual

We will have one provider manual for both the MississippiCAN and Mississippi CHIP providers, clearly outlining the programmatic differences. Our provider manual will be developed with the dual purpose of a useful tool to assist in answering everyday questions and setting expectations and requirements. The manual will guide the user’s clinical and operational needs and will be made available in print and online.

We will incorporate all required elements described in Appendix A – Draft Contract Section 6.9.2 Provider Manual. We will start with our standard handbook templates used in other Medicaid programs and apply key contractual requirements, state regulations and other materials that providers need to know and use in their day-to-day operations. We will submit our provider manual to the Division for approval 90 calendar days prior to implementation, upon change, and at least annually.

MississippiCAN and Mississippi CHIP Provider Manual Major Sections

Introduction to MississippiCAN and CHIP	Description of the Care Management System and protocols	Description of the role of a PCP and covered services, including excluded services, copayments and benefit limitations
Description of the role of a PCMH	Emergency room utilization	Member access to specialists, including standing referrals and specialists as PCPs
Contact information, including relevant telephone number(s), email address(es) and websites	Contact follow-up responsibilities for missed appointments	Translation and verbal interpretation services for members
Information about filing provider disputes	Prior authorization review and reconsideration, Grievance, Appeal and State Administrative Hearing information	Prior authorization clinical and technical criteria guidelines
Billing instructions, including claims submission time frame requirements and manual or invoice pricing requirements	Provider performance expectations	Information about EPSDT screening requirements and EPSDT services
Provider responsibility to follow up with members not in compliance with the EPSDT screening requirements and EPSDT services	A definition of "medically necessary" consistent with the language in this contract	Information about member privacy and confidentiality requirements
Information about the process for communicating with the contractor on limitations on panel size	Information about the process for contacting the contractor regarding assignment of a member to an alternate PCP/PCMH	Non-exclusivity requirements
Description of provider web portal and the process for accessing it	Credentialing and recredentialing and the use of the CVO	Instructions on working with carved-out services and contact information for those vendors

4. Describe how the Offeror will develop Provider trainings and workshops, including brief descriptions ...

Provider training and communication are part of our detailed network implementation action plan, which we consider necessary to facilitate a complete and tailored network before go-live.

How We Develop Provider Trainings and Workshops

We will train providers as required in Appendix A, CCO Contract Section 6.9.3 on new processes and updates communicated by the Division of Medicaid. We will train and develop providers by identifying trending claim issues, new policies and procedures and feedback from the provider community and by partnering with our local associations. Engaging internal and external partners, our trainings will address current initiatives, processes and resources most relevant to the needs of providers.

Six Possible Provider Training Topics

These training sessions will include:

- Offering initial education on our administrative processes and requirements (e.g., claims, operations, available data and quality reporting)

- Training on providing cultural competency, health equity, implicit bias and other topics critical to serving the MississippiCAN and CHIP population
- Working with centralized functions: CVO credentialing and recredentialing, pharmacy benefit administration
- EPSDT, well-baby and well-child services (training materials on the portal, specific trainings and educational sessions)
- Training on care management services and how to engage and optimize care management
- Educating on key resources available (e.g., provider manual, provider portal, network bulletins, newsletters, our provider services center, claims escalation and issue resolution)

5. Describe how the Offeror will provide education to Providers concerning cultural competency, ...

A disproportionate burden of disease is borne by racial and ethnic minority populations and the rural and urban poor. Mississippi's Delta Region, among the poorest in the state, experiences nearly double the rate of low-birth-weight births than other parts of the state. Across the state, cardiovascular disease kills Black males disproportionately, and diabetes is more likely in undereducated adults ages 65 – 74.[1] With a physician workforce shortage in Mississippi, members residing in such underserved areas will most likely need access to specialty providers, located in urban areas, who may not routinely encounter such disparate patient needs. Thus, we will assist providers in overcoming barriers to providing culturally competent, equitable and unbiased care.

Training Providers in Cultural Humility and Implicit Bias

We will employ a health equity director, who, in collaboration with other clinical and senior leaders, will develop our cultural humility and implicit bias provider training curriculum complete with Mississippi-specific modules to support providers as they relate to the men, women and children we serve.

We will include this training in providers' onboarding education and offer ongoing training through our provider portal, provider forums, newsletters and provider manual. Our website will offer easy access to state-specific, self-paced and instructor-led education and training on cultural diversity and disability competency, and their effect on health and other topics related to cultural competency such as obtaining interpretive services and accommodating the special needs of members. Upon completion of each module, the provider will be required to attest to the successful completion of the training and details about how the provider will incorporate this strategy into their day-to-day operations. Providers will have access to free continuing medical education credits (CMEs) and continuing education units (CEUs) through our training website. To participate in our value-based purchasing, we will require providers to complete cultural competency training. We will reinforce the importance of cultural sensitivity through select sponsorships and educational opportunities.

6. Describe the Offeror's proposed approach to assess Provider satisfaction, including tools the Offeror plans ...

We will use both formal and informal tools and processes to proactively identify and assess provider satisfaction. Our annual provider survey, quarterly Provider Advisory Committee meetings and Joint Operating Committee meetings will provide formal and regular opportunities to engage providers. Providers may offer satisfaction feedback to their provider relations or phone representatives. This approach will allow our teams to identify opportunities to update provider education materials or improve a current process.

Provider Satisfaction Approach, Tools and Frequency

Assessing provider satisfaction via the following methods helps us improve the quality of our provider services. Here are examples of tools we will use:

[1] Mississippi State Department of Human Services Office of Rural Health and Primary Care 2021 Annual Report.

Tool – Frequency	Responsible Parties	Description
Provider Satisfaction Survey – Annually	**Director Network Management**	Part of our core strategy is to engage an independent research company to assess provider satisfaction using statistically validated questions. They will send an annual provider satisfaction survey to a statistically valid sample of our PCPs and specialists. Areas assessed include UM processes, authorizations, credentialing, claims processing, reimbursement, service support and more. In accordance with the provider satisfaction survey requirements in Appendix A, CCO Contract, we agree to continue to file our survey results with the Division at least 90 calendar days following survey completion.
Physician Practice Manager Survey – Quarterly	**Director Network Management**	National survey triggered by a claims project event as part of a closed-loop process to share results with providers and provide additional opportunity for provider feedback and resolution. If a provider expresses dissatisfaction with the process or other issue, the provider relations representative will reach out to the provider to identify the root cause and resolve and close the issue to the provider's satisfaction.
Net Promoter Score (NPS) – Monthly	**Director Network Management**	Many leading organizations embrace the NPS concept that willingness to recommend a company is an outcome of putting the customer first. We use NPS to track provider satisfaction to better understand how to create a differentiated, provider-friendly experience. Our provider NPS process is based on monthly feedback on experiences that measure key CAHPS-like metrics. We will monitor our impact, identify drivers of satisfaction and use informed decision making and improvement planning.
Provider Services Center Survey – Daily	**Provider Phone Representative**	We will offer each caller to our provider services center the opportunity to participate in a brief post call survey conducted by an analyst who was not part of the provider's call. We will ask four questions that provide feedback about the service provided during their call. These findings will be reported monthly to the director of provider services who will intervene immediately if an issue is identified. These four questions have been shown to highly correlate with Net Promoter Score (NPS), which is a nationally recognized measure of satisfaction. We will use these results to trend satisfaction and formulate topics for ongoing provider phone representative training.
Informal Opportunities for Provider Feedback – Daily	**Provider Relations Representative**	We will engage providers to obtain feedback through focus groups, visits and calls from our executive leaders, provider service and education events, provider services center, monthly provider webinar town halls, ongoing communication with local professional groups and our provider portal's question-and-answer capability. In addition, we will establish Joint Operating Committees with key providers to collaborate with them to develop solutions that affect health care operations.

7. Describe the Offeror's proposed approach to educating Providers concerning EPSDT services and ...

Our Approach to Provider EPSDT, Well-Baby and Well-Child Services Education

Our proposed policies and procedures comply with the Division's adherence to the recommendations of American Academy of Pediatrics Bright Futures Guidelines for periodic health screenings and Advisory Committee on Immunization Practices for recommended immunizations.

Our child wellness team and provider relations representatives will educate new pediatric providers on EPSDT processes through orientation within 30 days of provider enrollment. Providers can continue to learn about EPSDT, well-child and well-baby covered services in our provider manual and online learning modules, newsletters and our reports that show member care opportunities. Our child wellness manager will present an overview of the EPSDT and child wellness programs during scheduled provider training events with topics including program requirements (screening instruments and schedules), best practices for identifying and referring children with developmental delays, collaboration opportunities, requirements for reimbursement and value-based purchasing arrangements.

8. Describe the Offeror's proposed approach to educating Providers regarding the needs of Members ...

a. Perinatal;

b. Behavioral Health;

c. Substance Use Disorder;

d. Chronic Conditions; and

e. Foster Children.

Educating Provider and Members with Specified Conditions and Circumstances

Our field-based registered nurse consultants will provide training for providers through on-site visits and Joint Operating Committees (JOCs) to address the identified conditions and circumstances. We will provide on-demand resources and reporting specific to the providers' patients.

Perinatal

We will offer the following tools and services to help providers manage pregnant members in their care:

- Data through provider portals, registries or other methods to help the practitioner identify potential new and ongoing risk factors, open gaps in care based on evidence-based guidelines and other data and information to help manage care
- Health education and other member engagement materials and interactive tools to offer patients education on important topics such as breastfeeding and safe sleeping practices
- Education regarding the perinatal care management program, including information about eligibility criteria, how a provider may enroll a member and how we will work with all practitioners who treat pregnant members. This information will be available through several communication channels:
  - Provider administrative guide
  - Provider newsletters
  - Provider websites
  - Provider town halls
  - ACO Joint Operating Committees
- Publicly available clinical guidelines, reimbursement policies and authorization criteria based on latest American College of Obstetricians and Gynecologists (ACOG)
- In-person events for PCP training on LARC insertion

Behavioral Health and Substance Use Disorder

All new providers will have an orientation training within 30 days of joining the network. This orientation will include our approach to person-centered care and the importance of identifying members' behavioral health disorder needs and how to manage or refer members to behavioral health professionals. In addition, providers will be provided information on how to register for live educational trainings held monthly by the provider relations representative and how to navigate our organization to successfully treat our members with behavioral health needs and collaborate with other health professionals. We will offer educational materials for providers regarding the needs of members with behavioral health and substance use disorders; this information will be available at the educational trainings and on the provider portal.

Our behavioral health toolkit and addiction recovery toolkit will provide helpful links to important information for PCPs about behavioral health conditions and treatment such as depression screening and attention deficit hyperactivity disorder (ADHD) and will be accessible on our provider portal. These toolkits promote the use of behavioral health screening tools such as the PHQ-9 depression and the AUDIT-C alcohol screeners and help providers link members to treatment, including clinical practice guidelines for prevalent behavioral health and

childhood disorders. Our portal will offer trainings and behavioral health educational materials for providers and members, including information on evidence-based practices and suicide prevention and awareness.

Chronic Conditions

Our field-based registered nurse consultants will engage and educate providers about the specific needs of members with chronic conditions. These nurses will orient providers to our disease-specific online resources. They will use HEDIS measures to drive maximum wellness in the chronically ill. When providers are willing to engage in VBP arrangements, our nurses will track and exchange real-time data acquired through our **Chronic Condition Retrospective Shared Savings programs.** Our field-based nurses will educate providers on best practices for conditions or procedures, including critical, high-cost conditions such as asthma, COPD, joint replacement, opioid use disorder (OUD), cardiac and gastroenterology procedures.

Children in Foster Care

Recognizing the importance of equipping those directly responsible for the care of children in foster care with the appropriate knowledge on how to care for this population, we will offer innovative trainings targeted to providers and supports surrounding the child.

Our care management team in Mississippi will be required to participate in extensive training in trauma, brain development and secondary trauma, including trauma-focused cognitive-behavioral therapy, cognitive-processing therapy, child-parent relationship therapy and the neuro-sequential model of therapeutics.

The care management team will provide individualized training to caregivers and older and former foster youth based on needs identified through the member assessment. Available trainings will include concepts related to transitions, nurturing environments, trauma triggers, self-regulation for children, co-regulation for caregivers and trauma signs and symptoms.

We will partner with the National Foster Parent Association and the National Child Traumatic Stress Network to provide trainings and resources to providers, agencies and family members about bias, the effects of trauma, including generational trauma, and relevant resources, which are available nationally to all caregivers and stakeholders, not only our members.

We will offer free education to credentialed providers, such as physicians, pharmacists and nurses, on a variety of topics, including education about implementing a trauma-informed approach and psychotropic medications.

D. Collaboration with Providers

Mississippi is the only state with every county in the Centers for Disease Control and Prevention's (CDC's) "Diabetes Belt."[2] In 2020, more than 14% of Mississippi adults were told by their health care provider that they had diabetes.[3] Asthma is common among all age groups in Mississippi, with one in every 10 children under age 10 and one in every 14 adults aged 18 and over with asthma.[4] Statistics such as these, combined with a provider workforce shortage, underscore the need for CCOs to work collaboratively with all health-oriented stakeholders.

1. Describe how the Offeror will collaborate with PCPs/PCMHs regarding the care of Members with chronic ...

The PCP and PCMH are the gateway to comprehensive health care and serves as the medical home for our members. We will offer our PCP and PCMH partners clear, timely and comprehensive data at the member and

[2] msdpp.org

[3] America's Health Rankings 2021 Annual Report

[4] Mississippi State Department of Health

population level. We will monitor trends and gaps in care to inform improved policy, training and practice- and clinic-level supports.

Collaborating with PCPs for Members with Chronic Illnesses

Our member risk stratification engine will use health screening and comprehensive assessments, claims data and information received from members and their families to identify members with chronic illnesses, including obesity, diabetes and asthma. We will communicate with PCPs about their members with chronic illnesses in person, by phone and electronically through our provider portal, our EMR tool, through partnerships in value-based purchasing arrangements and regular reports.

Our field-based registered nurse consultants and provider relations representatives will work with PCPs to improve quality outcomes through care gap closure. Dedicated practice care managers will work collaboratively to transform practices from reactive to proactive. They will share information from the provider quality scorecard and our care management platform. We will assign provider relations representatives to all network providers based on geography and provider types. We will provide communication and education for providers on how to use our available resources to monitor follow-up care for the member and communicate with our team of available subject matter experts for support. We will provide this information through the following touchpoints:

- **Provider portal:** Our provider portal will offer online tools and resources to help providers streamline their work. When the provider checks member eligibility through the provider portal, we will automatically display HEDIS, EPSDT and immunization gaps for that member. The portal will give providers actionable information to identify members who may be due or past due for treatments or screenings. Monthly, providers will be able to access detailed Patient Profile reports, which will include information on health risk, chronic conditions, inpatient and ER visits, pharmacy claims details and total cost of care.
- **Care management system:** Our secure web-based care management system will automatically integrate claims and clinical data to identify the provider's members with gaps in care or those who require follow-up care. PCPs and medical homes will have access to the same information and tools as the care manager, such as gaps-in-care alerts; admission, discharge and transfer (ADT) alerts; and the ability to view and update the member's treatment plan. Through this system, the PCP and medical home can view and update a member's treatment plan; view actionable information; monitor the member's progress toward achieving their goals; and validate improved health outcomes.
- **EMR tool:** This tool will **deliver providers integrated access to real-time data** by integrating real-time patient medical records, including clinical, pharmacy, labs, prior authorization and cost transparency, with existing electronic medical records (EMRs) to provide real-time insights on care needs. The tool will simplify data access while increasing understanding of what a patient needs at the time of care, assisting providers in determining care and treatment. The tool will enable providers to gain insights on patient needs in the following ways:
  - Eliminate blind spots in care by identifying potential care opportunities
  - Quickly check prior authorization for a patient's medical plan
  - Reduce pre-visit prep time by identifying member needs and gaps in care
  - Stay current on member plan benefit changes, providers in the patient's network and any expected cost sharing for CHIP members

Retrospective Shared Savings Program: Chronic diseases are among the most common health problems in Mississippi. To help improve the management of diabetes, we propose using our Diabetes Retrospective Shared Savings (APM 3a) program, which builds on standard reimbursement and offers shared savings opportunities based on cost of care across a defined set of services related to conditions or procedures critical to Mississippi. This approach will provide the primary accountable provider (PAP) for diabetes the opportunity to be rewarded

for quality and savings tied to benchmarks for the cost per episode. We propose to pilot our Diabetes Retrospective Shared Savings program in Mississippi as willing providers are identified. We have additional chronic condition retrospective shared savings programs, including asthma, CHF and opioid use disorder (OUD), which we may recommend for deployment in Mississippi as appropriate.

2. Describe how the Offeror will collaborate with PCPs/PCMHs to reduce pre-term births and ...

Provider Collaboration to Improve Perinatal Care and Maternal and Infant Outcomes

Collaborating with PCPs, PCMHs and obstetrical providers is core to our approach to improve perinatal care quality and outcomes in Mississippi. We will call on our resources and impactful partners across the state to address this critical need in Mississippi. **We will invest over $2 million** in Mississippi to deploy innovative models in partnership with PCPs and PCMHs, OB/GYNs and other community perinatal providers to improve perinatal care and reduce preterm rates, severe maternal morbidity and avoidable C-sections through the following mechanisms.

Invest in Providers to Launch Innovative Perinatal Care Delivery Models and Expand Access

We recognize a diverse set of providers' needs and will partner with providers (rural, urban, large and small) to better understand those needs and offer collaborative support. We will leverage financial and technology resources to support their ability to improve perinatal care and improve preterm birth. Examples include:

Supporting Remote Patient Monitoring (RPM) Pilot for High-Risk Pregnancies: We will invest over $500,000 to test the effect of RPM in at least six provider practices in high-need areas. Remote patient monitoring will modernize maternity care and support management of high-risk conditions, such as hypertension and diabetes, especially where there are access challenges.

- **Enabling Evidence-Based Group Prenatal Care:** We will partner with a national prenatal care organization that provides group-based care and invest **over $100,000** to support group care model adoption at up to three provider practices in high-need areas. Group care programs, such as Centering Pregnancy, are an innovative delivery model shown to reduce preterm birth rates and disparities among Black mothers by combining elements of traditional prenatal care with cohort-based education and social support.
- **Addressing the Needs of the Health Care Workforce:** There is a physician workforce shortage in Mississippi, and OB/GYNs are no exception. With a significant number of Mississippi women receiving care by non-OB/GYN providers, there is often a knowledge deficit of effective contraceptive methods such as long-acting reversible contraceptives (LARCs). A recent study by the Center for Mississippi Health Policy reported that only 29% of family practice physicians and 22% of general nurse practitioners claimed having sufficient experience with LARC insertion. To address this, we will partner with local OB/GYNs and fund up to $200,000 in LARC and contraceptive training workshops for all provider types. This will equip other providers with the knowledge and skills to use LARCs in their practice.

Increasing Access to High Quality Care

Hospital Quality Improvement (QI): We recently provided nearly $3 million to a national partner to reduce disparities in maternal outcomes in six states by collaborating with hospitals to improve race and ethnicity data collection to better track birth inequities and implement quality improvement interventions to place the patient at the center of decision making, enable respectful care practices and create a culture of health equity to improve birth outcomes. Mississippi is one of the states targeted for the effort.

Mobile Clinics to Enable Perinatal Care Access: In a state of similar geographic and demographic makeup to Mississippi, we provided $50,000 for a provider's Mobile Women's Health Program staffed by a nurse practitioner, case manager and interpreter with the goal of expanding access to perinatal care. We commit to partnering with local providers to support similar innovation specific to state need.

Leverage Advanced Payment Models to Improve Quality of Perinatal Care

We will offer advanced payment models (APMs) to standardize and drive quality of care and support equitable outcomes in perinatal care. Our programs include the following:

- **Our Maternity Retrospective Shared Savings Program** will offer shared savings if providers can achieve predetermined health outcome quality metrics. We recently updated this maternity program to drive greater provider accountability by including health outcome monitoring metrics such as preterm birth rate and severe maternal morbidity (SMM). We will provide clinical transformation tools and other supports to help providers improve their practices to realize shared savings, optimize care and deliver results.

In three states where the **Maternity Retrospective Shared Savings** program is implemented, initial year one results show providers demonstrating a **4% reduction** in C-section rates, accompanied by a **5% savings reduction**.

- **Our Obstetrical (OB) Quality Gap Closure Incentive** will reward qualifying OB/GYN practices through annual bonus payments for achieving or exceeding target scores related to HEDIS prenatal and postpartum measures. To improve health equity and address disparities seen in prenatal and postpartum measures between populations, we will tier incentives, so providers earn higher incentives by decreasing disparities. Our OB Quality Gap Closure Incentive has resulted in a **39% year-over-year increase in prenatal and postpartum rates for targeted providers.**
- **Obstetrical Risk Assessment Form (OBRAF) Incentive:** Early identification and engagement is crucial to improving neonatal outcomes such as preterm birth. We will offer a financial incentive to providers for each OBRAF received, rewarding them for timely submission. We will use this information to support earlier engagement of pregnant members and make sure they have resources needed to support positive outcomes.

Provide Resources Including Referrals to Care Management, Social Determinants of Health and Provider Training

- **Provider Referrals to Perinatal Care Management (PCM):** We will educate providers on our PCM program so they can refer high-risk members as needed to get this enhanced support. Through our PCM program, local care managers will engage and empower members to participate in regular prenatal and postpartum care, and our perinatal care managers will coordinate services and collaborate with the member's entire care team, including OB/GYNs, PCPs, PCMHs, behavioral health providers and social service providers to make sure members get the comprehensive care they need.
- **Educate Providers on Community and Social Support Services for Pregnant Members and Families:** Given unmet social and safety needs contribute to poor perinatal outcomes, we will offer value-added benefits to address needs such as food insecurity and transportation. We will educate providers on the availability of these benefits and how to refer members. For example, we will offer prepared, home-delivered meals to members experiencing food insecurity and an enhanced transportation benefit that provides up to 20 rides to community resources such as WIC offices and food banks.
- **Provider Training on Birth Equity to Improve Racial Inequities:** We will develop and offer a range of trainings for all providers, including PCPs, PCMHs and obstetrical providers. For example, we developed the Addressing Health Equity Training and partnered with the Centers for Disease Control and Prevention (CDC), a Historically Black College or University (HBCU) medical school and a prominent national organization to develop Addressing Maternal Mortality training. Through these trainings, providers learn about racial inequities in birth outcomes, such as preterm birth, the role of bias in perinatal and neonatal health outcomes and how to improve outcomes.

3. Describe any other conditions for which the Offeror anticipates collaboration with providers to develop ...

We will target conditions identified as priorities by the state in the Quality Strategy, including depression, respiratory illness, diabetes and asthma. We will focus on the clinical conditions outlined in the Division's Potentially Preventable Hospital Returns (PPHR) program. With these areas of focus, we will drive collaborations among providers, other CCOs and the Division and structure our incentive programs so that efforts will be recognized.

Annually, we will identify conditions or measures to target in the QI work plan. For each of our overarching goals, we will monitor relevant nationally recognized metrics based on established clinical practice guidelines, such as measures from HEDIS®, CMS, CAHPS® and AHRQ, to measure areas such as preventive health, chronic disease management and acute care. Bimonthly reporting will enable us to trend progress over time, tracking against established performance targets. Any other conditions that drive overall health and cost will be identified as impactful and will be incorporated into our performance improvement processes. An emerging trend across the southeast, including Mississippi, is the prevalence of attention deficit hyperactivity disorder (ADHD) coupled with the highest rate of amphetamine use. In addition to the items noted above, we will address this observation through provider and member engagement.

E. Provider Payment

1. Describe the Offeror's proposed process for ensuring that non-participating Providers who provide ...

Our process for ensuring nonparticipating providers who provide emergency services to members will be paid promptly is simple and straightforward. When a claim is recognized as an ER or emergency services claim, it will be paid at 100% of Mississippi Medicaid rates regardless of whether the rendering provider has a contract with us or not. We will adhere to the same standards when processing claims from nonparticipating emergency providers as for our contracted providers. We are committed to meeting or exceeding all requirements in Appendix A, Draft Contract.

Recognition and payment of the claim as an emergency services claim will be determined through deliberate configuration of our claims system to allow payment for non-network emergency providers without an authorization. Specifically, we will have system edits in place to recognize certain codes used to represent emergency services, including facility, ambulance and professional claims.

These claim code indicators will reliably indicate when a claim has been received for emergency services and confirm that, during adjudication of the claim, no consideration is given to the network status of the provider who rendered the services and no prior authorization was required. Thus, any non-network medical provider who delivers emergency services, necessary for diagnosis, treatment or stabilization for the specific condition, will receive prompt and complete reimbursement for all covered services that are submitted on a correctly coded claim for payment.

In states similar to Mississippi, we consistently exceed claims processing standards, including claims from nonparticipating providers. Nonparticipating provider claims will undergo our normal processing channels with no reduction in processing times, just as quickly as participating provider claims. Consistently, 99.99% of electronic and paper claims from nonparticipating providers will be processed within 25 days of receipt, and there will be no difference for emergency services.

2. Discuss the Offeror's willingness to pay claims with dates of services on and after the date of credentialing ...

Our goal is to always process claims in a timely manner for all provider types both in network and out. We will pay all providers for all services rendered as contractually obligated and not dependent on a load that may be delayed.

The first step to becoming a participating provider in our network will be to successfully complete credentialing. The credentialing process will validate that a provider is clinically competent to render services to members. Within seven days of being deemed competent through credentialing, the provider will be offered a contract. This contract will be the legally binding document that will signify both we and the provider agree to jointly serve members in accordance with the MississippiCAN program and CHIP. We will align with the effective date of this agreement with what is reflected in the contract executed by both parties. If a load is delayed and services are rendered before a load, we will retroactively reimburse services to the effective date of the contract. This approach will ensure all parties are clear on the effective date of participation, expectations of both parties to comply with contractual requirements, regulatory standards and reimbursement rates.

Achieving Operational Excellence

As required, we will load the provider into our claim and demographic system within 21 calendar days of credentialing approval. Currently, in similar states, **we are completing this task 100% of the time**.

Provider participation will not affect reimbursement for emergency services, or the claim being paid promptly. Nonparticipating providers will be eligible for reimbursement for non-emergent services with appropriate authorizations.

Our Approach to Credentialed Provider Payments

We are committed to processing providers' claims in a timely and accurate manner, allowing them to focus on the clinical care of MississippiCAN and CHIP members. We will have an advanced infrastructure for prompt and efficient claims processing and payment procedures that will allow us to consistently meet or exceed federal and state prompt payment requirements while maintaining the highest levels of accuracy and quality in claims processing.

Our claims team will maximize automation and will use various management tools, reports, audits and quality improvement processes to identify issues and develop controls to resolve them for prompt and accurate claims processing and payment. These functionalities will include the auto-adjudication of claims, which reduces payment time and increases claims payment accuracy.

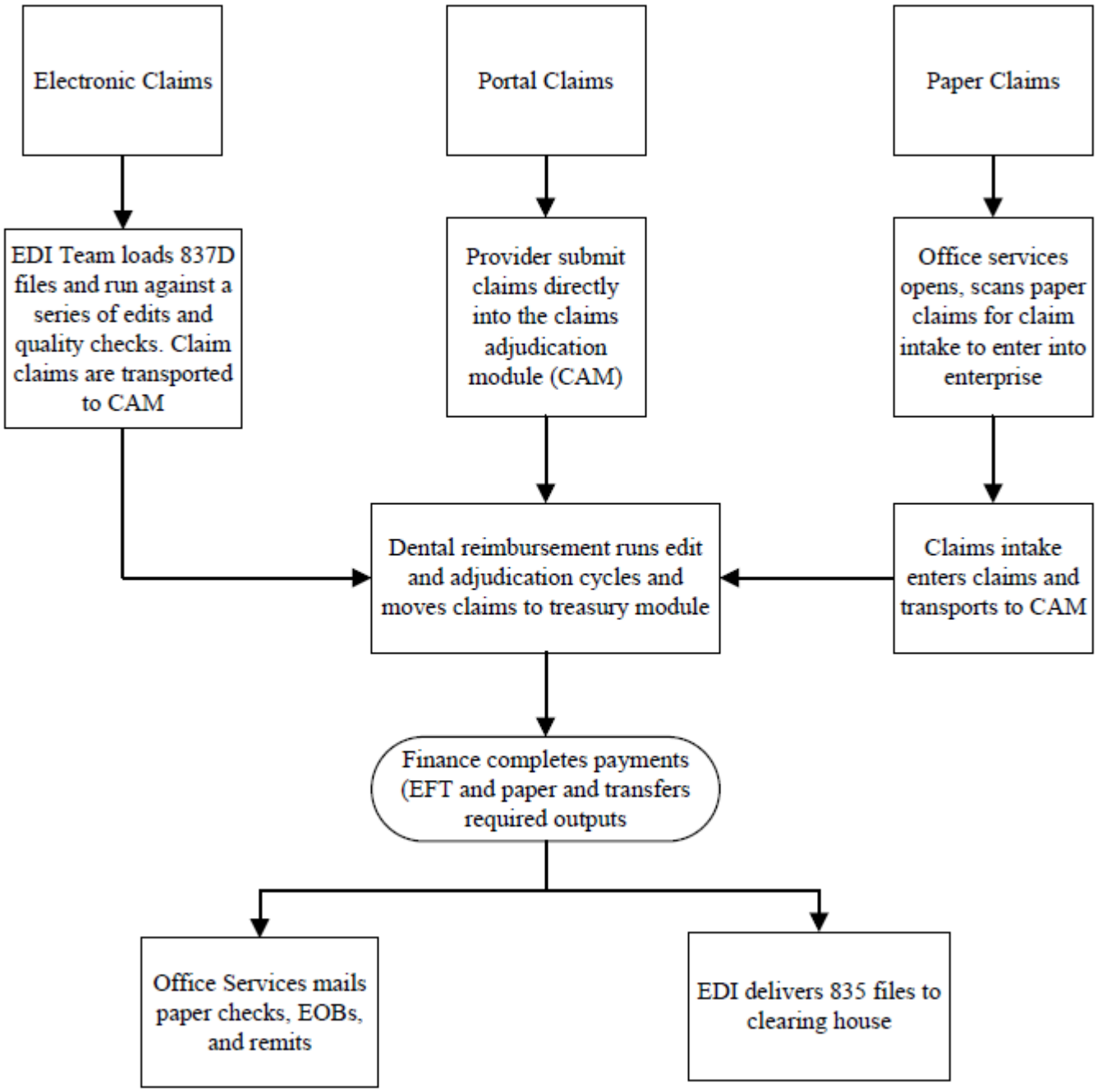
3. To the extent that any subcontractor(s) will be processing and/or paying claims, include a systems diagram ...

Our Subcontractor Claims Payment Processes

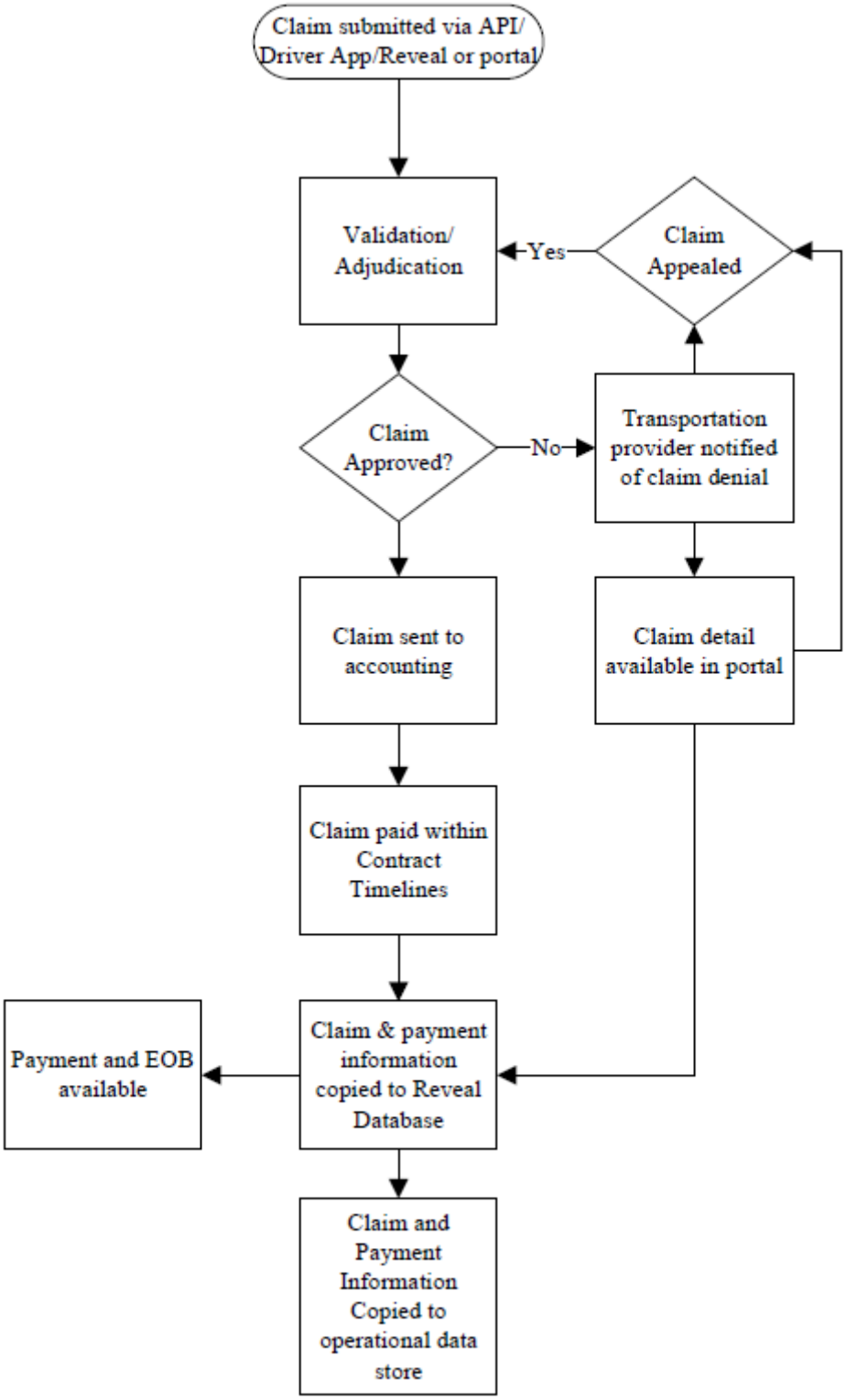
Our core claims processing system supports standard CMS-1500 (HCFA) and UB-04 claims. These are standard claims for most provider types, including medical, behavioral/SUD, durable medical equipment, hospitals, infusion centers, ambulatory surgery centers, FQHCs, RHCs and Indian Health Services. Although wholly owned entities and not subcontractors, our dental and vision claims will be processed within their respective systems. Dental providers will use a platform that supports ADA claims, while vision providers will use a platform more conducive to optometric services. The diagram demonstrates how those claims will ultimately flow back into a centralized database where we can track utilization and total cost of care.

Our systems diagrams for our dental subcontractor, our transportation subcontractor and our vision subcontractor are provided below.

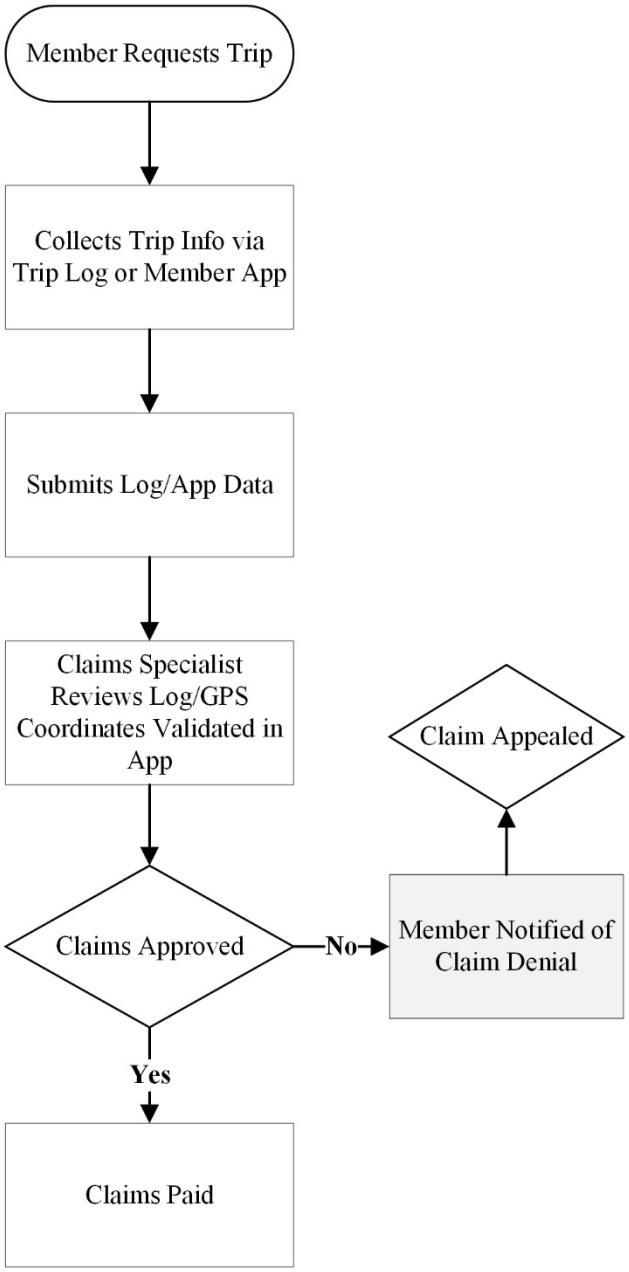
Dental Subcontractor Claims Workflow



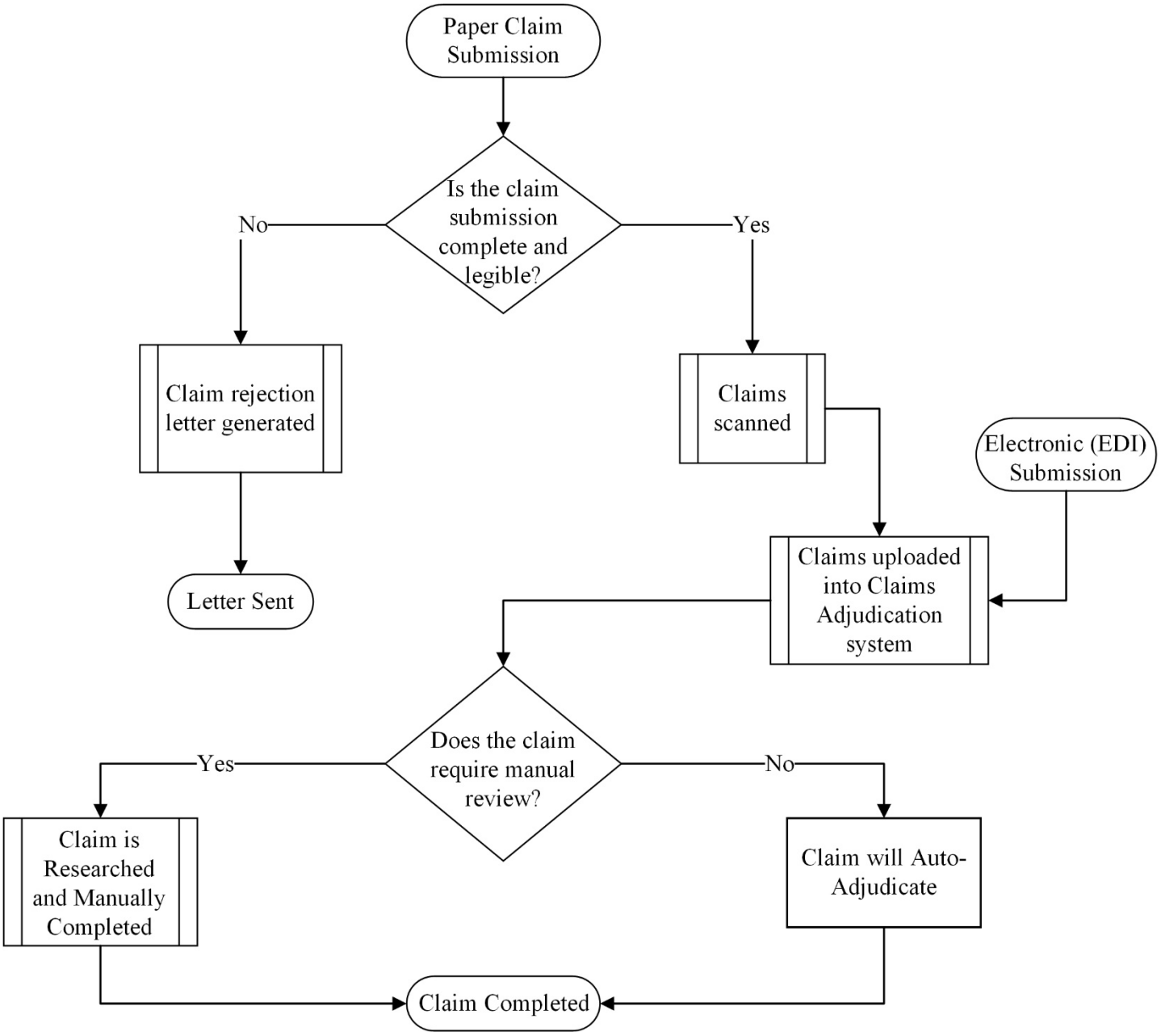
Transportation Subcontractor Claims Workflow



Gas Mileage Reimbursement (GMR) Claims



Vision Subcontractor Claims Workflow



F. Provider Grievances and Appeals

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

To deliver a quality customer service experience, we will have dedicated teams, an efficient tracking and monitoring system and well-managed processes for resolving provider grievances and appeals. Our skilled grievances and appeals (G&A) staff will include both national and health plan employees who will deliver oversight of our grievances and appeals system to confirm all components adhere to contract, state and federal requirements.

Our health plan team will include our grievances and appeals coordinator, who, along with our regulatory adherence, compliance team and state-specific subject matter experts, will monitor the effectiveness of our grievances and appeals system and verify provider issues are resolved promptly and according to requirements.

a. Compliance with State requirements as described in Section 6.10, Provider Grievance, Appeal, and State ...

Our process to ensure compliance with the model contract requirements for grievances, appeals and administrative hearings will be reflected in our policies and procedures. We will promptly submit these policies to the Division and, upon approval, will provide them to subcontractors and providers for shared accountability. We will share these policies with providers on our web portal and in the provider manual exactly as presented in Table 6.3 of the Model Contract, and we will inform providers that the Division may act on their behalf. We fully acknowledge that the Division retains the right to render the final decision in the course of any disagreement expressed by a provider.

Figure 2. G&A Performance Nationally

We commit to resolving provider grievances and appeals within required time frames, including expedited appeals, or as quickly as a member's condition requires. We will educate providers on the grievances and appeals processes and how they can easily file by way of our easy-to-use online provider portal. We will execute the resolution of provider grievances and appeals in full compliance with RFQ Appendix A, Draft Contract Section 6.10 provider grievance, appeal, and State administrative hearing process.

b. Process for elevating Provider Grievances; and,

Each grievance is an opportunity to improve the services we provide. Provider grievances represent a means of understanding trends, which allows us to make continual improvements, thereby reducing the number of grievances and appeals filed overall.

Grievance cases will be routed to a resolution analyst (RA) via our G&A tracking system for investigation and resolution. Resolution analysts will have excellent communication skills, sound deductive reasoning skills and extensive knowledge of federal and state laws, regulations and policies. They will use these skills to investigate all pertinent facts efficiently and accurately and provide prompt resolution of the provider's grievance. If the grievance is regarding a provider's claim, the RA will make every effort to resolve the issue, and if a claim adjustment is needed, the issue will be routed to our claim adjustment team for adjudication.

The RA may work collaboratively with cross-departmental team members, such as claims and provider relations, to investigate and resolve the issue. If an issue is identified that may be interrupting how the provider is able to conduct their services, or if the issue may impact a larger provider population, the matter will be escalated to the appropriate area for investigation and remediation. In addition, we will have a dedicated claims

reconsideration elevation team that will address claims issues and grievances that were not resolved during the reconsideration process. There will be a 48-hour response time for this elevated claim review. Upon completion of this process, the RA will issue a written Notice of Resolution within 30 calendar days.

Expedited grievances often require a faster review because the time frames for a standard resolution may seriously jeopardize a member's life, health or ability to attain, maintain or regain maximum function. Our expedited review and resolution of appeals process will comply with Section 6.10, Appendix A, Draft Contract, of the RFQ, including resolving the request within 72 hours of receipt, unless this time frame is extended pursuant to 42 C.F.R. 438.408(c).

c. Process for identifying, tracking, and trending Grievances, using data to make program improvements, and ...

With state Medicaid programs across the country, we comply with federal regulations for the grievances and appeals system, including the state agency's state administrative hearings and independent external reviews system. Data collection and transparency is critical to managing ongoing performance and identifying and resolving issues. We have an organizational governance structure that oversees the entire grievances and appeals process and verifies compliance with federal and state laws and regulations.

Identifying, Tracking and Trending Grievances

Our G&A tracking system will allow us to administer and process grievances and appeals. This system will enable our grievances and appeals team to:

- Manage and track resolution on submitted grievances and appeals against policy-mandated time frames for provider contact and grievance or appeal resolution
- Generate reports related to the outcomes of grievances and appeals using state-required data elements
- Provide data downstream for reporting
- Tie to our fulfillment processes for delivery materials to members and providers

Case files include information such as:

- The date the grievance or appeal was received
- The date we acknowledged receipt of the grievance or appeal
- Member name and identification number (if applicable for provider grievances)
- A general description of the reason for the grievance or appeal
- Grievances and appeals staff member assigned for disposition
- The grievance or appeal review dates and review activities
- Referrals to other functional areas (e.g., clinical) to resolve the grievance or appeal
- Date of resolution, description of resolution and member notification date

In addition, our grievances and appeals staff will use our tracking system to:

- Generate member and provider communications, such as acknowledgement letters, additional information requests, assignment of representative waivers and resolution letters
- Identify open, outstanding or urgent grievances and appeals requiring expedited resolution
- Query and review member and provider grievance and appeal history
- Track staff compliance with resolution time frames
- Share data and reports with our quality management department to:
  - Assess provider satisfaction
  - Identify opportunities for improving the provider experience

- Identify and resolve any potential quality-of-care issues
- Develop customized reporting and inquiry capabilities on multiple data elements

Using our tracking system's reporting capabilities, we will provide records of grievances and appeals as required by the state agency. We will follow the state's published guidelines for submission format, method and frequency required.

Sharing Data with the Division

We will follow Mississippi's published guidelines for data submission format, method and frequency required. Our tracking system will provide standard management reports to track our resolution time frames and provide ad hoc query functionality. The tracking system will provide us significant flexibility to add or remove data fields, as specified by Mississippi, and to provide reporting capabilities based on multiple data elements, filters or sorting options. Our tracking system reporting capabilities will include:

- Adding or removing data elements for reporting to the state agency
- Tracking grievances and appeals by type, status or other elements, as requested
- Identifying resolution of all cases with open, closed or outstanding grievances or appeals
- Tracking staffing resolution time frames for grievances and appeals
- Tracking referrals to other entities
- Tracking all provider state administrative hearing requests and outcomes, as the state agency reports
- Customizing reporting and inquiry capabilities on multiple data elements
- Identifying and trending recurring issues that result in grievances and appeals

Using Data to Make Program Improvements

Reviewing and understanding grievances and appeals data helps us identify underlying barriers to care and systemic issues. Therefore, we will use grievances and appeals data to identify opportunities to address disparities and improve the way we provide care and services. Our quality management team will use the tracking system's data to collect, review, analyze and trend grievances and appeals data to confirm our compliance, assess provider satisfaction and identify opportunities for improving the provider experience, identify issues with other aspects of our operations (e.g., claims processing) that may be causing an unwanted trend and identify opportunities for improvement in our service delivery and operations.

Our operations team will review grievance and appeal outcome reports monthly to identify and address any concerns or emerging trends. This trending will highlight providers with the highest number of appeals, top appeal drivers and appeals per thousand members, along with other data points. Dedicated staff will research the data to identify root cause and develop action plans to remedy the issue. For example, we will use the information to follow up with individual providers as needed, remediate system issues and address barriers to care or pain points for members or providers.

[END OF RESPONSE]

SECTION 4.2.2.2-1: SAMPLE PROVIDER CONTRACT TEMPLATES

Note: With the exception of the redaction of the fee schedule that appears on page 267 of the Vision Vendor Provider Services Agreement, redactions that appear within the sample provider contracts are intended to remove potentially identifying information, not intended as a confidentiality redaction.

Behavioral Health
Facility Participating Provider Agreement

Redacted
FACILITY PARTICIPATING PROVIDER AGREEMENT

THIS AGREEMENT is between Redacted ("Redacted") and the undersigned facility provider (hereinafter referred to as the "Provider"). This Agreement will become effective upon the date set forth in Redacted executed Acceptance Letter (the "Effective Date"). This Agreement sets forth the terms and conditions under which Provider shall participate in one or more networks developed by Redacted as a Participating Provider of Covered Services to Members.

ARTICLE 1
Definitions

Any capitalized term herein shall have the meaning as set forth in this Agreement. Any undefined term herein shall have the meaning as defined in the Provider Manual, the Protocols, or as may be defined by applicable state or federal laws or regulations, as applicable.

Affiliate: Each and every entity or business concern with which Redacted, directly or indirectly, in whole or in part, either: (i) owns or controls; (ii) is owned or controlled by; or (iii) is under common ownership or control.

Benefit Plan: The specific plan of benefits for health care coverage, including MHSA Services, for a particular Member that is provided, sponsored or administered by Redacted directly or through its Affiliate, or through a network rental arrangement Redacted may have with a third-party, and contains the terms and conditions of a Member's coverage for MHSA Services, including applicable Member Expenses, exclusions and limitations, and all other provisions applicable to the coverage of such MHSA Services such as services rendered outside specified networks.

CMHC: A Community Mental Health Center.

CMHC Provider: An employee of a CMHC who provides mental health and/or substance abuse services, but is not a CMHC Supervising Provider.

CMHC Supervising Provider: A psychiatrist, psychologist, social worker, family or other therapist duly licensed and qualified in the state in which MHSA Services are provided to Members who practices as an employee of CMHC and has been approved as a CMHC Supervising Provider in writing by Redacted.

Covered Services: MHSA Services that meet the terms and conditions for coverage pursuant to the Member's Benefit Plan, including such conditions as Medically Necessary and proper authorization, and in accordance with the Provider Manual, Protocols, and applicable laws and regulations.

Customary Charge: The fee for MHSA Services charged by Provider that does not exceed the fee Provider would ordinarily charge any other person regardless of whether the person is a Member.

Emergency Services: Unless otherwise defined by applicable state law, a serious health condition that arises suddenly and requires immediate care and treatment, generally received within twenty-four (24) hours of onset, to stabilize or avoid jeopardy to the life or health of a Member or, by actions of the Member, to the life or health of another. Emergency Services shall be available twenty-four (24) hours per day, seven
(7) days per week.

Facility-based Provider: A health care professional, who is employed by or under contract or supervision to render MHSA Services to Members. Facility-based Providers include, but are not limited to, emergency room physicians, pathologists, radiologists, anesthesiologists, certified registered nurse anesthetists ("CRNAs"), and internists.

Facility Participating Provider: A health care professional, facility, CMHC Supervising Provider, or other organization that has a written Facility Participating Provider Agreement in effect with Redacted, directly or through another entity, to provide MHSA Service to Members.

Medicaid: A Medical Assistance Program providing health coverage benefits for low income persons pursuant to applicable state and federal laws and regulations.

Medically Necessary: Except as otherwise required by applicable state or federal law or regulations, for purposes of this Agreement, Medically Necessary means the term as it may be described in the Member's Benefit Plan for MHSA Services and which meets Payor's defined criteria for coverage as Covered Services. It may also, when applicable, have the meaning defined within the Protocols. Generally, however, Medically Necessary means treatment that is commonly recognized in the industry as consistent treatment that must be: (a) solely to treat the condition of the Member; (b) for the illness or injury of a diagnosis that is commonly recognized as a disease or injury; (c) reasonably expected to directly result in the restoration of health or function; (d) not experimental or investigational but is consistent with established and accepted national medical practice guidelines regarding type, frequency and duration of treatment; (e) without alternative treatment that is less intensive or invasive for the efficient treatment of the Member's condition; (f) not based on convenience for the Member; and (g) not otherwise excluded from the definition of Covered Services based upon the terms and conditions of the Member's Benefit Plan.

Medicare: Federally sponsored program providing health coverage benefits to individuals of qualifying age, disability, or disease.

Member: An individual who is eligible for, properly enrolled in, and covered under a Benefit Plan.

Member Expenses: Any amount of Customary Charges that are the Member's responsibility to pay Provider in accordance with the terms of the Member's Benefit Plan, including co-payments, co-insurance and deductible amounts.

Mental Health and Substance Abuse Services ("MHSA Services"): Health care services, treatment or supplies that are used to treat a mental health or substance

abuse illness, condition or disease and which may be eligible for coverage under the Member's Benefit Plan.

Payment Policies: Guidelines adopted by Redacted, from time to time, for calculating payment of claims under Benefit Plans.

Payor: The entity or person that has the financial responsibility for funding payment of Covered Services on behalf of a Member, and that is authorized to access MHSA Services in accordance with this Agreement.

Protocols: The programs, policies, protocols, processes, procedures, and requirements as such may change or be modified from time to time, and that are adopted by Redacted or Payor, and which Provider agrees to follow as a condition of Redacted accepting Provider as a Participating Provider, including, but not limited to, authorization procedures, credentialing and re-credentialing processes and plans, utilization management and care management processes, billing procedures, Payment Policies, providing or arranging for Emergency Services, quality improvement, peer review, on-site review, Member grievance and appeals processes, and any other policies, procedures, processes, activities or standards, wherever located as may apply to Provider's rights, obligations or responsibilities as a Provider of MHSA Services, whether in this Agreement, Provider Manual, or any other document as made accessible or available to Provider from time to time.

Provider Manual: A document or manual, however known or named, such as the Network Manual, containing the administrative policies, procedures and Protocols applicable to Benefit Plans provided, sponsored or administered by Redacted or a Payor including, but not limited to, policies and procedures for credentialing, claims, quality improvement, and utilization management to which Provider is obligated.

ARTICLE 2
Duties of Provider

2.1 Provision of MHSA Services. Provider hereby acknowledges and agrees to cooperate and comply with all of the terms and conditions of the Provider Manual, Protocols, and this Agreement, and to dutifully perform as a Participating Provider for the provision of MHSA Services to Members within the Redacted network(s) as designated by Redacted or Payor. At the request of a Payor, Provider or Facility-based Provider may not be authorized to provide MHSA Services for some or all of Payor's Members. Provider shall otherwise accept Members as new patients on the same basis as Provider is accepting non-Members as new patients without regard to race, religion, gender, color, national origin, age or physical or mental health status, or on any other basis deemed unlawful under federal, state or local law. At all times, Provider shall require any employed or subcontracted health care professionals and facilities to comply with the terms and conditions of this Agreement, all Protocols of Redacted and Payor, the Provider Manual, as well as the requirements of all applicable laws and regulations.

2.2 Benefit Plan & Eligibility. MHSA Services provided by Provider to a Member pursuant to this Agreement are subject to all the terms and conditions of the Member's Benefit Plan including eligibility of the Member on the date MHSA Services are provided to the Member. Provider shall make reasonable effort to verify Member's eligibility at time of service by following appropriate procedures, including without limitation, and at a minimum, the terms and conditions of this Agreement, Protocols, the Provider Manual, and review of the Member's Benefit Plan identification card. Provider however recognizes that the Member eligibility information may be inaccurate at the time Provider obtains verification and that the Member, or the MHSA Services provided to the Member, may later be determined to be ineligible for coverage and, except as otherwise required by law, not eligible for payment under this Agreement. Under such circumstances, Provider may then, except as otherwise stated herein, directly bill the Member or other responsible party for such MHSA Services.

2.3 Provider Manual & Protocols. Provider shall be bound by, accept, strictly comply with, and cooperate with, the requirements set forth in the Provider Manual, credentialing plan, and all Protocols, as amended or modified from time to time by Redacted and/or Payor, all of which are hereby incorporated herein by reference as if set forth fully herein, including without limitation quality improvement activities. Provider acknowledges and agrees that the Provider Manual and/or Protocols may contain service and contract requirements of certain Payors to which Provider shall strictly comply. Provider's failure to comply with the Provider Manual, Protocols and any other standards, procedures or policies may result in loss of, or reduction of paymentor reimbursement to Provider, termination of this Agreement or the imposition of other corrective action by Redacted.

2.4 Authorization Requirements. Subject to all applicable terms and conditions, including without limitation Section 2.2 above, and in accordance with the Provider Manual, Protocols, and requirements of the Member's Benefit Plan regarding authorization, Provider must request authorization for MHSA Services from Redacted either telephonically or by another approved and accepted method recognized by Redacted before providing any MHSA Services to a Member as a Covered Service. Authorizations shall subsequently be confirmed by Redacted in writing. Except as otherwise permitted herein, only Emergency Services will be eligible for retroactive authorization at the sole discretion of Redacted or as required by applicable law. Any authorization resulting from wrongful, fraudulent or negligent actions of Provider or a breach of this Agreement shall be null and void as of the time given. The terms of this section shall prevail over any inconsistent term or condition in the Member's Benefit Plan or other document related to obtaining priorauthorization.

2.5 Provider's Standard of Care. Nothing in this Agreement, the Provider Manual, the Benefit Plan, or the Protocols, including without limitation, Redacted utilization management and quality assurance and improvement standards and procedures, shall dictate MHSA Services provided by Provider or otherwise diminish Provider's obligation to freely communicate with and/or provide MHSA Services to Members in accordance with the applicable standard of care.

2.6 Continuity of Care; Referral to Other Health Professionals. Provider shall furnish Covered Services in a manner providing continuity of care and ready referral of Members to other Participating Providers at times as may be appropriate and consistent with the standards of care in the community. If a Member requires additional services or evaluation, including Emergency Services, Provider agrees to refer Member to his/her primary care physician or another Participating Provider in accordance with the terms and conditions of Member's Benefit Plan. A Member requiring Emergency Services shall also be referred to the "9-1-1" emergency response system.

2.7 Member Access to Care. Provider shall ensure that Members have timely and reasonable access to MHSA Services and shall at all times be reasonably available to Members as is appropriate. If Provider is unavailable when Members call, instructions must be provided for the Member referring the Member to another Participating Provider or to his/her Benefit Plan. Provider shall arrange for an answering machine or service that shall provide the office hours and emergency information and be capable of receiving messages 24 hours a day.

2.8 Employees and Contractors of Provider. Provider will be responsible for and shall ensure that all of its employees and contractors are bound by, and meet the terms and conditions of, this Agreement, the Provider Manual and Protocols, at the time of providing Covered Services to Members. Failure of such employees or contractors to meet such terms and conditions, including without limitation, credentialing requirements, Redacted may restrict them from providing Covered Services to Members.

2.9 Credentialing. Provider shall provide Redacted with the criteria utilized by Provider to select and credential employed or subcontracted health care professionals and facilities including, but not limited to, Facility-based Providers. Redacted shall have the right to audit such criteria upon reasonable advance written notice to Provider.

2.10 Payment of Services. All payments obligated by Payor shall be paid to Provider and Provider will be solely responsible for payments to its employees, contractors and Facility-based Providers who may have provided MHSA Services. Provider agrees to defend, indemnify and hold Redacted harmless for any claims, damages, actions, or judgments arising from any employee or contractor of Provider related to the provision of MHSA Services to Members.

2.11 Arrangements for Post-Discharge Follow-up Care. Prior to discharging a Member, Provider shall coordinate post-discharge follow-up care with Redacted and assure that the Member has a follow-up plan including a scheduled appointment with the appropriate providers as deemed necessary.

ARTICLE 3
Payment Provisions

3.1 Payment for Covered Services. In accordance with the terms and conditions hereof, Payor shall pay Provider for Covered Services provided to a Member by Provider. Payment shall be the lesser of: (a) Provider's Customary Charge, less any

applicable Member Expenses; or (b) the fee pursuant to the Standard Payment Appendix(ces) attached hereto, if any.

Subject to the terms and conditions herein, the obligation for payment for Covered Services provided to a Member, less any applicable Member Expenses, is solely that of Payor. Additionally, Redacted may arrange for claims processing services. When Redacted is the Payor, Redacted shall make obligated claim payments to Provider within 45 days (and shall use best efforts to encourage a third- party Payor to make payments within 45 days), or as otherwise required by law, of the date Payor receives all information necessary to process and pay a clean claim, except for claims for which there is coordination of benefits, Member Expense adjustments, disputes about coverage, systems failure or other such causes.

In the event a Member's Benefit Plan provides for a Member Expense whether stated as a flat fee or a percentage, the amount of the Member Expense shall be calculated in accordance with the Member's Benefit Plan or as determined by the Payor. The amount calculated pursuant to the preceding sentence shall be deducted from the amount Provider is to be paid for the Covered Services pursuant to this Agreement.

3.2 Submission of Claims. Provider shall submit claims for MHSA Services to Redacted in a manner and format prescribed by Redacted, whether in Protocols or otherwise, and which may be in an electronic format. All information necessary to process the claims must be received by Redacted no more than 90 days from the date of discharge and 90 days from the date all outpatient MHSA Services are rendered. Provider agrees that claims received after this time period may be rejected for payment, at Redacted and/or Payor's sole discretion.

Unless otherwise directed by Redacted, Provider shall submit claims using current CMS (HCFA) 1500 or UB04 forms, whichever is appropriate, with applicable coding including, but not limited to, ICD9, CPT, Revenue and HCPCS coding. Provider shall include in a claim the Member number, Customary Charges for the MHSA Services rendered to a Member during a single instance of service, Provider's Federal Tax I.D. number and/or other identifiers requested by Redacted.

Payor shall have the right to make, and Provider shall have the right to request, corrective adjustments to a previous payment; provided however, that Payor shall have no obligation to pay additional amounts after 12 months from the date the initial claim was paid.

3.3 Payment in Full. Provider shall accept as payment in full for Covered Services rendered to Members such amounts as are paid by Payor pursuant to this Agreement and shall not bill Members for non-covered charges, other than Member Expenses, which result from Payor's reimbursement methodologies. In no event shall Provider bill a Member for the difference between Customary Charges and the amount Provider has agreed to accept as full reimbursement under this Agreement. Provider may collect Member Expenses from the Member. If Payor denies payment for services rendered by Provider on grounds that the services are not Medically Necessary, Provider shall not

collect payment from the Member for the services unless the Member has knowledge of the determination of lack of Medical Necessity and has subsequently agreed in writing to be responsible for such charges and MHSA Services. Further, if any payment to Provider is denied, in part or full, due to Provider's failure to strictly comply with any term or condition in this Agreement, the Provider Manual, the Protocols, including without limitation, obtaining prior authorization, untimely filing of a claim, inaccurate or incorrect submission of or claim processing, or the insolvency of Payor pursuant to applicable law, it is agreed that Provider shall not, except for applicable Member Expenses, bill the Member or otherwise, directly or indirectly, seek or collect payment from the Member for any of the denied amounts. Any violation hereof by Provider shall be deemed a material breach. This provision shall apply regardless of whether any waiver or other document of any kind purporting to allow Provider to collect payment from the Member exists. These provisions shall survive the termination hereof and shall be construed to be for the benefit of the Member.

Provider acknowledges that the amounts paid to Provider under this Agreement includes payment for services provided by Provider to Members who are enrolled as Medicare beneficiaries.

3.4 Coordination of Benefits. Provider shall be paid in accordance with Payor's coordination of benefits rules.

3.5 Financial Responsibility. In the event of a default (meaning a systematic failure by Payor to fund undisputed claim payments for Covered Services) by a Payor, except when due to the insolvency of Payor, Redacted shall notify Provider in writing of such default following Redacted determination thereof. Any services which have been rendered by Provider prior to or after such notification, and which have not been paid for by Payor, shall be considered ineligible for reimbursement under this Agreement, and Provider may seek payment directly from the Payor and Member for such services.

3.6 Member Protection Provision. This provision supersedes and replaces the Financial Responsibility section (section 3.5 above) only in those cases where Redacted, or its Affiliate, is the Payor, or when required by another specific Payor, or when required pursuant to applicable laws, statutes and regulations.

In no event, including, but not limited to, non-payment by Payor for MHSA Services rendered to Members by Provider, insolvency of Payor, or breach by Redacted of any term or condition of this Agreement, shall Provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against any Member or persons acting on behalf of the Member for MHSA Services eligible for reimbursement under this Agreement; provided, however, that Provider may collect from the Member, any Member Expenses or charges for services that are not covered as benefits under the Member's Benefit Plan.

The provisions of this Article shall apply to all Member protection provisions in this Agreement and shall: (a) apply to all MHSA Services rendered while this Agreement is in force; (b) survive the termination of this Agreement regardless of the

cause of termination; (c) be construed to be for the benefit of the Members; and (d) except as otherwise stated in section 3.3, supersede any oral or written agreement, existing or subsequently entered into, between Provider and a Member or person acting on a Member's behalf, that requires the Member to pay for such MHSA Services.

3.7 Contracted Rate for Members. Provider agrees to continue to provide MHSA Services to Members who have exhausted his/her covered benefits under the Benefit Plan and agrees not to collect or charge more than the contracted rate for those MHSA Services. Provider may bill the Member directly for those MHSA Services for which there is no longer any coverage under the Benefit Plan, in accordance herewith.

ARTICLE 4
Laws, Regulations, and Licenses, and Liabilities of Parties

4.1 Laws, Regulations and Licenses. Provider shall maintain in good standing all federal, state and local licenses, certifications and permits -- without sanction, revocations, suspension, censure, probation or material restriction -- which are required to provide health care services according to the laws of the jurisdiction in which MHSA Services are provided, and shall comply with all applicable statutes and regulations. Provider shall also require that all health care professionals employed by or under contract with Provider to render MHSA Services to Members, including covering Providers, comply with this provision.

4.2 Responsibility for Damages. Any and all damages, claims, liabilities or judgments, attorney fees, which may arise as a result of Provider's or its employee's or contractor's negligence or intentional wrongdoing shall be the sole responsibility of Provider.

4.3 Provider Liability Insurance. Provider offering acute care services shall procure and maintain, at Provider's sole expense, (a) medical malpractice insurance in the amounts of $5,000,000 per occurrence and in aggregate, and (b) comprehensive general and/or umbrella liability insurance in the amount of $5,000,000 per occurrence and in aggregate. Whereas Provider offering non-acute care services shall procure and maintain, at Provider's sole expense, (c) medical malpractice insurance in the amounts of $1,000,000 per occurrence and $3,000,000 in aggregate, and (d) comprehensive general and/or umbrella liability insurance in the amount of $1,000,000 per occurrence and $3,000,000 in aggregate. Provider shall also require that all health care professionals employed by or under contract with Provider to render MHSA Services to Members procure and maintain, unless they are covered under Provider's insurance policies, a comprehensive general and/or umbrella liability insurance in the amount of $1,000,000 per occurrence and in aggregate and medical malpractice or professional liability insurance and comprehensive coverage in the amount of $1,000,000 per occurrence and $3,000,000 in aggregate if a Medical Doctor, and $1,000,000 per occurrence and in aggregate if not a Medical Doctor.

Provider's and other health care professionals' medical malpractice insurance shall be on either an "occurrence" or "claims made" basis provided that for a "claims

made" policy, such policy must be written with an extended period reporting option under such terms and conditions as may be reasonably required by Redacted. Prior to the Effective Date of this Agreement and at each policy renewal thereafter, Provider shall submit to Redacted in writing evidence of insurance coverage.

4.4 Self-Insurance Option. In lieu of compliance with section 4.3 above, Provider may with the prior written approval of Redacted, self-insure for medical malpractice liability, as well as comprehensive general liability. Provider shall maintain a separate reserve for its self-insurance. Upon reasonable request by Redacted, Provider shall provide a statement, verified by an independent auditor or actuary, that the reserve maintained by Provider for its self-insurance is sufficient and adequate. In addition to maintaining its self-insurance, Provider shall assure that all health care professionals employed by or under contract with Provider to render MHSA Services to Members procure and maintain adequate medical malpractice insurance unless they are covered by Provider's self-insurance. Failure to maintain adequate self- insurance shall trigger the requirement to obtain and maintain Insurance under section 4.3.

ARTICLE 5
Notices

5.1 Notices. Provider shall notify Redacted within ten (10) days of knowledge of any of the following:

(a) changes in liability insurance carriers, termination of, renewal of or any other material changes in Provider's liability insurance, including reduction of limits, erosion of aggregate, changes in retention or non-payment of premium, or any material adverse change in Provider's financial status which affects its self-insurance;

(b) action which may result in or the actual suspension, sanction, revocation, condition, limitation, qualification or other material restriction on Provider's or any of Facility-based Provider's licenses, certifications or permits by any government or accrediting or regulatory agency under which Provider or Facility-based Provider is accredited or regulated by or authorized to provide health care services;

(c) a change in Provider's name, address, ownership or Federal Tax I.D. number;

(d) indictment, arrest or conviction for a felony or for any criminal charge related to the practice of Provider's profession;

(e) claims or legal actions for professional negligence or bankruptcy;

(f) provider's termination, for cause, from any other provider network offered by any plan, including, without limitation, any health care service plan, health maintenance organization, any health insurer, any preferred provider organization, any employer or any trust fund;

(g) any occurrence or condition that might materially impair the ability of Provider or Facility-based Provider to perform its duties under this Agreement;

(h) any condition or circumstance that may pose a direct threat to the safety of Provider, Providers' staff, Facility-based Provider or Members; or

(i) action taken by Provider to suspend, revoke or allow the voluntary relinquishment of the medical staff membership or clinical privileges of any Facility-based Provider or Facility Participating Provider, unless the action will last 30 days or less.

Unless otherwise specified in this Agreement, each and every notice and communication to the other party shall be in writing. All written notices or communication shall be deemed to have been given when delivered in person; or, on the date mailed, if delivered by first-class mail, proper postage prepaid and properly addressed to the appropriate party at the address set forth at the signature portion of this Agreement or to another address of which sending party has been notified, including without limitation, to Redacted Network Manager at the applicable address for notice as identified in the Provider Manual or Protocols. The parties shall, by written notice, provide and update each other with the most current address and names of all parties or designees that should receive certain notices or communication.

ARTICLE 6
Records

6.1 Confidentiality of Records. Redacted and Provider shall maintain the confidentiality of all Member information and records in accordance with all applicable state and federal laws, statutes and regulations, including without limitation, the Health Insurance Portability and Accountability Act.

6.2 Maintenance of and Redacted Access to Records. Provider shall maintain adequate medical, treatment, financial and administrative records related to MHSA Services provided by Provider under this Agreement for a period and in a manner consistent with the standards of the community and in accordance with the Provider Manual, Protocols and all applicable state and federal laws, statutes and regulations.

In order to perform its utilization management and quality improvement activities, Redacted shall have access to such information and records, including claim records, within 14 days from the date the request is made, except that in the case of an audit by Redacted, such access shall be given at the time of the audit. If requested by Redacted, Provider shall provide copies of such records free of charge. During the term of this Agreement Redacted shall have access to and the right to audit information and records to the extent permitted by the Provider Manual, or as otherwise required by state or federal laws, statutes or regulations or regulatory authority. Said rights shall continue following the termination hereof for the longer of three years or for such period as may be permitted by applicable state or federal law, regulatory authority, or Protocols.

It is Provider's responsibility to obtain any Member's consent in order to provide Redacted with requested information and records or copies of records and to allow Redacted to release such information or records to Payors as necessary for the administration of the Benefit Plan or compliance with any state or federal laws, statutes and regulations applicable to the Payors.

Provider acknowledges that in receiving, storing, processing or otherwise dealing with information from Redacted or Payor about Members, it is fully bound by the provisions of the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2; and Provider agrees that it will resist in judicial proceedings any effort to obtain access to information pertaining to patients otherwise than as expressly provided for in the federal confidentiality regulations, 42 CFR Part 2.

This section shall not be construed to grant Redacted access to Provider's records that are created for purposes of assessing Provider's financial performance or for Provider's peer review activities, except to the extent the federal and/or state government and any of their authorized representatives have access to such records pursuant to Section 6.3.

6.3 Government and Accrediting Agency Access to Records. It is agreed that the federal, state and local government, or accrediting agencies including, but not limited to, the National Committee for Quality Assurance (the "NCQA"), and any of their authorized representatives, shall have access to, and Redacted and Provider are authorized to release, in accordance with applicable statutes and regulations, all information and records or copies of such, within the possession of Redacted or Provider, which are pertinent to and involve transactions related to this Agreement if such access is necessary to comply with accreditation standards, statutes or regulations applicable to Redacted, Payor or Provider. Such access shall be available and provided during the term of this Agreement and for three years following the termination hereof, or such longer period as may be identified in the Provider Manual or Protocols or as required by applicable state or federal laws, statutes or regulations.

ARTICLE 7
Resolution of Disputes

7.1 Resolution of Disputes. It is agreed that prior to any other remedy available to the parties, Redacted, Payor and/or Provider shall provide written notice of any disputes or claims arising out of their business relationship (the “Dispute”) to the other party within thirty (30) days of the final decision date, action, omission or cause from which the Dispute arose, whichever is later (the “Dispute Date”). If the Dispute pertains to a matter which is generally administered by certain Redacted procedures, such as a credentialing or quality improvement plan, the procedures set forth in that plan must be fully exhausted by Provider before Provider may invoke his or her rights as described herein. After receipt of the written notice of the Dispute, the parties agree to work together in good faith to resolve the Dispute. If the parties are unable to resolve the Dispute within thirty (30) days following receipt of the notice of the Dispute, and if either Redacted, Provider or Payor desires to pursue formal resolution of the Dispute, then said party shall issue a notice of arbitration to the other parties. It is agreed that the parties knowingly and voluntarily waive any right to a Dispute if arbitration is not initiated within one year after the Dispute Date.

Any arbitration proceeding under this Agreement shall be submitted to binding arbitration in accordance with the rules of the American Arbitration Association (AAA) and shall be conducted in a location agreed to by the parties or as selected by the AAA if the parties cannot agree on a location. The arbitrators may construe or interpret but shall not vary or ignore the terms of this

Agreement, shall have no authority to award any punitive or exemplary damages, and shall be bound by controlling law. The parties acknowledge that because this Agreement affects interstate commerce the Federal Arbitration Act applies.

ARTICLE 8
Term and Termination

8.1 Term. This Agreement shall begin on the Effective Date and it shall remain in effect for one year, and shall automatically renew for successive 1-year terms until it is terminated in accordance with the provisions herein.

8.2 Termination. This Agreement may be terminated as follows:

(a) by mutual agreement of Redacted and Provider;
(b) by Provider at the end of any term, as defined in Section 8.1, upon 120 days prior written notice to Redacted;
(c) by Redacted upon 120 days prior written notice to Provider;
(d) by either party, in the event of a material breach of this Agreement by the other party, upon 30 days prior written notice to the other party. The written notice shall specify the precise nature of the breach. In the event the breaching party cures the breach to the reasonable satisfaction of the non- breaching party, within 30 days after the non-breaching party's written notice, this Agreement shall not terminate;
(e) by Redacted immediately upon written notice to Provider, due to Provider's loss, suspension, restriction, probation, voluntary relinquishment, or any other adverse action taken against any of Provider's licenses or certifications, or loss of insurance or failure to maintain financial reserves sufficient to provide the level of self-insurance required under this Agreement;
(f) by Provider upon 60 days prior written notice to Redacted due to a unilateral amendment made to this Agreement pursuant to section 9.1;
(g) by Redacted in accordance with its credentialing plan;
(h) by Redacted immediately if Redacted determines, in its sole discretion, that the health, safety or welfare of Members may be jeopardized by the continuation of this Agreement; or
(i) by Redacted in accordance with the Provider Manual or Protocols.

During periods of notice of termination, Redacted reserves the right to transfer Members to another Participating Provider, and Provider agrees to cooperate and assist with such transfers.

If Provider is terminated through the Redacted credentialing or recredentialing process, this Agreement shall be deemed terminated as of the date Provider has been terminated pursuant to a final action resulting from that process.

8.3 Information to Members. Provider acknowledges and agrees that Redacted has the right to inform Members of Provider's termination and/or the notice of termination to Provider, and agrees to cooperate with Redacted in matters concerning the termination/transition, and agrees to hold Redacted harmless for exercising its rights hereunder. Provider also agrees to clearly inform Members of Provider's impending non-participation status upon the earlier of Member's next appointment or prior to the effective termination date.

8.4 Continuation of Services After Termination. At the option of Redacted, Provider shall continue to provide MHSA Services authorized by Redacted to Members who are receiving such services from Provider as of the effective date of termination of this Agreement, until Member can be satisfactorily transferred to another Participating Provider. Payor shall continue to pay Provider for such services at Provider's contracted rate.

ARTICLE 9
Miscellaneous

9.1 Amendment. Redacted may amend this Agreement by sending notice of the amendment to Provider at least 30 days prior to its effective date. The Provider's signature is not required. It is agreed that this Agreement shall be automatically amended to comply with any and all applicable state or federal laws, regulations, statutes or the requirements of applicable regulatory authorities as of the effective date thereof, and which shall be deemed to be incorporated herein by reference as of its effective date. Likewise, if a Payor that is a governmental entity requires that certain provisions of this Agreement be removed, replaced, amended or that additional provisions be incorporated, such provisions shall be deemed to be removed, replaced, amended or additional provisions incorporated into this Agreement as of the effective date of such Payor requirement for all MHSA Services provided which are subject to such Payor requirements without the signature of Provider being required. Renegotiation of the rates in this Agreement, shall be upon the mutual consent of the parties.

9.2 Assignment. Redacted may assign all or any of its rights and responsibilities under this Agreement to any of its Affiliates. Provider may assign any of his or her rights and responsibilities under this Agreement to any person or entity only upon the prior written consent of Redacted, which consent shall not be unreasonably withheld.

9.3 Administrative Responsibilities. Redacted may delegate certain administrative responsibilities under this Agreement to another entity, including, but not limited to, its Affiliate or to Payor or its designee. In addition, certain Payor responsibilities may actually be performed by its designee.

9.4 Relationship Between Redacted and Provider. The relationship between Redacted and Provider is solely that of independent contractors and nothing in this Agreement or otherwise shall be construed or deemed to create any other relationship, including one of employment, agency, joint venture or partnership.

9.5 Name, Symbol and Service Mark. During the term of this Agreement, Provider, Redacted and Payor shall have the right to use each other's name solely to make public reference to Provider as a Participating Provider. Provider, Redacted and Payor shall not otherwise use each other's name, symbol or service mark or that of their Affiliates without the prior written approval from the appropriate party.

9.6 Confidentiality. Neither party shall disclose to third parties any confidential or proprietary business information which it receives from the other party, including, but not limited to, financial statements, business plans, Protocols and programs; except that (a) Provider may disclose information to a Member relating to the Member's treatment plan and the payment methodology, but not specific rates; (b) Redacted may disclose certain terms to Payors or designees that need the information to process claims or administer a Benefit Plan, and may file the form of this Agreement with any federal or state regulatory entity as may be required by applicable law; and (c) Redacted shall be permitted to disclose, in its sole discretion, any other data or information that may be requested by applicable state and federal law, state regulations or governing agencies that pertain to this Agreement or that may relate to the enforcement of any right granted or term or condition of this Agreement.

9.7 Communication. Redacted encourages Provider to discuss with Members treatment options and their associated risks and benefits, regardless of whether the treatment is covered under the Member's Benefit Plan. Nothing in this Agreement is intended to interfere with Provider's relationship with Members as patients of Provider, or with Redacted ability to administer its quality improvement, utilization management and credentialing programs.

9.8 Effects of New Statutes and Regulations and Changes of Conditions. The parties agree to re-negotiate this Agreement if either party would be materially adversely affected by continued performance as a result of a change in laws or regulations, a requirement that one party comply with an existing law or regulation contrary to the other party's prior reasonable understanding, or a change in Redacted arrangements with Payors. The party affected must promptly notify the other party of the change or required compliance and its desire to re-negotiate this Agreement. If a new agreement is not executed within 30 days of receipt of the re-negotiation notice, the party adversely affected shall have the right to terminate this Agreement upon 45 days prior written notice to the other party. Any such notice of termination must be given within 10 days following the expiration of the 30-day re- negotiation period.

9.9 Appendices. Additional and/or alternative provisions, if any, related to certain MHSA Services rendered by Provider to Members covered by certain Benefit Plans, rates, and fees are set for in the Appendices, Attachments and Addendum.

9.10 Entire Agreement. On the Effective Date, this Agreement supersedes and replaces any existing Provider Agreements between the parties related to the provision of MHSA Services, including any agreements between Provider and Affiliates of Redacted for MHSA Services. This Agreement, together with any and all documents referenced herein, attachments, addenda, appendices, as may be amended or modified from time

to time, whether contemporaneous or subsequently made pursuant to Section 9.1, are hereby incorporated herein by reference, and constitutes the entire agreement between the parties in regard to its subject matter (herein collectively referred to as this "Agreement").

9.11 Strict Compliance. The waiver of strict compliance or performance of any of the terms or conditions of this Agreement, the Provider Manual or the Protocols or of any breach thereof shall not be held or deemed to be a waiver of any subsequent failure to comply strictly with or perform the same or any other term or condition thereof or any breach thereof.

9.12 Severability. Should any provision of this Agreement violate the law or be held invalid or unenforceable as written by a court of competent jurisdiction, then said provision along with the remainder of this Agreement shall nonetheless be enforceable to the extent allowable under applicable law by first modifying said provision to the extent permitted so as to comply with applicable law; otherwise said provision shall be deemed void to the extent of such prohibition without invalidating the remainder of this Agreement.

9.13 Rules of Construction. In the event of any conflict between the terms of this Agreement and the terms of any other agreement or any other controlling document or any applicable state or federal laws, statutes and regulations relating to the subject matter hereof, the terms, except as otherwise expressly stated herein, shall first be read together to the extent possible; otherwise the terms that afford the greater protections to first Redacted and second to the Benefit Plan shall prevail over the conflicting term, to the extent permitted by and in accordance with and subject to applicable law, statutes or regulations. The remainder of the Agreement shall otherwise remain without invalidating or deleting the remainder of the conflicting provision or the Agreement.

9.14 Governing Law. This Agreement shall be governed by and construed in accordance with applicable state and federal laws, statutes and regulations, including without limitation, ERISA.

9.15 Medicaid Members. If a Medicaid Appendix is attached to this Agreement Provider agrees to provide MHSA Services to Members enrolled in a Benefit Plan for Medicaid recipients and to comply with any additional requirements set forth in the Medicaid Appendix.

9.16 Medicare Members. If a Medicare Appendix is attached to this Agreement, Provider agrees to provide MHSA Services under this Agreement, to Members who are enrolled in a Benefit Plan for Medicare beneficiaries and to cooperate and comply with the provisions set forth in the attached Medicare Advantage Addendum. Provider also understands that Redacted agreements with Participating Providers are subject to review and approval by the Centers for Medicare and Medicaid Services (“CMS”).

9.17 Survival. Upon any termination or expiration of this Agreement, the provisions herein which contemplates performance or observance subsequent to termination or

expiration, including without limitation, sections 2.9, 2.10, 2.11, 3.1, 3.2, 3.3, 3.6, 8.3, 8.4, 9.6 and Articles 6 and 7, shall survive and remain of full force and effect between the parties.

THIS AGREEMENT CONTAINS A BINDING ARBITRATION PROVISION THAT MAY BE ENFORCED BY THE PARTIES.

Upon the acceptance and execution hereof by both parties hereto, the Effective Date of this Agreement is: _____
(to be completed by Redacted only)

Redacted

Signature_____

Name_____

Title_____

Date_____

NAME OF PROVIDER

_____

_____

_____

Attn: _____

Signature_____

Print Name_____

Title_____

Date_____

Federal Tax ID Number: _____

Medicare Number:_____

Medicaid Number:_____

NPI Number:_____

Behavioral Health
Group Participating Provider Agreement

Redacted
GROUP PARTICIPATING PROVIDER AGREEMENT

THIS AGREEMENT is between Redacted ("Redacted") and the undersigned group provider (hereinafter referred to as the "Provider"). This Agreement will become effective upon the date set forth on the signature page of this Agreement or the date of first credentialed Group-based Provider whichever is later (the "Effective Date"). This Agreement sets forth the terms and conditions under which Provider shall participate in one or more networks developed by Redacted as a Participating Provider of Covered Services to Members.

ARTICLE 1
Definitions

Any capitalized term herein shall have the meaning as set forth in this Agreement. Any undefined term herein shall have the meaning as defined in the Provider Manual, the Protocols, or as may be defined by applicable state or federal laws or regulations, as applicable.

Affiliate: Each and every entity or business concern with which Redacted, directly or indirectly, in whole or in part, either: (i) owns or controls; (ii) is owned or controlled by; or (iii) is under common ownership or control.

Benefit Plan: The specific plan of benefits for health care coverage, including MHSA Services, for a particular Member that is provided, sponsored or administered by Redacted directly or through its Affiliate, or through a network rental arrangement Redacted may have with a third party, and contains the terms and conditions of a Member's coverage for MHSA Services, including applicable Member Expenses, exclusions and limitations, and all other provisions applicable to the coverage of such MHSA Services such as services rendered outside specified networks.

CMHC: A Community Mental Health Center.

CMHC Provider: An employee of a CMHC who provides mental health and/or substance abuse services, but is not a CMHC Supervising Provider.

CMHC Supervising Provider: A psychiatrist, psychologist, social worker, family or other therapist duly licensed and qualified in the state in which MHSA Services are provided to Members who practices as an employee of CMHC and has been approved as a CMHC Supervising Provider in writing by Redacted.

Covered Services: MHSA Services that meet the terms and conditions for coverage pursuant to the Member's Benefit Plan, including such conditions as Medically Necessary and proper authorization, and in accordance with the Provider Manual, Protocols, and applicable laws and regulations.

Customary Charge: The fee for MHSA Services charged by Provider that does not exceed the fee Provider would ordinarily charge any other person regardless of whether the person is a Member.

Emergency Services: Unless otherwise defined by applicable state law, a serious health condition that arises suddenly and requires immediate care and treatment, generally received within twenty-four (24) hours of onset, to stabilize or avoid jeopardy to the life or health of a Member or, by actions of the Member, to the life or health of another. Emergency Services shall be available twenty-four (24) hours per day, seven
(7) days per week.

Fee Maximums: The maximum amount Provider may receive as payment for provision of Covered Services to a Member, including Member Expenses, that are applicable to Provider pursuant to the Benefit Plan, as determined from time to time by Redacted will advise Provider of the then-current Fee Maximums to Provider upon request.

Group-based Provider: A health care professional, CMHC Supervising Provider, psychiatrist, psychologist, therapist or other behavioral health professional who is employed by or under contract or supervision to render MHSA Services to Members.

Group Participating Provider: An entity, organization, group, partnership or affiliation however categorized, consisting of health care professionals, facilities, CMHC Supervising Providers, psychiatrists, psychologists, therapists or other behavioral health professionals that is duly licensed or certified to provided MHSA Services within the state such MHSA Services are provided, and who has a written Group Participating Provider Agreement in effect with Redacted, directly or through another entity, to provide MHSA Services to Members.

Medicaid: A Medical Assistance Program providing health coverage benefits for low income persons pursuant to applicable state and federal laws and regulations.

Medically Necessary: Except as otherwise required by applicable state or federal law or regulations, for purposes of this Agreement, Medically Necessary means the term as it may be described in the Member's Benefit Plan for MHSA Services and which meets Payor's defined criteria for coverage as Covered Services. It may also, when applicable, have the meaning defined within the Protocols. Generally, however, Medically Necessary means treatment that is commonly recognized in the industry as consistent treatment that must be: (a) solely to treat the condition of the Member; (b) for the illness or injury of a diagnosis that is commonly recognized as a disease or injury; (c) reasonably expected to directly result in the restoration of health or function; (d) not experimental or investigational but is consistent with established and accepted national medical practice guidelines regarding type, frequency and duration of treatment; (e) without alternative treatment that is less intensive or invasive for the efficient treatment of the Member's condition; (f) not based on convenience for the Member; and (g) not otherwise excluded from the definition of Covered Services based upon the terms and conditions of the Member's Benefit Plan.

Medicare: Federally sponsored program providing health coverage benefits to individuals of qualifying age, disability, or disease.

Member: An individual who is eligible for, properly enrolled in, and covered under a Benefit Plan.

Member Expenses: Any amount of Customary Charges that are the Member's responsibility to pay Provider in accordance with the terms of the Member's Benefit Plan, including co-payments, co-insurance and deductible amounts.

Mental Health and Substance Abuse Services ("MHSA Services"): Health care services, treatment or supplies that are used to treat a mental health or substance abuse illness, condition or disease and which may be eligible for coverage under the Member's Benefit Plan.

Payment Policies: Guidelines adopted by Redacted, from time to time, for calculating payment of claims under Benefit Plans.

Payor: The entity or person that has the financial responsibility for funding payment of Covered Services on behalf of a Member, and that is authorized to access MHSA Services in accordance with this Agreement.

Protocols: The programs, policies, protocols, processes, procedures, and requirements as such may change or be modified from time to time, and that are adopted by Redacted or Payor, and which Provider agrees to follow as a condition of Redacted accepting Provider as a Participating Provider, including, but not limited to, authorization procedures, credentialing and re-credentialing processes and plans, utilization management and care management processes, billing procedures, Payment Policies, providing or arranging for Emergency Services, quality improvement, peer review, on-site review, Member grievance and appeals processes, and any other policies, procedures, processes, activities or standards, wherever located as may apply to Provider's rights, obligations or responsibilities as a Provider of MHSA Services, whether in this Agreement, Provider Manual, or any other document as made accessible or available to Provider from time to time.

Provider Manual: A document or manual, however known or named, such as the Network Manual, containing the administrative policies, procedures and Protocols applicable to Benefit Plans provided, sponsored or administered by Redacted or a Payor including, but not limited to, policies and procedures for credentialing, claims, quality improvement, and utilization management to which Provider is obligated.

ARTICLE 2
Duties of Provider

2.1 Provision of MHSA Services. Provider hereby acknowledges and agrees to cooperate and comply with all of the terms and conditions of the Provider Manual, Protocols, and this Agreement, and to dutifully perform as a Participating Provider for the provision of MHSA Services to Members within the Redacted network(s) as

by Redacted or Payor. At the request of a Payor, Provider or Group-based Provider may not be authorized to provide MHSA Services for some or all of Payor's Members. Provider shall otherwise accept Members as new patients on the same basis as Provider is accepting non-Members as new patients without regard to race, religion, gender, color, national origin, age or physical or mental health status, or on any other basis deemed unlawful under federal, state or local law. At all times, Provider shall require any employed or subcontracted health care professionals and facilities to comply with the terms and conditions of this Agreement, all Protocols of Redacted and Payor, the Provider Manual, as well as the requirements of all applicable laws and regulations.

2.2 Benefit Plan & Eligibility. MHSA Services provided by Provider to a Member pursuant to this Agreement are subject to all the terms and conditions of the Member's Benefit Plan including eligibility of the Member on the date MHSA Services are provided to the Member. Provider shall make reasonable effort to verify Member's eligibility at time of service by following appropriate procedures, including without limitation, and at a minimum, the terms and conditions of this Agreement, Protocols, the Provider Manual, and review of the Member's Benefit Plan identification card. Provider however recognizes that the Member eligibility information may be inaccurate at the time Provider obtains verification and that the Member, or the MHSA Services provided to the Member, may later be determined to be ineligible for coverage and, except as otherwise required by law, not eligible for payment under this Agreement. Under such circumstances, Provider may then, except as otherwise stated herein, directly bill the Member or other responsible party for such MHSA Services.

2.3 Provider Manual & Protocols. Provider shall be bound by, accept, strictly comply with, and cooperate with, the requirements set forth in the Provider Manual, credentialing plan, and all Protocols, as amended or modified from time to time by Redacted and/or Payor, all of which are hereby incorporated herein by reference as if set forth fully herein, including without limitation quality improvement activities. Provider acknowledges and agrees that the Provider Manual and/or Protocols may contain service and contract requirements of certain Payors to which Provider shall strictly comply. Provider's failure to comply with the Provider Manual, Protocols and any other standards, procedures or policies may result in loss of, or reduction of payment or reimbursement to Provider, termination of this Agreement or the imposition of other corrective action by Redacted.

2.4 Authorization Requirements. Subject to all applicable terms and conditions, including without limitation Section 2.2 above, and in accordance with the Provider Manual, Protocols, and requirements of the Member’s Benefit Plan regarding authorization, Provider must request authorization for MHSA Services from Redacted either telephonically or by another approved and accepted method recognized by Redacted before providing any MHSA Services to a Member as a Covered Service. Authorizations shall subsequently be confirmed by Redacted in writing. Except as otherwise permitted herein, only Emergency Services will be eligible for retroactive authorization at the sole discretion of Redacted or as required by applicable law. Any authorization resulting from wrongful, fraudulent or negligent actions of Provider or a breach of this Agreement shall be null and void as of the time given

2.5 Provider's Standard of Care. Nothing in this Agreement, the Provider Manual, the Benefit Plan, or the Protocols, including without limitation, Redacted utilization management and quality assurance and improvement standards and procedures, shall dictate MHSA Services provided by Provider or otherwise diminish Provider's obligation to freely communicate with and/or provide MHSA Services to Members in accordance with the applicable standard of care.

2.6 Continuity of Care; Referral to Other Health Professionals. Provider shall furnish Covered Services in a manner providing continuity of care and ready referral of Members to other Participating Providers at times as may be appropriate and consistent with the standards of care in the community. If a Member requires additional services or evaluation, including Emergency Services, Provider agrees to refer Member to his/her primary care physician or another Participating Provider in accordance with the terms and conditions of Member's Benefit Plan. A Member requiring Emergency Services shall also be referred to the "9-1-1" emergency response system.

2.7 Member Access to Care. Provider shall ensure that Members have timely and reasonable access to MHSA Services and shall at all times be reasonably available to Members as is appropriate. If Provider is unavailable when Members call, instructions must be provided for the Member referring the Member to another Participating Provider or to his/her Benefit Plan. Provider shall arrange for an answering machine or service that shall provide the office hours and emergency information and be capable of receiving messages 24 hours a day.

2.8 Employees and Contractors of Provider. Provider will be responsible for and shall ensure that all of its employees and contractors are bound by, and meet the terms and conditions of, this Agreement, the Provider Manual and Protocols, at the time of providing Covered Services to Members. Failure of such employees or contractors to meet such terms and conditions, including without limitation, credentialing requirements, Redacted may restrict them from providing Covered Services to Members.

2.9 Credentialing. Provider shall provide Redacted with the criteria utilized by Provider pursuant to its applicable or required criteria to select and credential employed or subcontracted health care professionals, including, but not limited to, Group-based Providers. Redacted shall have the right to audit such criteria upon reasonable advance written notice to Provider.

2.10 Payment of Services. All payments obligated by Payor shall be paid to Provider and Provider will be solely responsible for payments to its employees, contractors and Group-based Providers who may have provided MHSA Services. Provider agrees to defend, indemnify and hold Redacted harmless for any claims, damages, actions, or judgments arising from any employee or contractor of Provider related to the provision of MHSA Services to Members.

ARTICLE 3
Payment Provisions

3.1 Payment for Covered Services. In accordance with the terms and conditions hereof, Payor shall pay Provider for Covered Services provided to a Member by Provider. Payment shall be the lesser of: (a) Provider's Customary Charge, less any applicable Member Expenses; or (b) the Fee Maximum for such MHSA Services, less any applicable Member Expenses, and in accordance with the Standard Payment Appendix(ces) attached hereto, if any.

Subject to the terms and conditions herein, the obligation for payment for Covered Services provided to a Member, less any applicable Member Expenses, is solely that of Payor. Additionally, Redacted may arrange for claims processing services. When Redacted is the Payor, Redacted shall make obligated claim payments to Provider within 45 days (and shall use best efforts to encourage a third- party Payor to make payments within 45 days), or as otherwise required by law, of the date Payor receives all information necessary to process and pay a clean claim, except for claims for which there is coordination of benefits, Member Expense adjustments, disputes about coverage, systems failure or other such causes.

In the event a Member's Benefit Plan provides for a Member Expense whether stated as a flat fee or a percentage, the amount of the Member Expense shall be calculated in accordance with the Member's Benefit Plan or as determined by the Payor. The amount calculated pursuant to the preceding sentence shall be deducted from the amount Provider is to be paid for the Covered Services pursuant to this Agreement.

3.2 Submission of Claims. Provider shall submit claims for MHSA Services to Redacted in a manner and format prescribed by Redacted, whether in Protocols or otherwise, and which may be in an electronic format. All information necessary to process the claims must be received by Redacted no more than 90 days from the date the MHSA Services are rendered. Provider agrees that claims received after this time period may be rejected for payment, at Redacted and/or Payor’s sole discretion.

Unless otherwise directed by Redacted, Provider shall submit claims using current CMS (HCFA) 1500 or UB04 forms, whichever is appropriate, with applicable coding including, but not limited to, ICD9, CPT, Revenue and HCPCS coding. Provider shall include in a claim the Member number, Customary Charges for the MHSA Services rendered to a Member during a single instance of service, Provider's Federal Tax I.D. number and/or other identifiers requested by Redacted.

Payor shall have the right to make, and Provider shall have the right to request, corrective adjustments to a previous payment; provided however, that Payor shall have no obligation to pay additional amounts after 12 months from the date the initial claim was paid.

3.3 Payment in Full. Provider shall accept as payment in full for Covered Services rendered to Members such amounts as are paid by Payor pursuant to this Agreement

and shall not bill Members for non-covered charges, other than Member Expenses, which result from Payor's reimbursement methodologies. In no event shall Provider bill a Member for the difference between Customary Charges and the amount Provider has agreed to accept as full reimbursement under this Agreement. Provider may collect Member Expenses from the Member. If Payor denies payment for services rendered by Provider on grounds that the services are not Medically Necessary, Provider shall not collect payment from the Member for the services unless the Member has knowledge of the determination of lack of Medical Necessity and has subsequently agreed in writing to be responsible for such charges and MHSA Services. Further, if any payment to Provider is denied, in part or full, due to Provider's failure to strictly comply with any term or condition in this Agreement, the Provider Manual, the Protocols, including without limitation, obtaining prior authorization, untimely filing of a claim, inaccurate or incorrect submission of or claim processing, or the insolvency of Payor pursuant to applicable law, it is agreed that Provider shall not, except for applicable Member Expenses, bill the Member or otherwise, directly or indirectly, seek or collect payment from the Member for any of the denied amounts. Any violation hereof by Provider shall be deemed a material breach. This provision shall apply regardless of whether any waiver or other document of any kind purporting to allow Provider to collect payment from the Member exists. These provisions shall survive the termination hereof and shall be construed to be for the benefit of the Member.

3.4 Coordination of Benefits. Provider shall be paid in accordance with Payor's coordination of benefits rules.

3.5 Financial Responsibility. In the event of a default (meaning a systematic failure by Payor to fund undisputed claim payments for Covered Services) by a Payor, except when due to the insolvency of Payor, Redacted shall notify Provider in writing of such default following Redacted determination thereof. Any services which have been rendered by Provider prior to or after such notification, and which have not been paid for by Payor, shall be considered ineligible for reimbursement under this Agreement, and Provider may seek payment directly from the Payor and Member for such services.

3.6 Member Protection Provision. This provision supersedes and replaces the Financial Responsibility section (section 3.5 above) only in those cases where Redacted, or its Affiliate, is the Payor, or when required by another specific Payor, or when required pursuant to applicable laws, statutes and regulations.

In no event, including, but not limited to, non-payment by Payor for MHSA Services rendered to Members by Provider, insolvency of Payor, or breach by Redacted of any term or condition of this Agreement, shall Provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against any Member or persons acting on behalf of the Member for MHSA Services eligible for reimbursement under this Agreement; provided, however, that Provider may collect from the Member, any Member Expenses or charges for services that are not covered as benefits under the Member's Benefit Plan.

The provisions of this Article shall apply to all Member protection provisions in this Agreement and shall: (a) apply to all MHSA Services rendered while this Agreement is in force; (b) survive the termination of this Agreement regardless of the cause of termination; (c) be construed to be for the benefit of the Members; and (d) except as otherwise stated in section 3.3, supersede any oral or written agreement, existing or subsequently entered into, between Provider and a Member or person acting on a Member's behalf, that requires the Member to pay for such MHSA Services.

3.7 Contracted Rate for Members. Provider agrees to continue to provide MHSA Services to Members who have exhausted his/her Covered Services under the Benefit Plan and agrees not to collect or charge more than the contracted rate for those MHSA Services. Provider may bill the Member directly for those MHSA Services for which there is no longer any coverage under the Benefit Plan, in accordance herewith.

ARTICLE 4
Laws, Regulations, and Licenses, and Liabilities of Parties

4.1 Laws, Regulations and Licenses. Provider shall maintain in good standing all federal, state and local licenses, certifications and permits -- without sanction, revocations, suspension, censure, probation or material restriction -- which are required to provide health care services according to the laws of the jurisdiction in which MHSA Services are provided, and shall comply with all applicable statutes and regulations. Provider shall also require that all health care professionals employed by or under contract with Provider to render MHSA Services to Members, including covering Providers, comply with this provision.

4.2 Responsibility for Damages. Any and all damages, claims, liabilities or judgments, attorney fees, which may arise as a result of Provider's or its employee's or contractor's negligence or intentional wrongdoing shall be the sole responsibility of Provider.

4.3 Provider Liability Insurance. Provider shall procure and maintain, at Provider's sole expense, (a) medical malpractice or professional liability insurance in the amount of $1,000,000 per occurrence and $3,000,000 in aggregate if Provider is a Medical Doctor and $1,000,000 per occurrence and $1,000,000 in aggregate if Provider is not a Medical Doctor; and (b) comprehensive general and/or umbrella liability insurance in the amount of $1,000,000 per occurrence and $3,000,000 in aggregate. Provider shall also require that all health care professionals employed by or under contract with Provider to render MHSA Services to Members procure and maintain malpractice insurance, unless they are covered under Provider's insurance policies.

Provider's and other health care professionals' medical malpractice insurance shall be on either an "occurrence" or "claims made" basis provided that for a "claims made" policy, such policy must be written with an extended period reporting option under such terms and conditions as may be reasonably required by Redacted. Prior to the Effective Date of this Agreement and at each policy renewal thereafter, Provider shall submit to Redacted in writing evidence of insurance coverage.

ARTICLE 5
Notices

5.1 Notices. Provider shall notify Redacted within ten (10) days of knowledge of any of the following:

(a) changes in liability insurance carriers, termination of, renewal of or any other material changes in Provider's liability insurance, including reduction of limits, erosion of aggregate, changes in retention or non-payment of premium;

(b) action which may result in or the actual suspension, sanction, revocation, condition, limitation, qualification or other material restriction on Provider's licenses, certifications or permits by any government or applicable accrediting or regulatory agency under which Provider is accredited or regulated by or authorized to provide health care services, including without limitation, any action concerning Provider's credentialing criteria or the performance of its employees, contractors or its Group-based Providers; or any suspension, revocation, condition, limitation, qualification or other material restriction of Provider's staff privileges at any licensed hospital, nursing home or other facility at which Provider has staff privileges during the term of this Agreement;

(c) a change in Provider's name, address, ownership or Federal Tax I.D. number;

(d) indictment, arrest or conviction for a felony or for any criminal charge related to the practice of Provider's profession;

(e) claims or legal actions for professional negligence or bankruptcy;

(f) provider's termination, for cause, from any other provider network offered by any plan, including, without limitation, any health care service plan, health maintenance organization, any health insurer, any preferred provider organization, any employer or any trust fund;

(g) any occurrence or condition that might materially impair the ability of Provider or Group-based Provider to perform its duties under this Agreement; or

(h) any condition or circumstance that may pose a direct threat to the safety of Provider, Providers' staff, Group-based Provider or Members.

Unless otherwise specified in this Agreement, each and every notice and communication to the other party shall be in writing. All written notices or communication shall be deemed to have been given when delivered in person; or, on the date mailed, if delivered by first-class mail, proper postage prepaid and properly addressed to the appropriate party at the address set forth at the signature portion of this Agreement or to another address of which sending party has been notified, including without limitation, to Redacted Network Manager at the applicable address for notice as identified in the Provider Manual or Protocols. The parties shall, by written notice, provide and update each other with the most current address and names of all parties or designees that should receive certain notices or communication.

ARTICLE 6
Records

6.1 Confidentiality of Records. Redacted and Provider shall maintain the confidentiality of all Member information and records in accordance with all applicable state and federal laws, statutes and regulations, including without limitation, the Health Insurance Portability and Accountability Act.

6.2 Maintenance of and Redacted Access to Records. Provider shall maintain adequate medical, treatment, financial and administrative records related to MHSA Services provided by Provider under this Agreement for a period and in a manner consistent with the standards of the community and in accordance with the Provider Manual, Protocols and all applicable state and federal laws, statutes and regulations.

In order to perform its utilization management and quality improvement activities, Redacted shall have access to such information and records, including claim records, within 14 days from the date the request is made, except that in the case of an audit by Redacted, such access shall be given at the time of the audit. If requested by Redacted, Provider shall provide copies of such records free of charge. During the term of this Agreement Redacted shall have access to and the right to audit information and records to the extent permitted by the Provider Manual, or as otherwise required by state or federal laws, statutes or regulations or regulatory authority. Said rights shall continue following the termination hereof for the longer of three years or for such period as may be permitted by applicable state or federal law, regulatory authority, or Protocols.

It is Provider's responsibility to obtain any Member's consent in order to provide Redacted with requested information and records or copies of records and to allow Redacted to release such information or records to Payors as necessary for the administration of the Benefit Plan or compliance with any state or federal laws, statutes and regulations applicable to the Payors.

Provider acknowledges that in receiving, storing, processing or otherwise dealing with information from Redacted or Payor about Members, it is fully bound by the provisions of the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2; and Provider agrees that it will resist in judicial proceedings any effort to obtain access to information pertaining to patients otherwise than as expressly provided for in the federal confidentiality regulations, 42 CFR Part 2.

This section shall not be construed to grant Redacted access to Provider's records that are created for purposes of assessing Provider's financial performance or for Provider's peer review activities, except to the extent the federal and/or state government and any of their authorized representatives have access to such records pursuant to Section 6.3.

6.3 Government and Accrediting Agency Access to Records. It is agreed that the federal, state and local government, or accrediting agencies including, but not limited to, the National Committee for Quality Assurance (the "NCQA"), and any of their

authorized representatives, shall have access to, and Redacted and Provider are authorized to release, in accordance with applicable statutes and regulations, all information and records or copies of such, within the possession of Redacted or Provider, which are pertinent to and involve transactions related to this Agreement if such access is necessary to comply with accreditation standards, statutes or regulations applicable to Redacted, Payor or Provider. Such access shall be available and provided during the term of this Agreement and for three years following the termination hereof, or such longer period as may be identified in the Provider Manual or Protocols or as required by applicable state or federal laws, statutes or regulations.

ARTICLE 7
Resolution of Disputes

7.1 Resolution of Disputes. It is agreed that prior to any other remedy available to the parties, Redacted, Payor and/or Provider shall provide written notice of any disputes or claims arising out of their business relationship (the "Dispute") to the other party within thirty (30) days of the final decision date, action, omission or cause from which the Dispute arose, whichever is later (the "Dispute Date"). If the Dispute pertains to a matter which is generally administered by certain Redacted procedures, such as a credentialing or quality improvement plan, the procedures set forth in that plan must be fully exhausted by Provider before Provider may invoke his or her rights as described herein. After receipt of the written notice of the Dispute, the parties agree to work together in good faith to resolve the Dispute. If the parties are unable to resolve the Dispute within thirty (30) days following receipt of the notice of the Dispute, and if either Redacted, Provider or Payor desires to pursue formal resolution of the Dispute, then said party shall issue a notice of arbitration to the other parties. It is agreed that the parties knowingly and voluntarily waive any right to a Dispute if arbitration is not initiated within one year after the Dispute Date.

Any arbitration proceeding under this Agreement shall be submitted to binding arbitration in accordance with the rules of the American Arbitration Association ("AAA"), and shall be conducted in a location agreed to by the parties or as selected by the AAA if the parties cannot agree on a location. The arbitrators may construe or interpret but shall not vary or ignore the terms of this Agreement, shall have no authority to award any punitive or exemplary damages, and shall be bound by controlling law. The parties acknowledge that because this Agreement affects interstate commerce the Federal Arbitration Act applies.

ARTICLE 8
Term and Termination

8.1 Term. This Agreement shall begin on the Effective Date and it shall remain in effect for one year, and shall automatically renew for successive 1-year terms until it is terminated in accordance with the provisions herein.

8.2 Termination. This Agreement may be terminated as follows:

(a) by mutual agreement of Redacted and Provider;
(b) by either party upon 90 days prior written notice to the other party;
(c) by either party, in the event of a material breach of this Agreement by the other party, upon 30 days prior written notice to the other party. The written notice shall specify the precise nature of the breach. In the event the breaching party cures the breach to the reasonable satisfaction of the non- breaching party, within 30 days after the non-breaching party's written notice, this Agreement shall not terminate;
(d) by Redacted immediately upon written notice to Provider, due to Provider's loss, suspension, restriction, probation, voluntary relinquishment, or any other adverse action taken against any of Provider's or Group-based Providers licenses or certifications, or loss of insurance required under this Agreement, or failure to materially perform its credentialing and/or supervision of its employees, contractors or Group-based Providers;
(e) by Provider upon 60 days prior written notice to Redacted due to a unilateral amendment made to this Agreement pursuant to section9.1;
(f) by Redacted in accordance with its credentialing plan;
(g) by Redacted immediately if Redacted determines, in its sole discretion, that the health, safety or welfare of Members may be jeopardized by the continuation of this Agreement; or
(h) by Redacted in accordance with the Provider Manual or Protocols.

During periods of notice of termination, Redacted reserves the right to transfer Members to another Participating Provider, and Provider agrees to cooperate and assist with such transfers.

If Provider is terminated through the Redacted credentialing or recredentialing process, this Agreement shall be deemed terminated as of the date Provider has been terminated pursuant to a final action resulting from that process.

8.3 Information to Members. Provider acknowledges and agrees that Redacted has the right to inform Members of Provider's termination and/or the notice of termination to Provider, and agrees to cooperate with Redacted in matters concerning the termination/transition, and agrees to hold Redacted harmless for exercising its rights hereunder. Provider also agrees to clearly inform Members of Provider's impending non-participation status upon the earlier of Member's next appointment or prior to the effective termination date.

8.4 Continuation of Services After Termination. At the option of Redacted, Provider shall continue to provide MHSA Services authorized by Redacted to Members who are receiving such services from Provider as of the effective date of termination of this Agreement, until Member can be satisfactorily transferred to another Participating Provider. Payor shall continue to pay Provider for such services at Provider's contracted rate.

8.5 Termination of Group-based Provider. A Group-based Provider's participation with Redacted may be individually terminated under the same conditions Provider's

participation may be terminated, as specified above. In addition, a Group-based Provider's participation with Redacted may be terminated by Redacted (a) immediately upon written notice to Provider due to Group-based Provider loss or suspension of licensure or certification; (b) failure to abide by established criteria as required by section 2.9; (c) loss of insurance as required under this Agreement; or (d) in accordance with Redacted credentialing process.

Furthermore, it is agreed that upon any such termination of a Group-based Provider pursuant to this section 8.5 that Redacted shall deliver notice to Provider of such a termination, that Group-based Provider shall not provide MHSA Services to any Member as of the termination date of the Group-based Provider, unless otherwise agreed to by Redacted in writing, and that this Agreement shall not be terminated, absent notice otherwise, upon the termination of any Group-based Provider.

ARTICLE 9
Miscellaneous

9.1 Amendment. Redacted may amend this Agreement by sending notice of the amendment to Provider at least 30 days prior to its effective date. The Provider's signature is not required. It is agreed that this Agreement shall be automatically amended to comply with any and all applicable state or federal laws, regulations, statutes or the requirements of applicable regulatory authorities as of the effective date thereof, and which shall be deemed to be incorporated herein by reference as of its effective date. Likewise, if a Payor that is a governmental entity requires that certain provisions of this Agreement be removed, replaced, amended or that additional provisions be incorporated, such provisions shall be deemed to be removed, replaced, amended or additional provisions incorporated into this Agreement as of the effective date of such Payor requirement for all MHSA Services provided which are subject to such Payor requirements without the signature of Provider being required.

9.2 Assignment. Redacted may assign all or any of its rights and responsibilities under this Agreement to any of its Affiliates. Provider may assign any of his or her rights and responsibilities under this Agreement to any person or entity only upon the prior written consent of Redacted, which consent shall not be unreasonably withheld.

9.3 Administrative Responsibilities. Redacted may delegate certain administrative responsibilities under this Agreement to another entity, including, but not limited to, its Affiliate or to Payor or its designee. In addition, certain Payor responsibilities may actually be performed by its designee.

9.4 Relationship Between Redacted and Provider. The relationship between Redacted and Provider is solely that of independent contractors and nothing in this Agreement or otherwise shall be construed or deemed to create any other relationship, including one of employment, agency, joint venture or partnership.

9.5 Name, Symbol and Service Mark. During the term of this Agreement, Provider, Redacted and Payor shall have the right to use each other's name solely to make public

reference to Provider as a Participating Provider. Provider, Redacted and Payor shall not otherwise use each other's name, symbol or service mark or that of their Affiliates without the prior written approval from the appropriate party.

9.6 Confidentiality. Neither party shall disclose to third parties any confidential or proprietary business information which it receives from the other party, including, but not limited to, financial statements, business plans, Protocols and programs; except that (a) Provider may disclose information to a Member relating to the Member's treatment plan and the payment methodology, but not specific rates; (b) Redacted may disclose certain terms to Payors or designees that need the information to process claims or administer a Benefit Plan, and may file the form of this Agreement with any federal or state regulatory entity as may be required by applicable law; and (c) Redacted shall be permitted to disclose, in its sole discretion, any other data or information that may be requested by applicable state and federal law, state regulations or governing agencies that pertain to this Agreement or that may relate to the enforcement of any right granted or term or condition of this Agreement.

9.7 Communication. Redacted encourages Provider to discuss with Members treatment options and their associated risks and benefits, regardless of whether the treatment is covered under the Member's Benefit Plan. Nothing in this Agreement is intended to interfere with Provider's relationship with Members as patients of Provider, or with Redacted ability to administer its quality improvement, utilization management and credentialing programs.

9.8 Effects of New Statutes and Regulations and Changes of Conditions. The parties agree to re-negotiate this Agreement if either party would be materially adversely affected by continued performance as a result of a change in laws or regulations, a requirement that one party comply with an existing law or regulation contrary to the other party's prior reasonable understanding, or a change in Redacted arrangements with Payors. The party affected must promptly notify the other party of the change or required compliance and its desire to re-negotiate this Agreement. If a new agreement is not executed within 30 days of receipt of the re-negotiation notice, the party adversely affected shall have the right to terminate this Agreement upon 45 days prior written notice to the other party. Any such notice of termination must be given within 10 days following the expiration of the 30-day re- negotiation period.

9.9 Appendices. Additional and/or alternative provisions, if any, related to certain MHSA Services rendered by Provider to Members covered by certain Benefit Plans, rates, and fees are set for in the Appendices, Attachments and Addendum.

9.10 Entire Agreement. On the Effective Date, this Agreement supersedes and replaces any existing Provider Agreements between the parties related to the provision of MHSA Services, including any agreements between Provider and Affiliates of Redacted for MHSA Services. This Agreement, together with any and all documents referenced herein, attachments, addenda, appendices, as may be amended or modified from time to time, whether contemporaneous or subsequently made pursuant to Section 9.1, are hereby incorporated herein by reference, and constitutes the entire agreement between

the parties in regard to its subject matter (herein collectively referred to as this "Agreement").

9.11 Strict Compliance. The waiver of strict compliance or performance of any of the terms or conditions of this Agreement, the Provider Manual or the Protocols or of any breach thereof shall not be held or deemed to be a waiver of any subsequent failure to comply strictly with or perform the same or any other term or condition thereof or any breach thereof.

9.12 Severability. Should any provision of this Agreement violate the law or be held invalid or unenforceable as written by a court of competent jurisdiction, then said provision along with the remainder of this Agreement shall nonetheless be enforceable to the extent allowable under applicable law by first modifying said provision to the extent permitted so as to comply with applicable law; otherwise said provision shall be deemed void to the extent of such prohibition without invalidating the remainder of this Agreement.

9.13 Rules of Construction. In the event of any conflict between the terms of this Agreement and the terms of any other agreement or any other controlling document or any applicable state or federal laws, statutes and regulations relating to the subject matter hereof, the terms, except as otherwise expressly stated herein, shall first be read together to the extent possible; otherwise the terms that afford the greater protections to first Redacted and second to the Benefit Plan shall prevail over the conflicting term, to the extent permitted by and in accordance with and subject to applicable law, statutes or regulations. The remainder of the Agreement shall otherwise remain without invalidating or deleting the remainder of the conflicting provision or the Agreement.

9.14 Governing Law. This Agreement shall be governed by and construed in accordance with applicable state and federal laws, statutes and regulations, including without limitation, ERISA.

9.15 Medicaid Members. If a Medicaid Appendix is attached to this Agreement Provider agrees to provide MHSA Services to Members enrolled in a Benefit Plan for Medicaid recipients and to comply with any additional requirements set forth in the Medicaid Appendix.

9.16 Medicare Members. If a Medicare Appendix is attached to this Agreement, Provider agrees to provide MHSA Services under this Agreement, to Members who are enrolled in a Benefit Plan for Medicare beneficiaries and to cooperate and comply with the provisions set forth in the attached Medicare Advantage Addendum. Provider also understands that Redacted agreements with Participating Providers are subject to review and approval by the Centers for Medicare and Medicaid Services (“CMS”).

9.17 Survival. Upon any termination or expiration of this Agreement, the provisions herein which contemplates performance or observance subsequent to termination or expiration, including without limitation, sections 2.9, 2.10, 3.1, 3.2, 3.3, 3.6, 8.3, 8.4, 9.6

and Articles 6 and 7, shall survive and remain of full force and effect between the parties.

THIS AGREEMENT CONTAINS A BINDING ARBITRATION PROVISION THAT MAY BE ENFORCED BY THE PARTIES.

The Effective Date of this Agreement is: _____

(TO BE COMPLETED BY Redacted ONLY)

Redacted, INC.

Signature_____

Title_____

Date_____

NAME OF PROVIDER

_____

_____

Attn: _____

Signature_____

Print Name_____

Title_____

Date_____

Federal Tax ID Number: _____

Medicare Number:_____

Medicaid Number:_____

NPI Number: _____

Behavioral Health
Individual Participating Provider Agreement

Redacted
INDIVIDUAL PARTICIPATING PROVIDER AGREEMENT

THIS AGREEMENT is between Redacted ("Redacted") and the undersigned provider (hereinafter referred to as the "Provider"). This Agreement will become effective upon the date set forth in Redacted executed Acceptance Letter (the "Effective Date"). This Agreement sets forth the terms and conditions under which Provider shall participate in one or more networks developed by Redacted as a Participating Provider of Covered Services to Members.

ARTICLE 1
Definitions

Any capitalized term herein shall have the meaning as set forth in this Agreement. Any undefined term herein shall have the meaning as defined in the Provider Manual, the Protocols, or as may be defined by applicable state or federal laws or regulations, as applicable.

Affiliate: Each and every entity or business concern with which Redacted, directly or indirectly, in whole or in part, either: (i) owns or controls; (ii) is owned or controlled by; or (iii) is under common ownership or control.

Benefit Plan: The specific plan of benefits for health care coverage, including MHSA Services, for a particular Member that is provided, sponsored or administered by Redacted directly or through its Affiliate, or through a network rental arrangement Redacted may have with a third party, and contains the terms and conditions of a Member's coverage for MHSA Services, including applicable Member Expenses, exclusions and limitations, and all other provisions applicable to the coverage of such MHSA Services such as services rendered outside specified networks.

CMHC: A Community Mental Health Center.

CMHC Provider: An employee of a CMHC who provides mental health and/or substance abuse services, but is not a CMHC Supervising Provider.

CMHC Supervising Provider: A psychiatrist, psychologist, social worker, family or other therapist duly licensed and qualified in the state in which MHSA Services are provided to Members who practices as an employee of CMHC and has been approved as a CMHC Supervising Provider in writing by Redacted.

Covered Services: MHSA Services that meet the terms and conditions for coverage pursuant to the Member's Benefit Plan, including such conditions as Medically Necessary and proper authorization, and in accordance with the Provider Manual, Protocols, and applicable laws and regulations.

Customary Charge: The fee for MHSA Services charged by Provider that does not exceed the fee Provider would ordinarily charge any other person regardless of whether the person is a Member.

Emergency Services: Unless otherwise defined by applicable state law, a serious health condition that arises suddenly and requires immediate care and treatment, generally received within twenty-four (24) hours of onset, to stabilize or avoid jeopardy to the life or health of a Member or, by actions of the Member, to the life or health of another. Emergency Services shall be available twenty-four (24) hours per day, seven
(7) days per week.

Fee Maximums: The maximum amount Provider may receive as payment for provision of Covered Services to a Member, including Member Expenses, that are applicable to Provider pursuant to the Benefit Plan, as determined from time to time by Redacted will advise Provider of the then-current Fee Maximums to Provider upon request.

Medicaid: A Medical Assistance Program providing health coverage benefits for low income persons pursuant to applicable state and federal laws and regulations.

Medically Necessary: Except as otherwise required by applicable state or federal law or regulations, for purposes of this Agreement, Medically Necessary means the term as it may be described in the Member's Benefit Plan for MHSA Services and which meets Payor's defined criteria for coverage as Covered Services. It may also, when applicable, have the meaning defined within the Protocols. Generally, however, Medically Necessary means treatment that is commonly recognized in the industry as consistent treatment that must be: (a) solely to treat the condition of the Member; (b) for the illness or injury of a diagnosis that is commonly recognized as a disease or injury; (c) reasonably expected to directly result in the restoration of health or function; (d) not experimental or investigational but is consistent with established and accepted national medical practice guidelines regarding type, frequency and duration of treatment; (e) without alternative treatment that is less intensive or invasive for the efficient treatment of the Member's condition; (f) not based on convenience for the Member; and (g) not otherwise excluded from the definition of Covered Services based upon the terms and conditions of the Member's Benefit Plan.

Medicare: Federally sponsored program providing health coverage benefits to individuals of qualifying age, disability, or disease.

Member: An individual who is eligible for, properly enrolled in, and covered under a Benefit Plan.

Member Expenses: Any amount of Customary Charges that are the Member's responsibility to pay Provider in accordance with the terms of the Member's Benefit Plan, including co-payments, co-insurance and deductible amounts.

Mental Health and Substance Abuse Services ("MHSA Services"): Health care services, treatment or supplies that are used to treat a mental health or substance abuse illness, condition or disease and which may be eligible for coverage under the Member's Benefit Plan.

Participating Provider: A health care professional, facility, CMHC Supervising Provider, psychiatrist, psychologist or other behavioral health professional or

organization, that is duly licensed or certified to provide MHSA Services within the state such MHSA Services are provided, and who has a written Individual Participating Provider Agreement in effect with Redacted, directly or through another entity, to provide MHSA Services to Members.

Payment Policies: Guidelines adopted by Redacted, from time to time, for calculating payment of claims under Benefit Plans.

Payor: The entity or person that has the financial responsibility for funding payment of Covered Services on behalf of a Member, and that is authorized to access MHSA Services in accordance with this Agreement.

Protocols: The programs, policies, protocols, processes, procedures, and requirements as such may change or be modified from time to time, and that are adopted by Redacted or Payor, and which Provider agrees to follow as a condition of Redacted accepting Provider as a Participating Provider, including, but not limited to, authorization procedures, credentialing and re-credentialing processes and plans, utilization management and care management processes, billing procedures, Payment Policies, providing or arranging for Emergency Services, quality improvement, peer review, on-site review, Member grievance and appeals processes, and any other policies, procedures, processes, activities or standards, wherever located as may apply to Provider's rights, obligations or responsibilities as a Provider of MHSA Services, whether in this Agreement, Provider Manual, or any other document as made accessible or available to Provider from time to time.

Provider Manual: A document or manual, however known or named, such as the Network Manual, containing the administrative policies, procedures and Protocols applicable to Benefit Plans provided, sponsored or administered by Redacted or a Payor including, but not limited to, policies and procedures for credentialing, claims, quality improvement, and utilization management to which Provider is obligated.

ARTICLE 2
Duties of Provider

2.1 Provision of MHSA Services. Provider hereby acknowledges and agrees to cooperate and comply with all of the terms and conditions of the Provider Manual, Protocols, and this Agreement, and to dutifully perform as a Participating Provider for the provision of MHSA Services to Members within the Redacted network(s) as designated by Redacted or Payor. At the request of a Payor, Provider may not be authorized to provide MHSA Services for some or all of Payor's Members. Provider shall otherwise accept Members as new patients on the same basis as Provider is accepting non-Members as new patients without regard to race, religion, gender, color, national origin, age or physical or mental health status, or on any other basis deemed unlawful under federal, state or local law. At all times, Provider shall require any employed or subcontracted health care professionals and facilities to comply with the terms and conditions of this Agreement, all Protocols of Redacted and Payor, the Provider Manual, as well as the requirements of all applicable laws and regulations.

2.2 Benefit Plan & Eligibility. MHSA Services provided by Provider to a Member pursuant to this Agreement are subject to all the terms and conditions of the Member's Benefit Plan including eligibility of the Member on the date MHSA Services are provided to the Member. Provider shall make reasonable effort to verify Member's eligibility at time of service by following appropriate procedures, including without limitation, and at a minimum, the terms and conditions of this Agreement, Protocols, the Provider Manual, and review of the Member's Benefit Plan identification card. Provider however recognizes that the Member eligibility information may be inaccurate at the time Provider obtains verification and that the Member, or the MHSA Services provided to the Member, may later be determined to be ineligible for coverage and, except as otherwise required by law, not eligible for payment under this Agreement. Under such circumstances, Provider may then, except as otherwise stated herein, directly bill the Member or other responsible party for such MHSA Services.

2.3 Provider Manual & Protocols. Provider shall be bound by, accept, strictly comply with, and cooperate with, the requirements set forth in the Provider Manual, credentialing plan, and all Protocols, as amended or modified from time to time by Redacted and/or Payor, all of which are hereby incorporated herein by reference as if set forth fully herein, including without limitation quality improvement activities. Provider acknowledges and agrees that the Provider Manual and/or Protocols may contain service and contract requirements of certain Payors to which Provider shall strictly comply. Provider's failure to comply with the Provider Manual, Protocols and any other standards, procedures or policies may result in loss of, or reduction of payment or reimbursement to Provider, termination of this Agreement or the imposition of other corrective action by Redacted.

2.4 Authorization Requirements. Subject to all applicable terms and conditions, including without limitation Section 2.2 above, and in accordance with the Provider Manual, Protocols, and requirements of the Member's Benefit Plan regarding authorization, Provider must request authorization for MHSA Services from Redacted either telephonically or by another approved and accepted method recognized by Redacted before providing any MHSA Services to a Member as a Covered Service. Authorizations shall subsequently be confirmed by Redacted in writing. Except as otherwise permitted herein, only Emergency Services will be eligible for retroactive authorization at the sole discretion of Redacted or as required by applicable law. Any authorization resulting from wrongful, fraudulent or negligent actions of Provider or a breach of this Agreement shall be null and void as of the time given.

2.5 Provider's Standard of Care. Nothing in this Agreement, the Provider Manual, the Benefit Plan, or the Protocols, including without limitation, Redacted utilization management and quality assurance and improvement standards and procedures, shall dictate MHSA Services provided by Provider or otherwise diminish Provider's obligation to freely communicate with and/or provide MHSA Services to Members in accordance with the applicable standard of care.

Covered Services in a manner providing continuity of care and ready referral of

2.6 Continuity of Care; Referral to Other Health Professionals. Provider shall furnish

Members to other Participating Providers at times as may be appropriate and consistent with the standards of care in the community. If a Member requires additional services or evaluation, including Emergency Services, Provider agrees to refer Member to his/her primary care physician or another Participating Provider in accordance with the terms and conditions of Member's Benefit Plan. A Member requiring Emergency Services shall also be referred to the "9-1-1" emergency response system.

2.7 Member Access to Care. Provider shall ensure that Members have timely and reasonable access to MHSA Services and shall at all times be reasonably available to Members as is appropriate. If Provider is unavailable when Members call, instructions must be provided for the Member referring the Member to another Participating Provider or to his/her Benefit Plan. Provider shall arrange for an answering machine or service that shall provide the office hours and emergency information and be capable of receiving messages 24 hours a day.

2.8 Employees and Contractors of Provider. Provider will be responsible for and shall ensure that all of its employees and contractors are bound by, and meet the terms and conditions of, this Agreement, the Provider Manual and Protocols, at the time of providing Covered Services to Members. Failure of such employees or contractors to meet such terms and conditions, including without limitation, credentialing requirements, Redacted may restrict them from providing Covered Services to Members.

All payments obligated by Payor shall be paid to Provider and Provider will be solely responsible for payments to its employees and contractors who may have provided MHSA Services. Provider agrees to defend, indemnify and hold Redacted harmless for any claims, damages, actions, or judgments arising from any employee or contractor of Provider related to the provision of MHSA Services to Members.

ARTICLE 3
Payment Provisions

3.1 Payment for Covered Services. In accordance with the terms and conditions hereof, Payor shall pay Provider for Covered Services provided to a Member by Provider. Payment shall be the lesser of: (a) Provider's Customary Charge, less any applicable Member Expenses; or (b) the Fee Maximum for such MHSA Services, less any applicable Member Expenses.

Subject to the terms and conditions herein, the obligation for payment for Covered Services provided to a Member, less any applicable Member Expenses, is solely that of Payor. Additionally, Redacted may arrange for claims processing services. When Redacted is the Payor, Redacted shall make obligated claim payments to Provider within 45 days (and shall use best efforts to encourage a third- party Payor to make payments within 45 days), or as otherwise required by law, of the date Payor receives all information necessary to process and pay a clean claim, except for claims for which there is coordination of benefits, Member Expense adjustments, disputes about coverage, systems failure or other such causes.

In the event a Member's Benefit Plan provides for a Member Expense whether stated as a flat fee or a percentage, the amount of the Member Expense shall be calculated in accordance with the Member's Benefit Plan or as determined by the Payor. The amount calculated pursuant to the preceding sentence shall be deducted from the amount Provider is to be paid for the Covered Services pursuant to this Agreement.

3.2 Submission of Claims. Provider shall submit claims for MHSA Services to Redacted in a manner and format prescribed by Redacted, whether in Protocols or otherwise, and which may be in an electronic format. All information necessary to process the claims must be received by Redacted no more than 90 days from the date the MHSA Services are rendered. Provider agrees that claims received after this time period may be rejected for payment, at Redacted and/or Payor's sole discretion.

Unless otherwise directed by Redacted, Provider shall submit claims using current CMS (HCFA) 1500 or UB04 forms, whichever is appropriate, with applicable coding including, but not limited to, ICD9, CPT, Revenue and HCPCS coding. Provider shall include in a claim the Member number, Customary Charges for the MHSA Services rendered to a Member during a single instance of service, Provider's Federal Tax I.D. number and/or other identifiers requested by Redacted.

Payor shall have the right to make, and Provider shall have the right to request, corrective adjustments to a previous payment; provided however, that Payor shall have no obligation to pay additional amounts after 12 months from the date the initial claim was paid.

3.3 Payment in Full. Provider shall accept as payment in full for Covered Services rendered to Members such amounts as are paid by Payor pursuant to this Agreement and shall not bill Members for non-covered charges, other than Member Expenses, which result from Payor's reimbursement methodologies. In no event shall Provider bill a Member for the difference between Customary Charges and the amount Provider has agreed to accept as full reimbursement under this Agreement. Provider may collect Member Expenses from the Member. If Payor denies payment for services rendered by Provider on grounds that the services are not Medically Necessary, Provider shall not collect payment from the Member for the services unless the Member has knowledge of the determination of lack of Medical Necessity and has subsequently agreed in writing to be responsible for such charges and MHSA Services. Further, if any payment to Provider is denied, in part or full, due to Provider's failure to strictly comply with any term or condition in this Agreement, the Provider Manual, the Protocols, including without limitation, obtaining prior authorization, untimely filing of a claim, inaccurate or incorrect submission of or claim processing, or the insolvency of Payor pursuant to applicable law, it is agreed that Provider shall not, except for applicable Member Expenses, bill the Member or otherwise, directly or indirectly, seek or collect payment from the Member for any of the denied amounts. Any violation hereof by Provider shall be deemed a material breach. This provision shall apply regardless of whether any waiver or other document of any kind purporting to allow Provider to collect payment from the Member exists. These provisions shall survive the termination hereof and shall be construed to be for the benefit of the Member.

3.4 Coordination of Benefits. Provider shall be paid in accordance with Payor's coordination of benefits rules.

3.5 Financial Responsibility. In the event of a default (meaning a systematic failure by Payor to fund undisputed claim payments for Covered Services) by a Payor, except when due to the insolvency of Payor, Redacted shall notify Provider in writing of such default following Redacted determination thereof. Any services which have been rendered by Provider prior to or after such notification, and which have not been paid for by Payor, shall be considered ineligible for reimbursement under this Agreement, and Provider may seek payment directly from the Payor and Member for such services.

3.6 Member Protection Provision. This provision supersedes and replaces the Financial Responsibility section (section 3.5 above) only in those cases where Redacted, or its Affiliate, is the Payor, or when required by another specific Payor, or when required pursuant to applicable laws, statutes and regulations.

In no event, including, but not limited to, non-payment by Payor for MHSA Services rendered to Members by Provider, insolvency of Payor, or breach by Redacted of any term or condition of this Agreement, shall Provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against any Member or persons acting on behalf of the Member for MHSA Services eligible for reimbursement under this Agreement; provided, however, that Provider may collect from the Member, any Member Expenses or charges for services that are not covered as benefits under the Member's Benefit Plan.

The provisions of this Article shall apply to all Member protection provisions in this Agreement and shall: (a) apply to all MHSA Services rendered while this Agreement is in force; (b) survive the termination of this Agreement regardless of the cause of termination; (c) be construed to be for the benefit of the Members; and (d) except as otherwise stated in section 3.3, supersede any oral or written agreement, existing or subsequently entered into, between Provider and a Member or person acting on a Member's behalf, that requires the Member to pay for such MHSA Services.

3.7 Contracted Rate for Members. Provider agrees to continue to provide MHSA Services to Members who have exhausted his/her Covered Services under the Benefit Plan and agrees not to collect or charge more than the contracted rate for those MHSA Services. Provider may bill the Member directly for those MHSA Services for which there is no longer any coverage under the Benefit Plan, in accordance herewith.

ARTICLE 4
Laws, Regulations, and Licenses, and Liabilities of Parties

4.1 Laws, Regulations and Licenses. Provider shall maintain in good standing all federal, state and local licenses, certifications and permits -- without sanction, revocations, suspension, censure, probation or material restriction -- which are required to provide health care services according to the laws of the jurisdiction in which MHSA Services are provided, and shall comply with all applicable statutes and regulations.

Provider shall also require that all health care professionals employed by or under contract with Provider to render MHSA Services to Members, including covering Providers, comply with this provision.

4.2 Responsibility for Damages. Any and all damages, claims, liabilities or judgments, attorney fees, which may arise as a result of Provider's or its employee's or contractor's negligence or intentional wrongdoing shall be the sole responsibility of Provider.

4.3 Provider Liability Insurance. Provider shall procure and maintain, at Provider's sole expense, (a) medical malpractice or professional liability insurance in the amount of $1,000,000 per occurrence and $3,000,000 in aggregate if Provider is a Medical Doctor and $1,000,000 per occurrence and in aggregate if Provider is not a Medical Doctor; and (b) comprehensive general and/or umbrella liability insurance in the amount of $1,000,000 per occurrence and in aggregate. Provider shall also require that all health care professionals employed by or under contract with Provider to render MHSA Services to Members procure and maintain malpractice insurance, unless they are covered under Provider's insurance policies.

Provider's and other health care professionals' medical malpractice insurance shall be on either an "occurrence" or "claims made" basis provided that for a "claims made" policy, such policy must be written with an extended period reporting option under such terms and conditions as may be reasonably required by Redacted. Prior to the Effective Date of this Agreement and at each policy renewal thereafter, Provider shall submit to Redacted in writing evidence of insurance coverage.

ARTICLE 5
Notices

5.1 Notices. Provider shall notify Redacted within ten (10) days of knowledge of any of the following:

(a) changes in liability insurance carriers, termination of, renewal of or any other material changes in Provider's liability insurance, including reduction of limits, erosion of aggregate, changes in retention or non-payment of premium;

(b) action which may result in or the actual suspension, sanction, revocation, condition, limitation, qualification or other material restriction on Provider's licenses, certifications or permits by any government under which Provider is authorized to provide health care services; and, of any suspension, revocation, condition, limitation, qualification or other material restriction of Provider's staff privileges at any licensed hospital, nursing home or other facility at which Provider has staff privileges during the term of this Agreement;

(c) a change in Provider's name, address, ownership or Federal Tax I.D. number;

(d) indictment, arrest or conviction for a felony or for any criminal charge related to the practice of Provider's profession;

(e) claims or legal actions for professional negligence or bankruptcy;

(f) provider's termination, for cause, from any other provider network offered by any plan, including, without limitation, any health care service plan, health maintenance organization, any health insurer, any preferred provider organization, any employer or any trust fund;

(g) any occurrence or condition that might materially impair the ability of Provider to perform its duties under this Agreement; or

(h) any condition or circumstance that may pose a direct threat to the safety of Provider, Providers' staff, or Members.

Unless otherwise specified in this Agreement, each and every notice and communication to the other party shall be in writing. All written notices or communication shall be deemed to have been given when delivered in person; or, on the date mailed, if delivered by first-class mail, proper postage prepaid and properly addressed to the appropriate party at the address set forth at the signature portion of this Agreement or to another address of which sending party has been notified, including without limitation, to Redacted Network Manager at the applicable address for notice as identified in the Provider Manual or Protocols. The parties shall, by written notice, provide and update each other with the most current address and names of all parties or designees that should receive certain notices or communication.

ARTICLE 6
Records

6.1 Confidentiality of Records. Redacted and Provider shall maintain the confidentiality of all Member information and records in accordance with all applicable state and federal laws, statutes and regulations, including without limitation, the Health Insurance Portability and Accountability Act.

6.2 Maintenance of and Redacted Access to Records. Provider shall maintain adequate medical, treatment, financial and administrative records related to MHSA Services provided by Provider under this Agreement for a period and in a manner consistent with the standards of the community and in accordance with the Provider Manual, Protocols and all applicable state and federal laws, statutes and regulations.

In order to perform its utilization management and quality improvement activities, Redacted shall have access to such information and records, including claim records, within 14 days from the date the request is made, except that in the case of an audit by Redacted, such access shall be given at the time of the audit. If requested by Redacted, Provider shall provide copies of such records free of charge. During the term of this Agreement Redacted shall have access to and the right to audit information and records to the extent permitted by the Provider Manual, or as otherwise required by state or federal laws, statutes or regulations or regulatory authority. Said rights shall continue following the termination hereof for the longer of three years or for such period as may be permitted by applicable state or federal law, regulatory authority, or Protocols.

It is Provider's responsibility to obtain any Member's consent in order to provide Redacted with requested information and records or copies of records and to allow

release such information or records to Payors as necessary for the administration of the Benefit Plan or compliance with any state or federal laws, statutes and regulations applicable to the Payors.

Provider acknowledges that in receiving, storing, processing or otherwise dealing with information from Redacted or Payor about Members, it is fully bound by the provisions of the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2; and Provider agrees that it will resist in judicial proceedings any effort to obtain access to information pertaining to patients otherwise than as expressly provided for in the federal confidentiality regulations, 42 CFR Part 2.

This section shall not be construed to grant Redacted access to Provider's records that are created for purposes of assessing Provider's financial performance or for Provider's peer review activities, except to the extent the federal and/or state government and any of their authorized representatives have access to such records pursuant to Section 6.3.

6.3 Government and Accrediting Agency Access to Records. It is agreed that the federal, state and local government, or accrediting agencies including, but not limited to, the National Committee for Quality Assurance (the "NCQA"), and any of their authorized representatives, shall have access to, and Redacted and Provider are authorized to release, in accordance with applicable statutes and regulations, all information and records or copies of such, within the possession of Redacted or Provider, which are pertinent to and involve transactions related to this Agreement if such access is necessary to comply with accreditation standards, statutes or regulations applicable to Redacted, Payor or Provider. Such access shall be available and provided during the term of this Agreement and for three years following the termination hereof, or such longer period as may be identified in the Provider Manual or Protocols or as required by applicable state or federal laws, statutes or regulations.

ARTICLE 7
Resolution of Disputes

7.1 Resolution of Disputes. It is agreed that prior to any other remedy available to the parties, Redacted, Payor and/or Provider shall provide written notice of any disputes or claims arising out of their business relationship (the "Dispute") to the other party within thirty (30) days of the final decision date, action, omission or cause from which the Dispute arose, whichever is later (the "Dispute Date"). If the Dispute pertains to a matter which is generally administered by certain Redacted procedures, such as a credentialing or quality improvement plan, the procedures set forth in that plan must be fully exhausted by Provider before Provider may invoke his or her rights as described herein. After receipt of the written notice of the Dispute, the parties agree to work together in good faith to resolve the Dispute. If the parties are unable to resolve the Dispute within thirty (30) days following receipt of the notice of the Dispute, and if either Redacted, Provider or Payor desires to pursue formal resolution of the Dispute, then said party shall issue a notice of arbitration to the other parties. It is agreed that the parties

knowingly and voluntarily waive any right to a Dispute if arbitration is not initiated within one year after the Dispute Date.

Any arbitration proceeding under this Agreement shall be submitted to binding arbitration in accordance with the rules of the American Arbitration Association ("AAA"), and shall be conducted in a location agreed to by the parties or as selected by the AAA if the parties cannot agree on a location. The arbitrators may construe or interpret but shall not vary or ignore the terms of this Agreement, shall have no authority to award any punitive or exemplary damages, and shall be bound by controlling law. The parties acknowledge that because this Agreement affects interstate commerce the Federal Arbitration Act applies.

ARTICLE 8
Term and Termination

8.1 Term. This Agreement shall begin on the Effective Date and it shall remain in effect for one year, and shall automatically renew for successive 1-year terms until it is terminated in accordance with the provisions herein.

8.2 Termination. This Agreement may be terminated as follows:

(a) by mutual agreement of Redacted and Provider;
(b) by either party upon 90 days prior written notice to the other party;
(c) by either party, in the event of a material breach of this Agreement by the other party, upon 30 days prior written notice to the other party. The written notice shall specify the precise nature of the breach. In the event the breaching party cures the breach to the reasonable satisfaction of the non- breaching party, within 30 days after the non-breaching party's written notice, this Agreement shall not terminate;
(d) by Redacted immediately upon written notice to Provider, due to Provider's loss, suspension, restriction, probation, voluntary relinquishment, or any other adverse action taken against any of Provider's licenses or certification, or loss of insurance required under this Agreement;
(e) by Provider upon 60 days prior written notice to Redacted due to a unilateral amendment made to this Agreement pursuant to section 9.1;
(f) by Redacted in accordance with its credentialing plan;
(g) by Redacted immediately if Redacted determines, in its sole discretion, that the health, safety or welfare of Members may be jeopardized by the continuation of this Agreement; or
(h) by Redacted in accordance with the Provider Manual or Protocols.

During periods of notice of termination, Redacted reserves the right to transfer Members to another Participating Provider, and Provider agrees to cooperate and assist with such transfers.

If Provider is terminated through the Redacted credentialing or recredentialing process, this Agreement shall be deemed terminated as of the date Provider has been terminated pursuant to a final action resulting from that process.

8.3 Information to Members. Provider acknowledges and agrees that Redacted has the right to inform Members of Provider's termination and/or the notice of termination to Provider, and agrees to cooperate with Redacted in matters concerning the termination/transition, and agrees to hold Redacted harmless for exercising its rights hereunder. Provider also agrees to clearly inform Members of Provider's impending non-participation status upon the earlier of Member's next appointment or prior to the effective termination date.

8.4 Continuation of Services After Termination. At the option of Redacted, Provider shall continue to provide MHSA Services authorized by Redacted to Members who are receiving such services from Provider as of the effective date of termination of this Agreement, until Member can be satisfactorily transferred to another Participating Provider. Payor shall continue to pay Provider for such services at Provider's contracted rate.

ARTICLE 9
Miscellaneous

9.1 Amendment. Redacted may amend this Agreement by sending notice of the amendment to Provider at least 30 days prior to its effective date. The Provider's signature is not required. It is agreed that this Agreement shall be automatically amended to comply with any and all applicable state or federal laws, regulations, statutes or the requirements of applicable regulatory authorities as of the effective date thereof, and which shall be deemed to be incorporated herein by reference as of its effective date. Likewise, if a Payor that is a governmental entity requires that certain provisions of this Agreement be removed, replaced, amended or that additional provisions be incorporated, such provisions shall be deemed to be removed, replaced, amended or additional provisions incorporated into this Agreement as of the effective date of such Payor requirement for all MHSA Services provided which are subject to such Payor requirements without the signature of Provider being required.

9.2 Assignment. Redacted may assign all or any of its rights and responsibilities under this Agreement to any of its Affiliates. Provider may assign any of his or her rights and responsibilities under this Agreement to any person or entity only upon the prior written consent of Redacted, which consent shall not be unreasonably withheld.

9.3 Administrative Responsibilities. Redacted may delegate certain administrative responsibilities under this Agreement to another entity, including, but not limited to, its Affiliate or to Payor or its designee. In addition, certain Payor responsibilities may actually be performed by its designee.
Provider is solely that of independent contractors and nothing in this Agreement or

9.4 Relationship Between Redacted and Provider. The relationship between Redacted and

otherwise shall be construed or deemed to create any other relationship, including one of employment, agency, joint venture or partnership.

9.5 Name, Symbol and Service Mark. During the term of this Agreement, Provider, Redacted and Payor shall have the right to use each other's name solely to make public reference to Provider as a Participating Provider. Provider, Redacted and Payor shall not otherwise use each other's name, symbol or service mark or that of their Affiliates without the prior written approval from the appropriate party.

9.6 Confidentiality. Neither party shall disclose to third parties any confidential or proprietary business information which it receives from the other party, including, but not limited to, financial statements, business plans, Protocols and programs; except that (a) Provider may disclose information to a Member relating to the Member's treatment plan and the payment methodology, but not specific rates; (b) Redacted may disclose certain terms to Payors or designees that need the information to process claims or administer a Benefit Plan, and may file the form of this Agreement with any federal or state regulatory entity as may be required by applicable law; and (c) Redacted shall be permitted to disclose, in its sole discretion, any other data or information that may be requested by applicable state and federal law, state regulations or governing agencies that pertain to this Agreement or that may relate to the enforcement of any right granted or term or condition of this Agreement.

9.7 Communication. Redacted encourages Provider to discuss with Members treatment options and their associated risks and benefits, regardless of whether the treatment is covered under the Member's Benefit Plan. Nothing in this Agreement is intended to interfere with Provider's relationship with Members as patients of Provider, or with Redacted ability to administer its quality improvement, utilization management and credentialing programs.

9.8 Effects of New Statutes and Regulations and Changes of Conditions. The parties agree to re-negotiate this Agreement if either party would be materially adversely affected by continued performance as a result of a change in laws or regulations, a requirement that one party comply with an existing law or regulation contrary to the other party's prior reasonable understanding, or a change in Redacted arrangements with Payors. The party affected must promptly notify the other party of the change or required compliance and its desire to re-negotiate this Agreement. If a new agreement is not executed within 30 days of receipt of the re-negotiation notice, the party adversely affected shall have the right to terminate this Agreement upon 45 days prior written notice to the other party. Any such notice of termination must be given within 10 days following the expiration of the 30-day re- negotiation period.

9.9 Appendices. Additional and/or alternative provisions, if any, related to certain MHSA Services rendered by Provider to Members covered by certain Benefit Plans are set for in the Appendices.

9.10 Entire Agreement. On the Effective Date, this Agreement supersedes and replaces any existing Provider Agreements between the parties related to the provision

of MHSA Services, including any agreements between Provider and Affiliates of Redacted for MHSA Services. This Agreement, together with any and all documents referenced herein, attachments, addenda, appendices, as may be amended or modified from time to time, whether contemporaneous or subsequently made pursuant to Section 9.1, are hereby incorporated herein by reference, and constitutes the entire agreement between the parties in regard to its subject matter (herein collectively referred to as this "Agreement").

9.11 Strict Compliance. The waiver of strict compliance or performance of any of the terms or conditions of this Agreement, the Provider Manual or the Protocols or of any breach thereof shall not be held or deemed to be a waiver of any subsequent failure to comply strictly with or perform the same or any other term or condition thereof or any breach thereof.

9.12 Severability. Should any provision of this Agreement violate the law or be held invalid or unenforceable as written by a court of competent jurisdiction, then said provision along with the remainder of this Agreement shall nonetheless be enforceable to the extent allowable under applicable law by first modifying said provision to the extent permitted so as to comply with applicable law; otherwise said provision shall be deemed void to the extent of such prohibition without invalidating the remainder of this Agreement.

9.13 Rules of Construction. In the event of any conflict between the terms of this Agreement and the terms of any other agreement or any other controlling document or any applicable state or federal laws, statutes and regulations relating to the subject matter hereof, the terms, except as otherwise expressly stated herein, shall first be read together to the extent possible; otherwise the terms that afford the greater protections to first Redacted and second to the Benefit Plan shall prevail over the conflicting term, to the extent permitted by, in accordance with and subject to applicable law, statutes or regulations. The remainder of the Agreement shall otherwise remain without invalidating or deleting the remainder of the conflicting provision or the Agreement.

9.14 Governing Law. This Agreement shall be governed by and construed in accordance with applicable state and federal laws, statutes and regulations, including without limitation, ERISA.

9.15 Medicaid Members. If a Medicaid Appendix is attached to this Agreement Provider agrees to provide MHSA Services to Members enrolled in a Benefit Plan for Medicaid recipients and to comply with any additional requirements set forth in the Medicaid Appendix.

9.16 Medicare Members. If a Medicare Appendix is attached to this Agreement, Provider agrees to provide MHSA Services under this Agreement, to Members who are enrolled in a Benefit Plan for Medicare beneficiaries and to cooperate and comply with the provisions set forth in the attached Medicare Advantage Addendum. Provider also understands that Redacted agreements with Participating Providers are subject to review and approval by the Centers for Medicare and Medicaid Services (“CMS”).

9.17 Survival. Upon any termination or expiration of this Agreement, the provisions herein which contemplates performance or observance subsequent to termination or expiration, including without limitation, sections 3.1, 3.2, 3.3, 3.6, 8.3, 8.4, 9.6 and Articles 6 and 7, shall survive and remain of full force and effect between the parties.

THIS AGREEMENT CONTAINS A BINDING ARBITRATION PROVISION THAT MAY BE ENFORCED BY THE PARTIES.

NAME OF PROVIDER

_____

_____

Attn: _____

Signature_____

Print Name_____

Title_____

Date_____

Federal Tax ID Number: _____

Medicare Number:_____

Medicaid Number:_____

NPI Number: _____

Behavioral Health
MississippiCHIP Regulatory Requirements Appendix

MississippiCHIP Regulatory
Requirements Appendix
Downstream Provider

THIS MISSISSIPPICHIP PROGRAM REGULATORY REQUIREMENTS APPENDIX (this "Appendix") supplements and is made part of the provider agreement (the "Agreement") between Redacted ("Subcontractor") and the party named in the Agreement ("Provider").

SECTION 1
APPLICABILITY

This Appendix applies with respect to the provision of direct or health care related services that Provider directly provides to Members through CCO's (as defined herein) products or benefit plans under the Mississippi Children's Health Insurance Program (the "MississippiCHIP Program") as governed by the State's designated regulatory agencies. Provider has agreed to provide Covered Services to Members who receive their coverage pursuant to a contract between the State and CCO (the "MississippiChip Program Contract" as defined herein). The MississippiChip Program Contract and applicable State and federal law require that the provisions contained in this Appendix be part of the Agreement. In the event of a conflict between this Appendix and other appendices or any provision of the Agreement, the provisions of this Appendix shall control except with regard to benefit plans outside the scope of this Appendix or unless otherwise required by law. In the event Subcontractor is required to amend or supplement this Appendix as required or requested by the State to comply with federal or State regulations, Subcontractor will unilaterally initiate such additions, deletions or modifications. All provider agreements must be in writing and must include all specific activities and report responsibilities delegated to the Provider by Subcontractor.

SECTION 2
DEFINITIONS

Unless otherwise defined in this Appendix, all capitalized terms shall be as defined in the Agreement. For purposes of this Appendix, the following terms shall have the meanings set forth below; provided, however, in the event any definition set forth in this Appendix or the Agreement is inconsistent with any definition under the MississippiCHIP Program Contract, the definition shall have the meaning set forth under the MississippiCHIP Program Contract.

2.1 Abuse: Any Practice that is inconsistent with sound fiscal, business, or medical practices, and results in an unnecessary cost to CHIP, Contractor, a Provider or in reimbursement for services that are not Medically Necessary or that fail to meet professionally recognized standards for healthcare.

2.2 Action: Subcontractor's or CCO's decision to deny or limit authorization or payment (in whole or in part) for health care services, including new authorizations and previously authorized services; the reduction, suspension, or termination of a previously authorized service; or CCO's or Subcontractor's failure to provide services in a timely manner; failure to resolve Complaints, Grievances, or Appeals within the specified time frames.

2.3 Agreement: An agreement between the Subcontractor or CCO and an individual, business, university, government entity, affiliate, or nonprofit organization to perform part or all of Subcontractor's or CCO's responsibilities under the MississippiCHIP Program Contract. Agreements must be approved in writing by DOM prior to the start date of the Agreement.

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

2.5 Auto Enrollment: The process by which Members who have not voluntarily selected a CHIP Contractor are assigned to a CHIP Contractor.

2.6 Behavioral Health Services: Mental health and/or drug and alcohol abuse treatment services that are provided by the county mental health/Intellectually Delayed/Developmentally Delayed programs, the single county authority administrators, or other appropriately licensed health care practitioners.

2.7 Benchmark Plan: The State School Employee's Health Insurance Plan.

2.8 Child: An individual who is under nineteen (19) years of age who is not eligible for Medicaid benefits and is not covered by other health insurance. Child is also referred to as Member.

2.9 CHIP: The Children's Health Insurance Program as defined in Title XXI of the Social Security Act.

2.10 Complaint: An expression of dissatisfaction received orally or in writing that is of a less serious or formal nature that is resolved within one (1) business day of receipt.

2.11 Coordinated Care Organization (CCO): An organization that meets the requirements for participation as a Contractor in CHIP and manages the purchase and provision of health care services under CHIP. For purposes of this Appendix, CCO refers to Redacted of Mississippi, Inc.

2.12 Co-Payment: The fixed amount certain CHIP Members pay for a covered health care service. The amount may vary based on healthcare service being provided.

2.13 Cost Sharing: In accordance with 42 C.F.R. §457.10, premium charges, enrollment fees, deductibles, coinsurance, Co-Payments, or other similar fees that the Member has responsibility for paying.

2.14 Covered Services: Health care services or products for which a Member is enrolled with CCO to receive coverage under the MississippiCHIP Program Contract.

2.15 Disenrollment: Action taken by DOM, or its Agent, to remove a Member's name from the monthly Member Listing Report following DOM's receipt and approval of a request for Disenrollment or a determination that the Member is no longer eligible for Enrollment in Contractor. **DOM:** The Division of Medicaid, Office of the Governor, State of Mississippi.

2.16 Fraud: Fraud is any type of intentional deception or misrepresentation made by an entity or person with the knowledge that the deception could result in some unauthorized benefit to the entity, him or herself, or some other person. The Fraud can be committed by many entities, including a vendor, a subcontractor, a provider, a State employee, or a Member among others.

2.17 Grievance: An expression of dissatisfaction about any matter or aspect of Subcontractor or CCO or its operation, other than an Action as defined herein.

2.18 Marketing: The activities that promote visibility and awareness for the MississippiCHIP Program and Subcontractor's or CCO's participation in the program. All activities are subject to prior review and approval by DOM.

2.19 Medical Record: A single complete record, which documents the entire treatment plan developed for, and medical services received by, the Member including inpatient, outpatient, referral services and emergency medical services whether provided by Contracted Providers or Non-Contracted Providers.

2.20 Member: An individual who meets all of the eligibility requirements for CHIP, enrolls in a CCO under CHIP, and receives health benefits coverage through CHIP.

2.21 MississippiCHIP Program: The Mississippi Medicaid child health program for select individuals under the age of nineteen (19) years of age who are not eligible for Medicaid benefits and are not covered by other health insurances.

2.22 MississippiCHIP Program Contract: The DOM contract with CCO, for the purpose of providing and paying for Covered Services to Members enrolled in the MississippiCHIP Program.

2.23 Primary Care Provider (PCP): Any physician or health care practitioner or group operating within the scope of his or her licensure who is responsible for supervising, prescribing and providing primary care and primary case management services in the MississippiCHIP Program, whose practice is limited to the general practice of medicine or who is an Internist, Pediatrician, Obstetrician, Gynecologist, Family Practitioner, General Practitioner, Certified Nurse Practitioners whose specialty is pediatrics, adult, family, certified nurse midwife, obstetrics/gynecology, or a physician assistant.

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

2.25 Provider Network: The Panel of health service Providers with which the Subcontractor or CCO contracts for the provision of covered services to Members and Non-Contracted Providers administering services to Member.

2.26 State: The State of Mississippi or its designated regulatory agencies.

2.27 State Child Health Plan: The State of Mississippi's plan submitted to HHS for the administration of CHIP.

2.28 Third Party Liability/Resource: Any resource available to a Member for the payment of medical expenses associated with the provision of covered services, including but not limited to, insurers and workers' compensation plan.

2.29 Well-Baby and Well-Child Care Services: Regular or preventive diagnostic and treatment services necessary to ensure the health of babies, children, and adolescents as defined by DOM in the State Child Health Plan. For the purposes of Cost Sharing, the term has the meaning assigned at 42 C.F.R. § 457.520.

SECTION 3
PROVIDER REQUIREMENTS

The MississippiCHIP Program, through contractual requirements and federal and State statutes and regulations, requires that providers who provide services to Members enrolled in the MississippiCHIP Program comply with certain requirements as set forth below and elsewhere in this Appendix.

3.1 Definitions Related to the Provision of Covered Services. Provider shall follow the applicable MississippiCHIP Program Contract's requirements for the provision of Covered Services. Provider's decisions affecting the delivery of acute or chronic care services to Members shall be made on an individualized basis and in accordance with the following definitions:

(a) Emergency Medical Condition: In accordance with Section 1932(b) of the Act and 42 CFR §457.10, a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in any of the following: (1) 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; (2) serious impairment to body functions; or (3) serious dysfunction of any body organ or part.

(b) Emergency Services: Healthcare services that are (1) furnished by a provider who is qualified to furnish those health services and (2) needed to evaluate or stabilize an Emergency Medical Condition.

(c) Medically Necessary Services: As set forth in the Social Security Act, Section 1905 (42 U.S.C. 1396d(a)), Medically Necessary Services are defined as services, supplies, or equipment provided by a licensed health care professional that are:

1. Appropriate and consistent with the diagnosis or treatment of the patient's condition, illness, or injury;

2. In accordance with the standards of good medical practice consistent with the individual patient's condition(s);
3. Not primarily for the personal comfort or convenience of the Member, family, or Provider;
4. The most appropriate services, supplies, equipment, or levels of care that can be safely and efficiently provided to the Member;
5. Furnished in a setting appropriate to the patient's medical need and condition and, when applied to the care of an inpatient, further mean that the Member's medical symptoms or conditions require that the services cannot be safely provided to the Member as an outpatient;
6. Not experimental or investigational or for research or education;
7. Provided by an appropriatelylicensed practitioner; and
8. Documented in the patient's record in a reasonable manner, including the relationship of the diagnosis to the service.

Medically Necessary Services may also be those services for children that are necessary to correct or ameliorate defects and physical and mental illnesses and conditions discovered during an interperiodic or Well-Baby and Well-Child Care Services, whether such services are covered or exceed the benefit limits in the Medicaid State Plan and Title 23 of Mississippi Administrative Code.

3.2 Accessibility Standards. Provider shall provide for timely access for Member appointments in accordance with the appointment availability requirements established under the MississippiCHIP Program Contract, as further described in the applicable provider manual.

Type	Appointment Scheduling Time Frames
PCP (well care visit)	Not to exceed thirty (30) calendar days
PCP (routine sick visit)	Not to exceed seven (7) calendar days
PCP (urgent care visit)	Not to exceed twenty-four (24) hours
Specialists	Not to exceed forty-five (45) calendar days
Dental Providers (routine visits)	Not to exceed forty-five (45) calendar days
Dental Providers (urgent Care)	Not to exceed forty-eight (48) hours
Behavioral Health Providers (routine visit)	Not to exceed fourteen (14) calendar days
Behavioral Health Providers (urgent visit)	Not to exceed twenty-four (24) hours
Behavioral Health Providers (post-discharge from an acute psychiatric hospital when the Contractor is aware of the Member's discharge)	Not to exceed seven (7) calendar days

Urgent Care Providers	Not to exceed twenty-four (24) hours
Emergency Providers	Immediately (twenty-four (24) hours a day, seven (7) days a week) and without Prior Authorization

3.3 Hours of Operation; Appointments. Provider shall offer hours of operation that are no less than the hours of operation offered to commercial beneficiaries.

3.4 PCP Responsibilities. If applicable, and Provider is a PCP, Provider shall comply with the following:

3.4.1 PCPs who serve Members under the age of nineteen (19) are responsible for conducting all Well-Baby and Well-Child Care services. Should the PCP be unable to conduct the necessary Well-Baby and Well-Child Care services screens, the PCP is responsible for arranging to have the necessary Well-Baby and Well-Child Care services screens conducted by another network provider and ensure that all relevant medical information, including the results of the Well-Baby and Well-Child Care services screens, are incorporated into the Member's PCP Medical Record.

3.4.2 PCPs who serve Members under the age of nineteen (19) report encounter data associated with Well-Baby and Well-Child Care services, using a format approved by DOM, to Contractor within one hundred and eighty (180) calendar days from the date of service.

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

3.4.3.1 Contact Members identified in the quarterly Encounter lists as not complying with Well-Baby, Well-Child Care, and immunization schedules for Children;

3.4.3.2 Identify to Contractor any such Members who have not come into compliance with Well-Baby, Well-Child Care, and immunization schedules within one (1) month of such notification to the site by Contractor; and

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

3.4.4 PCP shall provide the full range of Well-Baby, Well-Child Care, well-adolescent care and childhood and adolescent immunization services recommended by the Advisory Committee on Immunization Practices (ACIP) for all Members under the age of nineteen (19) as defined in, and in accordance with, the State Child Health Plan, 42 C.F.R. §457.495 and the provisions of Mississippi CHIP Contract, including periodic examinations for vision, dental, and hearing and all Medically Necessary services. The following minimum elements must be included in the periodic health screening assessment of children:

a. Comprehensive health and development history (including assessment of both physical and mental development);

b. Measurements (including head circumference for infants);

c. Comprehensive unclothed physical examination;

d. Immunizations appropriate to age and health history;

e. Assessment of nutritional status;

f. Laboratory tests (including tuberculosis screening and Federally required blood lead screenings);

g. Vision Screening;

h. Hearing Screening;

i. Dental and Oral Health Assessment;

j. Development Assessment; and,

k. Health education and anticipatory guidance.

If a suspected problem is detected by a screening examination, the child must be evaluated as necessary for further diagnosis. This diagnosis is used to determine treatment needs.

3.4.5 Specialists as PCPs. Members with disabling conditions, chronic conditions, or with special health care needs may request that their PCP be a specialist. The designation of a specialist as a PCP must be pursuant to a treatment plan approved by Contractor; in consultation with the PCP to which the Member is currently assigned, the Member and, as appropriate, the specialist. When possible, the specialist must be a provider participating in Contractor's network. The specialist as a PCP must agree to provide or arrange for all primary care, including routine preventive care, and to provide those specialty medical services consistent with the Member's disabling condition, chronic illness, or special health care need in accordance with Contractor's standards and within the scope of the specialty training and clinical expertise. To accommodate the full spectrum of care, the specialist as a PCP must also have admitting privileges at a hospital in Contractor's network.

3.5 Provider Selection. To the extent applicable to Provider in performance under the Agreement, Provider shall comply with 42 CFR §438.214, as may be amended from time to time, which includes, but is not limited to the selection and retention of providers, credentialing and re-credentialing requirements and nondiscrimination. If Subcontractor or CCO delegates credentialing to Provider, Subcontractor or CCO will provide monitoring and oversight and Provider shall ensure that all licensed medical professionals are credentialed in accordance with Subcontractor's or CCO's and the MississippiCHIP Program Contract's credentialing requirements.

3.6 Records Retention. As required under State or federal law or the MississippiCHIP Program Contract, Provider shall maintain a record keeping system of current, detailed, and organized records for recording services, charges, dates and all other commonly accepted information elements sufficient to disclose the quality, quantity, appropriateness and timeliness of services rendered to Members. All financial records shall follow generally accepted accounting principles. Medical records and supporting management systems shall include all pertinent information related to the medical management of eachMember. Other records shall be maintained as necessary to clearly reflect all actions taken by Provider related to services provided under the MississippiCHIP Program Contract. Such records shall be maintained for a period of not less than five (5) years from the close of the Agreement, or such other period as required by law. If records are under review or audit or are the subject of litigation they must be retained for a minimum of five (5) years following resolution of such action. Prior approval for the disposal of records must be requested and approved by Subcontractor or CCO if the Agreement is continuous. Provider shall have written records retention policies and procedures and will make such policies and procedures available to Subcontractor, CCO or DOM upon request. DOM requires ready access to any and all documents and records of transactions pertaining to the provisions of services provided by Provider and those copies of requested documents/records will be provided to DOM or its designee free of charge.

3.7 Records Access. Provider acknowledges and agrees and shall require Provider to acknowledge and agree that DOM, the U.S. Department of Health and Human Services and other authorized federal and state personnel shall have complete access to all records pertaining to services provided to Members. Provider shall provide immediate access to facilities, records and supportive materials pertinent to the MississippiCHIP Program Contract for State or Federal fraud investigators.

3.8 Government Audit; Investigations. Provider acknowledges and agrees and shall require Provider to acknowledge and agree that the State or any of its duly authorized representatives, DOM, the U.S. Department of Health and Human Services, the Centers for Medicare & Medicaid Services, the Office of Inspector General, the General Accounting Office, or any other auditing agency or their authorized representatives, with prior approval by DOM, at any time during the term of the Agreement, shall, at all reasonable time and within regular business hours, with or without notice, have the right to inspect or otherwise evaluate the quality, appropriateness, and timeliness of services provided under the terms of the MississippiCHIP Program Contract and any other applicable federal and State law and regulation..

This shall include, but not be limited to, the right to enter onto Provider's premises, access to and the right to audit, inspect, monitor, and examine any pertinent books, documents, papers, medical records, financial records, surveys and computer databases and/or to otherwise evaluate the performance of Provider related to Provider's performance under the Agreement. Such monitoring activities may also include, without limitation, on-site inspections of all service locations and facilities; auditing and/or review of all records developed under the MississippiCHIP Program Contract or the Agreement; reviewing management systems and procedures developed under the MississippiCHIP Program Contract or the Agreement; and review of any other areas of materials relevant or pertaining to the MississippiCHIP Program Contract or the Agreement. All reviews and audits shall be performed in such a manner as will not unduly delay the work of Provider. There will be no restrictions on the right of the State or federal authorities to conduct inspections and audits as necessary.

The Provider must fully cooperate with any and all reviews and/or audits by state or federal agencies, such as the Department of Audit, Department of Health and Human Services, Centers for Medicare and Medicaid Services, Office of Inspector General, General Accounting Office, or any other auditing agency approved by DOM, by assuring that appropriate employees and involved parties are available for interviews relating to the reviews or audits.

All records shall be maintained and available for review by authorized federal and state agencies during the entire term of the MississippiCHIP Program Contract and for a period of five (5) years thereafter, unless an audit, litigation, or other legal action is in progress. When an audit or litigation is in progress or audit findings are unresolved, records shall be kept for a period of five (5) years or until all issues are finally resolved, whichever is later. The Provider must have written policies and procedures for storing this information. Records must be kept in an original paper state or preserved on micro media or electronic format.

3.9 Data; Reports. Provider shall and shall require that Provider cooperate with and release to Subcontractor or CCO any information necessary for Subcontractor or CCO to perform its obligations under the MississippiCHIP Program Contract to the extent applicable to Provider in performance of the Agreement, including the timely submission of reports and information required by Subcontractor or CCO. Such reports shall include well-baby/well-child reporting, as well as complete and accurate encounter and utilization management data in accordance with the requirements of Subcontractor, CCO and DOM.

3.10 Encounter Data. Provider shall agree to cooperate with Subcontractor or CCO to comply with Subcontractor's or CCO's obligation to prepare encounter data submissions, reports, and clinical information including, without limitation, and well-baby/well-child reporting and encounters, as applicable, and such other reporting regarding Covered Services as may be required under the MississippiCHIP Program Contract.

3.11 Claims Information. Provider shall promptly submit to Subcontractor or CCO the information needed to make payment and shall identify third party liability coverage, including Medicare and other insurance, and if applicable seek such third party liability payment before submitting claims to Subcontractor or CCO. Provider understands and agrees that each claim Provider submits to Subcontractor or CCO constitutes a certification that the claim is true and accurate to the best of Provider's knowledge and belief and that the Covered Services are 1) Medically Necessary and 2) have been provided to the Member prior to submitting the claim.

Provider must submit claims within six (6) months from the date of service. Claims filed within the appropriate time frame but denied may be resubmitted to Subcontractor or CCO within ninety (90) calendar days from the date of denial.

3.12 Third Party Resources. Provider shall report all Third Party Resources to Subcontractor or CCO identified through the provision of medical services.

3.13 Privacy; HIPAA. Provider shall comply with all applicable privacy rule and security rule provisions of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), and associated implementing regulations, as may be amended from time to time, and shall safeguard information about

Members in accordance with applicable federal and State privacy laws and rules including 42 CFR §438.224 and 42 CFR Part 431, Subpart F, as may be amended from time to time. Provider agrees that confidential information, including but not limited to, medical and other pertinent information relative to Members, shall not be disclosed to any person or organization for any purpose without the expressed, written authority of DOM or as otherwise required by law and that all such disclosures shall fully comply with HIPAA privacy and security standards.

3.14 Cultural Competency. Provider shall participate in Subcontractor's, CCO's and DOM's efforts to promote the delivery of services in a culturally competent manner to all Members, including those with limited English proficiency and diverse cultural and ethnic backgrounds and shall provide interpreter services in a Member's primary language and for the hearing impaired for all appointments and emergency services. Provider shall provide information to Members regarding treatment options and alternatives, as well as information on complaints and appeals, in a manner appropriate to the Member's condition and ability to understand.

3.15 Approval of Marketing Materials. As required under State or federal law or the applicable MississippiCHIP Program Contract, any marketing materials developed and distributed by Provider as related to the performance of the Agreement must be submitted to CCO for submission to DOM for prior approval.

3.16 Independent Contractor Relationship. Provider expressly agrees that Provider is acting in an independent capacity in the performance of the Agreement and not as an officer, agent or employee of DOM, CMS or the State. Provider further expressly agrees that the Agreement shall not be construed as a partnership or joint venture between Provider and DOM, CMS or the State. Nothing in the Agreement shall be construed, nor shall it be deemed to create, any right or remedy in any third party.

3.17 Certification on Relationship to State, DOM and CMS. Provider certifies that no officer, director, employee, subcontractor or agent of Provider, or person with an ownership or control interest in Provider, is also employed by, or is a public official of, the State of Mississippi or any of its agencies, DOM or CMS.

3.18 Ownership and Control Information. If applicable, Provider shall cooperate with Subcontractor and/or CCO in obtaining and providing information to DOM related to ownership and control, significant business transactions, and persons convicted of a criminal offense in compliance with§1128 of the Social Security Act, 42 USC §1320a-7 and 42 CFR Part 455, as amended and shall provide information upon request. Provider shall submit information related to ownership and control of subcontractors or wholly owned supplier within thirty-five (35) calendar days of a request for such information.

By executing the Agreement, Provider certifies that neither Provider nor any of its principals is presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in any State or federal health care program or from participating in transactions by any State or federal department or agency. Subcontractor will terminate the Agreement upon becoming aware or receiving notice from DOM, whichever is earlier, that Provider is or has been excluded from participation in any State or federal health care program or by any State or federal agency.

3.19 Excluded Individuals and Entities. Provider certifies that neither it nor any of its employees, principals, nor any providers, subcontractors or consultants or persons with an ownership or controlling interest in the Provider (an owner including the Provider himself or herself), or an agent or managing employee of the Provider, with whom Provider contracts and who are providing items or services that are significant and material to Provider's obligations under the Agreement is:

(a) excluded from participation in federal health care programs under either Section 1128 or section 1128A of the Social Security Act; or

(b) debarred, suspended, proposed for debarment, declared ineligible, or otherwise voluntarily excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549; or an affiliate, as defined in the Federal Acquisition Regulation, of such a person.

Provider acknowledges and agrees and shall require that Provider acknowledge and agree that payment will not be made for any items or Covered Services provided by an excluded individual pursuant to 42 CFR §1001.1901(b) and is obligated to screen all employees, contractors, and subcontractors for exclusion as required under applicable State and Federal laws. Additionally, Provider acknowledges that pursuant to 42 CFR §1003.102(a)(2) civil monetary penalties may be imposed against Provider if he or she employs or enters into contracts with excluded individuals or entities to provide items or Covered Services to Member under the Agreement. Provider agrees not to employ or subcontract with individuals or entities whose owner, those with a controlling interest, or managing employees are on a State or Federal exclusion list to provide items or Covered Services under the Agreement. Provider shall immediately report to Subcontractor and/or CCO any exclusion information discovered. Provider can search the HHS-OIG website, at no cost, by the names of any individuals or entities. The database is called LEIE and can be accessed at http://www.oig.hhs.gov/fraud/exclusions.asp. The GSA EPLS/SAM database can be accessed at https://www.sam.gov. Applicable state exclusion databases can be accessed through the State's Medicaid website. Subcontractor will terminate the Agreement immediately upon becoming aware or receiving notice from DOM, whichever is earlier, that Provider's owners, agents, managing employees, or any provider is or has been excluded from federal health care programs or terminated from the Medicare or the Medicaid program in any state.

3.20 Licensure. Provider represents that it is currently licensed and/or certified under applicable State and federal statutes and regulations and by the appropriate State licensing body or standard-setting agency, as applicable. Provider represents that it does not have a Medicaid provider agreement with DOM that is terminated, suspended, denied, or not renewed as a result of any action of DOM, CMS, HHS, or the Medicaid Fraud Control Unit of the State's Attorney General. Provider shall maintain at all times throughout the term of the Agreement all necessary licenses, certifications, registrations and permits as are required to provide the health care services and/or other related activities delegated to Provider by Subcontractor and/or CCO under the Agreement. If at any time during the term of the Agreement, Provider is not properly licensed as described in this Section, Provider shall discontinue providing services to Members.

3.21 National Provider ID (NPI). If applicable, Provider shall and shall require that Providers obtain a National Provider Identification Number (NPI) and when filing claims with Provider, the NPI

number used is the same NPI number used when filing claims with DOM.

3.22 Funding. Provider recognizes that the obligation of DOM to proceed under its MississippiCHIP Program Contract with Subcontractor and/or CCO is conditioned upon the appropriation of funds by the Mississippi State Legislature and the receipt of State and/or Federal funds. If the funds anticipated for the continuing fulfillment of the agreement are, at any time, not forthcoming or insufficient, either through the failure of the Federal government to provide or the State of Mississippi to appropriate funds, or the discontinuance, or material alteration of the program under which the funds were provided or if funds are not otherwise available to DOM, DOM has the right upon ten (10) working days written notice to Subcontractor and/or CCO to terminate the MississippiCHIP Program Contract.

3.23 Federal and State Funds Liability. Providers acknowledges and agrees that payments made to Provider for services provided under the Agreement are derived from federal and State funds and that any false claim or statement in documents or any concealment of material fact related to such services may be a cause for sanctions and prosecution under applicable federal and State laws. Provider shall be subject to all laws applicable to individuals and entities receiving State and federal funds and may be held civilly or criminally liable to Subcontractor, CCO and DOM in the event of nonperformance, misrepresentation, fraud, or abuse related to services provided pursuant to the MississippiCHIP Program Contract. Provider recognizes that payments made to the Provider are derived from federal and State funds, and are contingent upon and subject to availability and receipt of funds.

3.24 Insolvency. In the event Subcontractor and/or CCO becomes insolvent or unable to pay Provider, Provider shall not seek compensation for services rendered from DOM, its officers, Agents, or employees, or the Members or their eligible dependents.

3.25 Termination. In the event of termination of the Agreement, Provider shall promptly supply to Subcontractor or CCO all information necessary for the reimbursement of any outstanding MississippiCHIP Program claims.

3.26 Capitated Providers. If a Provider that is capitated terminates its agreement with Subcontractor or CCO, for any reason, Provider will provide services to Members assigned to Provider up to the end of the month in which the effective date of termination falls.

3.27 Fraud, Waste, and Abuse Prevention. Provider shall cooperate fully with the Subcontractor's and/or CCO's policies and procedures designed to protect program integrity and prevent and detect potential or suspected fraud, waste, and abuse in the administration and delivery of services under the MississippiCHIP Program Contract and shall cooperate and assist DOM and any other State or federal agency charged with the duty of preventing, identifying, investigating, sanctioning or prosecuting suspected fraud, waste, and abuse in state and/or federal health care programs. Provider, Subcontractor and CCO are responsible for reporting suspected fraud and abuse by participating and non-participating providers, as well as Members, when detected.

In accordance with Subcontractor's and/or CCO's policies and the Deficit Reduction Act of 2005 (DRA), Provider shall have written policies for its employees, contractors or agents that: (a) provide detailed information about the federal False Claims Act (established under sections 3729 through 3733 of title 31, United States Code); (b) cite administrative remedies for false claims and statements

(established under chapter 38 of title 31, United States Code) and whistleblower protections under federal and state laws; (c) reference state laws pertaining to civil or criminal penalties for false claims and statements; and (d) with respect to the role of such laws in preventing and detecting fraud, waste, and abuse in federal health care programs (as defined in section 1128B(f)), include as part of such written policies, detailed provisions regarding Provider's policies and procedures for detecting and preventing fraud, waste, and abuse. Provider agrees to train its staff on the aforesaid policies and procedures.

3.28 Quality Utilization Management. Pursuant to any applicable provider manuals and related protocols, or as elsewhere specified under the Agreement, Provider agrees to cooperate with Subcontractor's and CCO's quality improvement and utilization review and management activities. This shall include, but not be limited to, participation in any internal and external quality assurance, utilization review, peer review, and grievance procedures established by Subcontractor and CCO or as required under the MississippiCHIP Program Contract to ensure that Members have due process for their complaints, grievances, appeals, fair hearings or requests for external review of adverse decisions made by Subcontractor, CCO or Provider. Provider shall adhere to the quality assurance and utilization review standards of the MississippiCHIP Program and shall monitor quality and initiate corrective action to improve quality consistent with the generally accepted level of care.

3.29 Quality and Utilization Management Program. Provider shall cooperate with Subcontractor and CCO in meeting the Quality Management and Utilization Management Program standards outlined in the MississippiCHIP Program Contract.

3.30 Referrals. Provider shall make referrals for social, vocational, education or human services when a need for such service is identified.

3.31 Restrictions on Referrals. Provider shall not make inappropriate referrals for designated health services to health care entities with which Provider or a member of Provider's family has a financial relationship, pursuant to federal anti-kickback and physician self-referral laws that prohibit such referrals.

3.32 Complaints, Grievances and Appeals. Information on how Provider or Provider's authorized representative shall submit complaints and file grievances and appeals, and the resolution process, is contained in the Subcontractor or CCO MississippiCHIP Provider Manual.

3.33 Health Care Acquired/Preventable Conditions. Provider agrees that no payment shall be made for the provision of medical assistance for health care acquired conditions and other provider preventable conditions as may be identified by the State. As a condition of payment, Provider shall identify and report to Subcontractor and/or CCO any provider preventable conditions in accordance with 42 CFR Part 438, including but not limited to, 42 CFR § 438.6(f)(2)(i).

3.34 Compliance with Laws. Provider shall comply with all applicable federal and State laws and regulations and all provisions of the MississippiCHIP Program Contract that pertain to a Member's rights, including but not limited to the following, to the extent applicable to Provider in performance of the Agreement:

(a) Title VI of the Civil Rights Act of 1964; (b) Title XIX of the Social Security Act;

(c) Title IX of the Education Amendments of1972 (regarding education programs and activities); the Age Discrimination Act of 1975; the Rehabilitation Act of 1973; and The Genetic Information Non-Discrimination Act of 2008 (GINA), and their implementing regulations, as may be amended from time to time.

(d) 42 CFR Part 434 and 42 CFR § 438.6, as may be amended from time to time.

(e) All federal and State professional and facility licensing and accreditation requirements/standards that apply to the services Provider perform pursuant to the Agreement, including but not limited to:

(i) All applicable standards, orders or requirements issued under Section 306 of the Clean Air Act (42 USC 1857 (h)). Section 508 of the Clean Water Act (33 USC 1368), Executive Order 11738, and Environmental Protection Agency (EPA) regulations (40) CFR Part 15), which prohibit the use of facilities included on the EPA list of violating facilities. Any violations must be reported to DSHS, DHHS, and the EPA;

(ii) Any applicable mandatory standards and policies relating to energy efficiency that are contained in the State Energy Conservation Plan, including the Energy Policy & conservation Act (Pub. L. 94-165), and issued in compliance with the Federal Energy Policy & Conservation Act.

(f) All relevant federal and State statutes, regulations and orders related to equal opportunity in employment, including but not limited to compliance with E.O. 11246, "Equal Employment Opportunity," as amended by E.O. 11375, "Amending Executive Order 11246 Relating to Equal Employment Opportunity," and as supplemented by regulations at 41 CFR Part 60, "Office of Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor."

(g) If the Agreement is for an amount in excess of $100,000, Provider shall comply with all applicable standards, orders or regulations issued pursuant to the Clean Air Act, 42 U.S.C. 7401 et seq., and the Federal Water Pollution Control Act, as amended, 33 U.S.C. 1251 et seq. Any violations shall be reported to DHHS and the appropriate Regional Office of the Environmental Protection Agency.

(h) Those specified for laboratory services in the Clinical Laboratory Improvement Amendments (CLIA). All laboratory service sites must have a CLIA certificate of registration or waiver, and a CLIA identification number.

(i) The American with Disabilities Act (ADA). Provider shall make reasonable accommodation for Members with disabilities in accord with the ADA for all Covered Services and shall assure physical and communication barriers do not inhibit Members with disabilities from obtaining Covered Services;

(j) Section 1128B(d)(1) of the Balanced Budget Act of 1997; and,

(k) Any other requirements associated with the receipt of federal funds.

3.35 Non-Discrimination. Members must be provided Covered Services without regard to race, color, creed, sex, religion, age, national origin, ancestry, marital status, sexual orientation, language, health status, disease or pre-existing condition (including genetic information), anticipated need for health care or physical or mental handicap, except where medically indicated. Examples of prohibited practices include, but are not limited to, the following:

(a) Denying or not providing a Member any MississippiCHIP Covered Service. Health care and treatment necessary to preserve life must be provided to all Members who are not terminally ill or permanently unconscious, except where a competent Member objects to such care on his/her own behalf.

(b) Subjecting a Member to segregated, separate, or different treatment, including a different place or time from that provided to other Members or public or private patients, in any manner related to the receipt of any MississippiCHIP Covered Service, except where Medically Necessary.

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

3.36 Advance Directives. Provider shall comply with the advance directives requirements with 42 C.F.R §422.128 and with the Uniform Health-Care Decisions Act (Miss. Code Ann. § 41-41-201, *et. seq*.).

3.37 Physician Incentive Plans. In the event Provider participates in a physician incentive plan ("PIP") under the Agreement, Provider agrees that such PIPs must comply with 42 CFR § 417.479, 42 CFR § 438.6(h), 42 CFR § 422.208, and 42 CFR § 422.210, as may be amended from time to time. Subcontractor, CCO and Provider may not make a specific payment directly or indirectly under a PIP to a physician or physician group as an inducement to reduce or limit Medically Necessary services furnished to an individual Member. PIPs must not contain provisions that provide incentives, monetary or otherwise, for the withholding of services that meet the definition of Medical Necessity. Provider shall disclose annually to Subcontractor and/or CCO any PIP arrangement Provider may have with any physicians even if there is not substantial financial risk between Subcontractor and/or CCO and such physicians.

3.38 Lobbying. Provider agrees to comply with the following requirements related to lobbying:

(a) Prohibition on Use of Federal Funds for Lobbying: By signing the Agreement, Provider certifies to the best of Provider's knowledge and belief, pursuant to 31 U.S.C. § 1352 and 45 CFR Part 93, as may be amended from time to time, that no federally appropriated funds have been paid or will be paid to any person by or on Provider's behalf for the purpose of influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of

Congress in connection with the award of any federal contract, the making of any federal grant, the making of any federal loan, the entering into of any cooperative agreement, or the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan, or cooperative agreement.

(b) Disclosure Form to Report Lobbying: If any funds other than federally appropriated funds have been paid or will be paid to any person for the purpose of influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the award of any federal contract, the making of any federal grant, the making of any federal loan, the entering into of any cooperative agreement, or the extension, continuation, renewal, amendment or modification of any federal contract, grant, loan, or cooperative agreement and the value of the Agreement exceeds $100,000, Provider shall complete and submit Standard Form-LLL, "Disclosure Form to Report Lobbying," in accordance with its instructions.

(c) Contractor shall abide by lobbying laws of the State of Mississippi.

3.39 Gratuities. Provider represents that it has not violated, is not violating, and promises that it will not violate the prohibitions against gratuities set forth in Section 6-204 (Gratuities) of the Mississippi Personal Service Contract Procurement Regulations.

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

3.41 Insurance Requirements. As applicable, Provider shall and shall require that Provider secure and maintain during the term of the Agreement general liability insurance, professional liability insurance, and workers' compensation insurance for all employees connected with the provision of services under the Agreement. Such workers compensation insurance shall comply with Mississippi

Workers' Compensation Laws. Such comprehensive general liability insurance and professional liability insurance shall provide coverage in an amount established by Subcontractor and/or CCO pursuant to the Agreement or as required under the MississippiCHIP Program Contract.

3.42 Indemnification. To the extent applicable to Provider in performance under the Agreement, Provider shall indemnify, defend, protect, save and hold DOM and its employees and Members harmless from and against all injuries, deaths, losses, damages, claims, suits, demands, actions, recovery, liabilities, judgments, costs and expenses, including without limitation, court costs, investigative fees and expenses, and attorney fees, to the extent proximately caused by any negligent act or other intentional misconduct or omission of Provider, its agents, officers, employees or contractors arising from the Agreement. DOM may waive this requirement for public entities if Provider is a state agency or sub-unit as defined by the State or a public health entity with statutory immunity. This clause shall survive the termination of the Agreement for any reason, including breach due to insolvency.

3.43 Notice of Legal Action. Immediately upon obtaining knowledge or receiving notice of any legal action or notice listed below, Provider shall provide to Subcontractor and/or CCO written notice of such legal action or notice and, upon request by Subcontractor and/or CCO, a complete copy of all filings and other documents generated in connection with any such legal action:

(a) Any action, suit or counterclaim filed against Provider;

(b) Any regulatory action, or proposed action, respecting Provider's business or operations;

(c) Any notice received by Provider from the Department of Insurance or the State Health Officer;

(d) The filing of a petition in bankruptcy by or against Provider, or the insolvency of Provider;

(e) The conviction of any person who has an ownership or control interest in Provider, or who is an agent or managing employee of Provider, of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or Title XX of the Social Security Act; or

(f) A malpractice action against any Provider delivering service under an agreement.

3.44 Hold Harmless. Except for any applicable cost-sharing requirements under the MississippiCHIP Program Contract, Provider shall look solely to Subcontractor and/or CCO for payment of Covered Services provided to Members pursuant to the Agreement and the MississippiCHIP Program Contract and hold DOM, the State, the U.S. Department of Health and Human Services and Members harmless in the event that Subcontractor and/or CCO cannot or will not pay for such Covered Services. In accordance with 42 CFR § 447.15, as may be amended from time to time, the Member is not liable to Provider for any services for which Subcontractor and/or CCO is liable and as specified under the State's relevant health insurance or managed care statutes, rules or administrative agency guidance. Provider shall not require any copayment or cost sharing for Covered Services provided under the Agreement unless expressly permitted under the MississippiCHIP Program Contract. Provider shall also be prohibited from charging Members for missed appointments if such practice is prohibited

under the MississippiCHIP Program Contract or applicable law. Neither the State, DOM, nor Member shall be in any manner liable for the debts and obligations of Subcontractor and/or CCO and under no circumstances shall Subcontractor, CCO, or any providers used to deliver services covered under the terms of the MississippiCHIP Program Contract, charge Members for Covered Services.

3.45 Assignment/Delegation. Provider shall not assign or delegate the Agreement without the express written consent of Subcontractor, CCO or DOM. The transfer of five percent (5%) or more of the beneficial ownership in Provider at any time during the term of this Agreement shall be deemed an assignment under this Agreement.

3.46 Behavioral Health Providers. Behavioral Health Providers shall ensure that all Covered Persons receiving inpatient psychiatric services are scheduled for outpatient follow-up and/or continuing treatment prior to discharge from the inpatient psychiatric hospital if the Provider is aware of the Covered Person's inpatient hospitalization status. Behavioral Health Providers will be provided daily reports identifying Covered Persons known to be admitted to an inpatient facility.

SECTION 4
SUBCONTRACTOR AND CCO REQUIREMENTS

4.1 Communications with Members. Members are entitled to the full range of their Providers' opinions and counsel about the availability of Medically Necessary Services under the provisions of the MississippiCHIP Program Contract. Any contractual provisions, including gag clauses or rules, that restrict a Provider's ability to advise Members about Medically Necessary treatment options violate federal law and regulations. Subcontractor and CCO shall not prohibit or otherwise restrict Provider, when acting within the lawful scope of practice, from advising or advocating on behalf of a Member for the following:

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

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

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

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

(e) Information regarding the nature of treatment options including those that may not reflect Subcontractor's or CCO's position or may not covered by Subcontractor or CCO.

Subcontractor and CCO shall not prohibit a Provider from advocating on behalf of a Member in any grievance system, utilization review process, or individual authorization process to obtain necessary health care services.

4.2 Prompt Payment. Subcontractor and/or CCO shall pay Provider pursuant to the MississippiCHIP Program Contract and applicable State and federal law and regulations, including but not limited to Miss. Code Ann. §83-9-5, 42 CFR §447.46, 42 CFR §447.45(d)(2), 42 CFR §447.45(d)(3), 42 CFR §447.45(d)(5) and 42 CFR §447.45(d)(6), as applicable and as may be amended from time to time. If a third party liability exists, payment of claims shall be determined in accordance with federal and/or State third party liability law and the terms of the MississippiCHIP Program Contract. Unless Subcontractor or CCO otherwise requests assistance from Provider, Subcontractor or CCO will be responsible for third party collections in accordance with the terms of the MississippiCHIP Program Contract.

4.3 No Incentives to Limit Medically Necessary Services. Neither Subcontractor nor CCO shall structure compensation provided to individuals or entities that conduct utilization management and concurrent review activities so as to provide incentives for the individual or entity to deny, limit, or discontinue Medically Necessary services to any Member.

4.4 Provider Discrimination Prohibition. Subcontractor and CCO shall not discriminate with respect to participation, reimbursement, or indemnification of a provider who is acting within the scope of the provider's license or certification under applicable State law, solely on the basis of such license or certification. Subcontractor and CCO shall not discriminate against Provider for serving high-risk Members or if Provider specializes in conditions requiring costly treatments. This provision shall not be construed as prohibiting Subcontractor or CCO from limiting a provider's participation to the extent necessary to meet the needs of Members. This provision also is not intended and shall not interfere with measures established by Subcontractor or CCO that are designed to maintain quality of care practice standards and control costs. Subcontractor and CCO shall not provide false or misleading information to any person or entity in an attempt to recruit Providers for Subcontractor's or CCO's network.

4.5 Termination, Revocation and Sanctions. In addition to its termination rights under the Agreement, Subcontractor and/or CCO shall have the right to revoke any functions or activities Subcontractor and/or CCO delegates to Provider under the Agreement or impose other sanctions consistent with the MississippiCHIP Program Contract if in Subcontractor's or CCO's reasonable judgment Provider's performance under the Agreement is inadequate. Subcontractor or CCO shall also have the right to suspend, deny, refuse to renew or terminate the subcontract in accordance with the terms of the MississippiCHIP Program Contract and applicable law and regulation. However, Subcontractor and CCO shall not exclude or terminate a Provider from participation in Subcontractor's or CCO's Provider Network due to the fact that the Provider has a practice that includes a substantial number of patients with expensive medical conditions, and shall not terminate a Provider for filing a Complaint, Grievance, or Appeal on a Member's behalf.

SECTION 5
OTHER REQUIREMENTS

5.1 Compliance with MississippiCHIP Program Contract. All tasks performed under the Agreement shall be performed in accordance with the requirements of the MississippiCHIP Program Contract, as applicable, as set forth in this Appendix, applicable provider manuals, and protocols, policies and procedures that Subcontractor or CCO has provided or delivered to Provider. The applicable provisions of the MississippiCHIP Program Contract are incorporated into the Agreement by

reference. Nothing in the Agreement or this Appendix relieves CCO of its responsibility under the MississippiCHIP Program Contract. If any provision of the Agreement is in conflict with provisions of the MississippiCHIP Program Contract, the terms of the MississippiCHIP Program Contract shall control and the terms of the Agreement in conflict with those of the MississippiCHIP Program Contract will be considered waived.

5.2 Monitoring. In accordance with 42CFR § 457.950, Subcontractor and/or CCO shall perform ongoing monitoring (announced or unannounced) of services rendered by Provider under the Agreement and shall perform periodic formal reviews of Provider according to a schedule established by the State, consistent with industry standards or State managed care organization laws and regulations or requirements under the MississippiCHIP Program Contract. As a result of such monitoring activities, and/or as a result of the inspecting, auditing and monitoring activities of DOM or other authorities pursuant to section 4.4 above, Subcontractor and/or CCO shall identify to Provider any deficiencies or areas for improvement mandated under the MississippiCHIP Program Contract and Provider and Subcontractor and/or CCO shall take appropriate corrective action within the relevant timeframe permitted, as applicable. Provider shall comply with any corrective action plan initiated by Subcontractor, CCO and/or required by the MississippiCHIP Program. In addition, Provider shall monitor and report the quality of services delivered under the Agreement and initiate a plan of correction where necessary to improve quality of care, in accordance with that level of care which is recognized as acceptable professional practice in the respective community in which Subcontractor, CCO and Provider practice and/or the performance standards established under the MississippiCHIP Program Contract.

5.3 Enrollment. The parties acknowledge and agree that DOM is responsible for enrollment, reenrollment and disenrollment of Members.

5.4 No Exclusivity. Nothing in the Agreement or this Appendix shall be construed as prohibiting or penalizing Provider for contracting with a managed care organization other than Subcontractor or CCO or as prohibiting or penalizing Subcontractor or CCO for contracting with other providers. The Subcontractor or CCO may not require Providers who agree to participate in the MississippiCHIP Program to contract with the Contractor's other lines of business.

5.5 Revoking Delegation. The parties agree that, prior to execution of the Agreement, Subcontractor and/or CCO evaluated Provider's ability to perform any duties delegated to Provider under the Agreement. Any delegated duties and reporting responsibilities shall be set forth in the Agreement or other written delegation agreement or addendum between the parties. In addition to its termination rights under the Agreement, Subcontractor and/or CCO shall have the right to revoke any functions, assignment authority, or activities Subcontractor and/or CCO delegates to Provider under the Agreement or impose other sanctions if in Subcontractor's and/or CCO's reasonable judgment Provider's performance under the Agreement is inadequate or untimely.

5.6 Rights of DOM. DOM shall have the right to invoke against Provider any remedy set forth in the MississippiCHIP Program Contract, including the right to require the termination of the Agreement, for each and every reason for which it may invoke such a remedy against Subcontractor or CCO or require termination of the MississippiCHIP Program Contract. Suspected Fraud and Abuse by Provider will be investigated by DOM.

Behavioral Health
Mississippi Medicaid Program
Regulatory Requirements Appendix

MISSISSIPPI MEDICAID PROGRAM

REGULATORY REQUIREMENTS APPENDIX

DOWNSTREAM PROVIDER

THIS MISSISSIPPI MEDICAID PROGRAM REGULATORY REQUIREMENTS APPENDIX (this "Appendix") supplements and is made part of the provider agreement (the "Agreement") between Redacted ("Subcontractor") and the provider named in the Agreement ("Provider").

SECTION 1
APPLICABILITY

This Appendix applies with respect to the provision of health care services that Provider provides directly to Covered Persons through Health Plan's (as defined herein) products or benefit plans including Mississippi Coordinated Access Network Program (the "MississippiCAN Program") as governed by the State's designated regulatory agencies. Provider has agreed to provide Covered Services to Covered Persons who receive their coverage pursuant to a contract between the State and Health Plan (the "State Contract" as defined herein). The State Contract and applicable State and federal law require that the provisions contained in this Appendix be part of the Agreement. In the event of a conflict between this Appendix and other appendices or any provision of the Agreement, the provisions of this Appendix shall control except with regard to benefit contracts outside the scope of this Appendix or unless otherwise required by law. In the event Subcontractor is required to amend or supplement this Appendix as required or requested by the State and requested by Health Plan, Provider agrees that Subcontractor shall be permitted to unilaterally initiate such additions, deletions or modifications. All provider agreements must be in writing and must include all specific activities and report responsibilities delegated to the Provider by Subcontractor.

SECTION 2
DEFINITIONS

Unless otherwise defined in this Appendix, all capitalized terms shall be as defined in the Agreement. For purposes of this Appendix, the following terms shall have the meanings set forth below; provided, however, in the event any definition set forth in this Appendix or the Agreement is inconsistent with any definitions under the MississippiCAN Program, the definitions shall have the meaning set forth under the MississippiCAN Program.

2.1 Action: Health Plan's decision to deny or limit authorization or payment (in whole or in part) for health care services, including new authorizations and previously authorized services; the reduction, suspension, or termination of a previously authorized service; or Health Plan's failure to provide services in a timely manner; failure to resolve Complaints, Grievances, or Appeals within the specified time frames.

2.2 Appeal: A request for review by Health Plan of an Action related to a Covered Person or Provider. In the case of a Covered Person, an Action may include determinations on the health care services a Covered Person believes he or she is entitled to receive, including delay in

providing, arranging for, or approving the health care services (such that a delay would adversely affect the health of the Covered Person). In the case of a Provider, the Action may include, but is not limited to, delay or non-payment for covered services.

2.3 Behavioral Health Services: Mental health and/or drug and alcohol abuse treatment services that are provided by the county intellectually delayed/developmentally delayed programs, the single county authority administrators, or other appropriately licensed health care practitioners.

2.4 CMS: Center for Medicare and Medicaid Services is an agency within the U.S. Department of Health & Human Services responsible for administration of several key federal health care programs.

2.5 Complaint: An expression of dissatisfaction received orally or in writing that is of a less serious or formal nature that is resolved within one (1) business day of receipt.

2.6 Covered Person: An individual who meets all of the eligibility requirements for Mississippi Medicaid and is currently enrolled with Health Plan for the provision of services under a MississippiCAN Program. A Covered Person may also be referred to as an Enrollee, Member or Customer under the Agreement.

2.7 Covered Services: Health care services or products for which a Covered Person is enrolled with Health Plan to receive coverage under the State Contract.

2.8 DOM: Division of Medicaid, Office of the Governor, State of Mississippi.

2.9 Early, Periodic, Screening, Diagnosis, and Treatment (EPSDT) Services: Defined by DOM to include:

a. Age appropriate, comprehensive health and development history that includes physician and mental health assessments along with counseling and anticipatory guidance and risk factor reduction interventions;
b. Calculation of Body Mass Index;
c. Growth measurements and head circumference;
d. Nutritional counseling;
e. Developmental surveillance and Developmental and autism Spectrum Disorders Screenings as appropriate;
f. Comprehensive unclothed exam;
g. Appropriate laboratory tests (including blood level assessment appropriate to age and risk);
h. Appropriate immunizations in accordance with Recommended Childhood and Adolescent Immunization Schedule adopted by DOM;
i. A vision assessment;
j. A hearing assessment;
k. A dental screening and/or referral to dental care;
l. Health education; and
m. Referrals for identified abnormalities.

2.10 Fraud and Abuse: Fraud is any type of intentional deception or misrepresentation made by an entity or person with the knowledge that the deception could result in some unauthorized benefit to the entity, him or herself, or some other person. The Fraud can be committed by many entities, including a vendor, a subcontractor, a provider, a State employee, or a Covered Person, among others. Abuse is any practice that is inconsistent with sound fiscal, business, or medical practices, and results in an unnecessary cost to the Medicaid program, a vendor, a subcontractor or Provider or in reimbursement for services that are not Medically Necessary or that fail to meet professionally recognized standards for health care.

2.11 Grievance: An expression of dissatisfaction about any matter or aspect of Health Plan or its operation, other than an Action as defined herein.

2.12 Health Plan: An appropriately licensed entity that has entered into a contract with Subcontractor, either directly or indirectly, under which Subcontractor provides certain administrative services for Health Plan pursuant to the State Contract. For purposes of this Appendix, Health Plan refers to Redacted of Mississippi, Inc.

2.13 Marketing: The activities that promote visibility and awareness for the MississippiCAN Program and Health Plan's participation in the program. All activities are subject to prior review and approval by DOM.

2.14 Medical Record: A single complete record, which documents the entire treatment plan developed for, and medical services received by, the Covered Person including inpatient, outpatient, referral services and emergency medical services whether provided by contracted Providers or non-contracted providers.

2.15 Mississippi Coordinated Access Network (MississippiCAN) Program: Mississippi Medicaid's coordinated care program for select Medicaid Beneficiaries.

2.16 Primary Care Provider (PCP): Any physician or health care practitioner or group operating within the scope of his or her licensure who is responsible for supervising, prescribing and providing primary care and primary case management services in the MississippiCAN Program, whose practice is limited to the general practice of medicine or who is an Internist, Pediatrician, Obstetrician, Gynecologist, Family Practitioner, General Practitioner, Certified Nurse Practitioners whose specialty is pediatrics, adult, family, certified nurse midwife, obstetrics/gynecology, or a physician assistant.

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

2.18 Provider: A hospital, ancillary provider, physician group, individual physician or other healthcare provider who has entered into an Agreement.

2.19 Provider Network: The Panel of health service Providers with which Subcontractor and/or Health Plan contracts for the provision of covered services to Covered Persons and Non-Contracted Providers administering services to Covered Persons.

2.20 State: The State of Mississippi or its designated regulatory agencies.

2.21 State Contract: Health Plan's contract with the State for the purpose of providing and paying for Covered Services to Covered Persons enrolled in the MississippiCAN Program.

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

SECTION 3
PROVIDER REQUIREMENTS

The MississippiCAN Program, through the State Contract and federal and State statutes and regulations, requires the Agreement to contain certain conditions that Health Plan, Subcontractor and Provider agree to undertake, which include the following:

3.1 Definitions Related to the Provision of Covered Services. Provider shall follow the applicable State Contract's requirements for the provision of Covered Services. Provider's decisions affecting the delivery of acute or chronic care services to Covered Persons shall be made on an individualized basis and in accordance with the following definitions:

(a) Emergency Medical Condition: A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in any of the following: (1) 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; (2) serious impairment to body functions; or (3) serious dysfunction of any body organ or part.

(b) Emergency Services: Covered inpatient and outpatient services furnished by a provider who is qualified to furnish those health services and that are needed to evaluate or stabilize an Emergency Medical Condition.

(c) Medically Necessary Services: As set forth in the Social Security Act, Section 1905 (42 USC 1396d(a)), Medically Necessary Services are defined as services, supplies, or equipment provided by a licensed health care professional that are:

1. Appropriate and consistent with the diagnosis or treatment of the Covered Person's condition, illness, or injury;

2. In accordance with the standards of good medical practice consistent with the individual Covered Person's condition(s);

3. Not primarily for the personal comfort or convenience of the Member, family, or Provider;

4. The most appropriate services, supplies, equipment, or levels of care that can be safely and efficiently provided to the Covered Person;

5. Furnished in a setting appropriate to the Covered Person's medical need and condition and, when applied to the care of an inpatient, further mean that the Covered Person's medical symptoms or conditions require that the services cannot be safely provided to the Covered Person as an outpatient;

6. Not experimental or investigational or for research or education;

7. Provided by an appropriately licensed practitioner; and

8. Documented in the patient's record in a reasonable manner, including the relationship of the diagnosis to the service.

Medically Necessary Services may also be those services for children that are necessary to correct or ameliorate defects and physical and mental illnesses and conditions discovered during an interperiodic or periodic EPSDT screen, whether such services are covered or exceed the benefit limits in the Medicaid State Plan and Title 23 of Mississippi Administrative Code.

3.2 Provider Eligibility. Provider must be enrolled in the Mississippi Medicaid program and must use the same National Provider Identifier (NPI) number. Health Plan and Subcontractor will exclude from its network any provider who has been terminated or suspended from the Medicare or Medicaid program in any state.

3.3 Accessibility Standards. Provider shall provide for timely access for Covered Person appointments in accordance with the appointment availability requirements established under the State Contract, as further described in the applicable provider manual.

Type	Appointment Scheduling Time Frames
PCP (well care visit)	Not to exceed thirty (30) calendar days
PCP (routine sick visit)	Not to exceed seven (7) calendar days
PCP (urgent care visit)	Not to exceed twenty-four (24) hours
Specialists	Not to exceed forty-five (45) calendar days
Dental Providers (routine visits)	Not to exceed forty-five (45) calendar days
Dental Providers (urgent Care)	Not to exceed forty-eight (48) calendar days
Behavioral Health Providers (routine visit)	Not to exceed fourteen (14) calendar days
Behavioral Health Providers (urgent visit)	Not to exceed twenty-four (24) hours

Behavioral Health Providers (post-discharge from an acute psychiatric hospital when the Contractor is aware of the Member's discharge)	Not to exceed seven (7) calendar days
Urgent Care Providers	Not to exceed twenty-four (24) hours
Emergency Providers	Immediately (twenty-four (24) hours a day, seven (7) days a week) and without Prior Authorization

3.4 Hours of Operation; Appointments. Provider shall offer hours of operation that are no less than the hours of operation offered to commercial beneficiaries or comparable to Medicaid fee-for-service if Provider serves only Medicaid beneficiaries.

3.5 Hold Harmless. Except for any applicable cost-sharing requirements under the State Contract, Provider shall look solely to Subcontractor and Health Plan for payment of Covered Services provided to Covered Persons pursuant to the Agreement and the State Contract and hold the State, DOM, the U.S. Department of Health and Human Services and Covered Persons harmless in the event that Subcontractor and/or Health Plan cannot or will not pay for such Covered Services. In accordance with 42 CFR 447.15, as may be amended from time to time, the Covered Person is not liable to Provider for any services for which Subcontractor and/or Health Plan is liable and as specified under the State's relevant health insurance or managed care statutes, rules or administrative agency guidance. Provider shall not require any copayment or cost sharing for Covered Services provided under the Agreement unless expressly permitted under the State Contract. Provider shall also be prohibited from charging Covered Persons for missed appointments if such practice is prohibited under the State Contract or applicable law. Neither the State, DOM nor Covered Persons shall be in any manner liable for the debts and obligations of Subcontractor and/or Health Plan and under no circumstances shall Subcontractor, Health Plan, or any providers used to deliver services covered under the terms of the State Contract, charge Covered Persons for Covered Services.

Covered Person may be responsible for non-covered item(s) and/or service(s), only if the Provider ensures that written documentation in compliance with the Advance Beneficiary Notification (ABN) is received from the Covered Person that an item(s) or service(s) rendered is a non-covered item and/or service(s) and that the Covered Person will be financially responsible for the item(s) and/or service(s). If Subcontractor and/or Health Plan determines a Covered Person was charged for Covered Services inappropriately, such payment may be recovered, as applicable.

This provision shall survive any termination of the Agreement, including breach of the Agreement due to insolvency.

3.6 Indemnification. To the extent applicable to Provider in performance of the Agreement, Provider shall indemnify, defend protect, save and hold DOM and its employees and Covered Persons harmless from and against all injuries, deaths, losses, damages, claims, suits, liabilities, judgments, costs and expenses, including, without limitation, court costs, investigative fees and expenses and attorney fees, to the extent proximately caused by any negligent act or other intentional misconduct or omission of Provider, its agents, officers, employees or contractors

arising from the Agreement. DOM may waive this requirement for public entities if Provider is a state agency or sub-unit as defined by the State or a public health entity with statutory immunity. This clause shall survive the termination of the Agreement for any reason, including breach due to insolvency.

3.7 Provider Selection. To the extent applicable to Provider in performance of the Agreement, Provider shall comply with 42 CFR 438.214, as may be amended from time to time, which includes, but is not limited to the selection and retention of providers, credentialing and recredentialing requirements and nondiscrimination. If Subcontractor and/or Health Plan delegates credentialing to Provider, Subcontractor and Health Plan will provide monitoring and oversight and Provider shall ensure that all licensed medical professionals are credentialed in accordance with Health Plan's and the State Contract's credentialing requirements.

3.8 Restrictions on Referrals. Provider shall not make inappropriate referrals for designated health services to health care entities with which Provider or a member of Provider's family has a financial relationship, pursuant to federal anti-kickback and physician self-referral laws that prohibit such referrals.

3.9 Records Retention. As required under State or federal law or the State Contract, Provider shall maintain an adequate record keeping system for recording services, charges, dates and all other commonly accepted information elements sufficient to disclose the quality, quantity, appropriateness and timeliness of services rendered to Covered Persons. All financial records shall follow generally accepted accounting principles. Medical records and supporting management systems shall include all pertinent information related to the medical management of each Covered Person. Other records shall be maintained as necessary to clearly reflect all actions taken by Provider related to services provided under the State Contract. Such records shall be maintained for a period of not less than five (5) years from the close of the Agreement, or such other period as required by law. If records are under review or audit, they must be retained for a minimum of five (5) years following resolution of such action. Prior approval for the disposal of records must be requested and approved by Health Plan if the Agreement is continuous.

3.10 Records Access. Provider acknowledges and agrees that the State, DOM, the U.S. Department of Health and Human Services and other authorized federal and state personnel shall have complete access to all records pertaining to services provided to Covered Persons. Provider shall provide immediate access to facilities, records and supportive materials pertinent to the State Contract for State or Federal fraud investigators. Copies of requested documents shall be provided to the State, DOM, the U.S. Department of Health and Human Services and other authorized federal and state personnel or their designees free of charge.

3.11 Government Audit; Investigations. Provider acknowledges and agrees that the State and the U.S. Department of Health and Human Services, the Centers for Medicare & Medicaid Services, the Office of Inspector General, the General Accounting Office, or any other auditing agency or their authorized representatives, with prior approval by DOM, shall, at all reasonable time, with or without notice, or their authorized representatives shall have the right to inspect or otherwise evaluate the quality, appropriateness, and timeliness of services provided under the terms of the State Contract and any other applicable rules. There shall be no restrictions on the right of the State or federal government to conduct whatever inspections and audits are necessary

to assure quality, appropriateness or timeliness of services provided pursuant to the State Contract and the reasonableness of their costs.

3.12 Privacy; HIPAA. Provider shall comply with all applicable privacy rule and security rule provisions of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), and associated implementing regulations, as may be amended from time to time, and shall safeguard information about Covered Persons in accordance with applicable federal and State privacy laws and rules including 42 CFR 438.224 and 42 CFR Part 431, Subpart F, as may be amended from time to time. Redacted agrees and shall require Provider to agree that confidential information, including but not limited to medical and other pertinent information relative to Covered Persons, shall not be disclosed to any person or organization for any purpose without the expressed, written authority of DOM or as otherwise required by law and that all such disclosures shall fully comply with HIPAA privacy and security standards.

3.13 Compliance with Law. Provider shall comply with all applicable federal and State laws and regulations, and all provisions of the State Contract, that pertain to a Covered Person's rights, including but not limited to the following to the extent applicable to Provider in performance of the Agreement:

(a) Title VI of the Civil Rights Act of 1964; Title XIX of the Social Security Act; 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 Genetic Information Non-Discrimination Act of 2008 (GINA); and the Americans with Disabilities Act, and their implementing regulations, as may be amended from time to time.

(b) 42 CFR 434 and 42 CFR 438.6, as may be amended from time to time.

(c) All relevant federal and State statutes, regulations and orders related to equal opportunity in employment, including but not limited to compliance with E.O. 11246, "Equal Employment Opportunity," as amended by E.O. 11375, "Amending Executive Order 11246 Relating to Equal Employment Opportunity," and as supplemented by regulations at 41 CFR part 60, "Office of Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor."

(d) All federal and State professional and facility licensing and accreditation requirements/standards that apply to the services Redacted and Provider perform pursuant to the Agreement, including but not limited to:

1. All applicable standards, orders or requirements issued under Section 306 of the Clean Air Act (42 USC 1857 (h)). Section 508 of the Clean Water Act (33 USC 1368), Executive Order 11738, and Environmental Protection Agency (EPA) regulations (40) CFR Part 15), which prohibit the use of facilities included on the EPA list of violating facilities. Any violations must be reported to DSHS, DHHS, and the EPA;

2. Any applicable mandatory standards and policies relating to energy

efficiency that are contained in the State Energy Conservation Plan, including the Energy Policy & conservation Act (Pub. L. 94-165), and issued in compliance with the Federal Energy Policy & Conservation Act.

3. Those specified for laboratory services in the Clinical Laboratory Improvement Amendments (CLIA). All laboratory service sites must have a CLIA certificate of registration or waiver, and a CLIA identification number.

4. Section 1128B(d)(1) of the Balanced Budget Act of 1997; and,

5. Any other requirements associated with the receipt of federal funds.

3.14 Physician Incentive Plans. In the event Provider participates in a physician incentive plan ("PIP") under the Agreement, Provider agrees that such PIPs must comply with 42 CFR 417.479, 42 CFR 438.6(h), 42 CFR 422.208, and 42 CFR 422.210, as may be amended from time to time. Subcontractor, Health Plan nor Provider may make a specific payment directly or indirectly under a PIP to a physician or physician group as an inducement to reduce or limit Medically Necessary services furnished to an individual Covered Person. PIPs must not contain provisions that provide incentives, monetary or otherwise, for the withholding of services that meet the definition of Medical Necessity.

3.15 Lobbying. Provider agrees to comply with the following requirements related to lobbying:

(a) Prohibition on Use of Federal Funds for Lobbying: By signing the Agreement, Provider certifies to the best of Provider's knowledge and belief, pursuant to 31 U.S.C. Section 1352 and 45 CFR Part 93, as may be amended from time to time, that no federally appropriated funds have been paid or will be paid to any person by or on Provider's behalf for the purpose of influencing or attempting to influence an officer or employee of any agency, a member of Congress, an officer or employee of Congress, or an employee of a member of Congress in connection with the award of any federal contract, the making of any federal grant, the making of any federal loan, the entering into of any cooperative agreement, or the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan, or cooperative agreement.

(b) Disclosure Form to Report Lobbying: If any funds other than federally appropriated funds have been paid or will be paid to any person for the purpose of influencing or attempting to influence an officer or employee of any agency, a member of Congress, an officer or employee of Congress, or an employee of a member of Congress in connection with the award of any federal contract, the making of any federal grant, the making of any federal loan, the entering into of any cooperative agreement, or the extension, continuation, renewal, amendment or modification of any federal contract, grant, loan, or cooperative agreement and the value of the Agreement exceeds $100,000, Provider shall complete and submit Standard Form-LLL, "Disclosure Form to Report Lobbying," in accordance with its instructions.

3.16 Excluded Individuals and Entities. Provider certifies that neither it nor any of its employees, principals, nor any providers, subcontractors or consultants or persons with an ownership or controlling interest in the Provider (an owner including the Provider himself or herself), or an agent or managing employee of the Provider, with whom Provider contracts and who are providing items or services that are significant and material to Provider's obligations under the Agreement is:

(a) excluded from participation in federal health care programs under either Section 1128 or section 1128A of the Social Security Act; or

(b) debarred, suspended or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in nonprocurement activities under regulations issued under Executive Order no. 12549 or under guidelines implementing Executive Order No. 12549; or an affiliate, as defined in the Federal Acquisition Regulation, of such a person.

Provider acknowledges and agrees that payment will not be made for any items or Covered Services provided by an excluded individual pursuant to 42 CFR 1001.1901(b) and is obligated to screen all employees, contractors, and subcontractors for exclusion as required under applicable State and Federal laws. Additionally, Provider acknowledges that pursuant to 42 CFR 1003.102(a)(2) civil monetary penalties may be imposed against Provider if he or she employs or enters into contracts with excluded individuals or entities to provide items or Covered Services to Covered Persons under this Agreement. Provider agrees not to employ or subcontract with individuals or entities whose owner, those with a controlling interest, or managing employees are on a State or Federal exclusion list to provide items or Covered Services under this Agreement. Provider shall immediately report to Subcontractor and/or Health Plan any exclusion information discovered. Provider can search the HHS-OIG website, at no cost, by the names of any individuals or entities. The database is called LEIE and can be accessed at http://www.oig.hhs.gov/fraud/exclusions.asp. The GSA EPLS/SAM database can be accessed at https://www.sam.gov. Applicable state exclusion databases can be accessed through the State's Medicaid website. Subcontractor and Health Plan will terminate the Agreement immediately and exclude from its network any provider who has been excluded from federal health care programs or terminated from the Medicare or the Medicaid program in any state. Subcontractor and Health Plan may also terminate the Agreement if Provider's owners, agents, or managing employees are found to be excluded on a State or Federal exclusion list.

3.17 Disclosure. Provider shall cooperate with Subcontractor and Health Plan in disclosing information DOM may require related to ownership and control, significant business transactions, and persons convicted of crimes in accordance with 42 CFR Part 455 and shall provide information upon request. Provider shall submit information related to ownership and control of subcontractors or wholly owned suppliers within thirty-five (35) calendar days of a request for such information.

By executing this Agreement, Provider certifies that neither Provider nor any of its principals is presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in any State or federal health care program or from participating in

transactions by any State or federal department or agency. Subcontractor and/or Health Plan will terminate the Agreement upon becoming aware or receiving notice from DOM, whichever is earlier, that Provider is or has been excluded from participation in any State or federal health care program or by any State or federal agency.

3.18 Cultural Competency. Provider shall participate in Subcontractor and Health Plan's and the State's efforts to promote the delivery of services in a culturally competent manner to all Covered Persons, including those with limited English proficiency and diverse cultural and ethnic backgrounds and shall provide interpreter services in a Covered Person's primary language and for the hearing impaired for all appointments and emergency services. Provider shall provide information to Covered Persons regarding treatment options and alternatives, as well as information on complaints and appeals, in a manner appropriate to the Covered Person's condition and ability to understand.

3.19 Marketing. As required under State or federal law or the applicable State Contract, any marketing materials developed and distributed by Provider as related to the performance of the Agreement must be submitted to Health Plan for submission to DOM for prior approval.

3.20 Fraud, Waste and Abuse Prevention. Provider shall cooperate fully with Subcontractor and Health Plan's policies and procedures designed to protect program integrity and prevent and detect potential or suspected fraud, waste, and abuse in the administration and delivery of services under the State Contract and shall cooperate and assist DOM and any other State or federal agency charged with the duty of preventing, identifying, investigating, sanctioning or prosecuting suspected fraud, waste, and abuse in state and/or federal health care programs.

In accordance with Health Plan's policies and the Deficit Reduction Act of 2005 (DRA), Provider shall have written policies for its employees, contractors or agents that: (a) provide detailed information about the federal False Claims Act (established under sections 3729 through 3733 of title 31, United States Code); (b) cite administrative remedies for false claims and statements (established under chapter 38 of title 31, United States Code) and whistleblower protections under federal and state laws; (c) reference state laws pertaining to civil or criminal penalties for false claims and statements; and (d) with respect to the role of such laws in preventing and detecting fraud, waste, and abuse in federal health care programs (as defined in section 1128B(f)), include as part of such written policies, detailed provisions regarding Provider's policies and procedures for detecting and preventing fraud, waste, and abuse. Provider agrees to train its staff on the aforesaid policies and procedures.

3.21 Data; Reports. Provider shall cooperate with and release to Subcontractor and Health Plan any information necessary for Subcontractor and Health Plan to perform its obligations under the State Contract to the extent applicable to Provider in performance of the Agreement, including the timely submission of reports and information required by Subcontractor and Health Plan. Such reports shall include child health check-up reporting, if applicable, as well as complete and accurate encounter data in accordance with the requirements of Subcontractor and Health Plan and the State.

3.22 Encounter Data. Provider agrees to cooperate with Subcontractor and Health Plan to comply with Subcontractor and Health Plan's obligation to prepare encounter data submissions, reports, and clinical information including, without limitation, child and adolescent health check-up reporting, EPSDT encounters, and cancer screening encounters, as applicable, and such other reporting regarding Covered Services as may be required under the State Contract.

3.23 Claims Information. Provider shall promptly submit to Subcontractor or Health Plan the information needed to make payment and shall identify third party liability coverage, including Medicare and other insurance, and if applicable seek such third party liability payment before submitting claims to Subcontractor or Health Plan. Provider understands and agrees that each claim Provider submits to Subcontractor constitutes a certification that the claim is true and accurate to the best of Provider's knowledge and belief and that the Covered Services are 1) Medically Necessary and 2) have been provided to the Covered Person prior to submitting the claim.

Effective July 1, 2014, Provider must submit claims within six (6) months from the date of service. Claims filed within the appropriate time frame but denied may be resubmitted to the Contractor within ninety (90) calendar days from the date of denial

3.24 Reserved.

3.25 Licensure. Provider represents that it is currently licensed and/or certified under applicable State and federal statutes and regulations and by the appropriate State licensing body or standard-setting agency, as applicable. Provider represents that it is in compliance with all applicable State and federal statutory and regulatory requirements of the Medicaid program and that it is eligible to participate in the Medicaid program. Provider represents that it does not have a Medicaid provider agreement with DOM that is terminated, suspended, denied, or not renewed as a result of any action of DOM, CMS, HHS, or the Medicaid Fraud Control Unit of the State's Attorney General. Provider shall maintain at all times throughout the term of the Agreement all necessary licenses, certifications, registrations and permits as are required to provide the health care services and/or other related activities delegated to Provider by Redacted under the Agreement. If at any time during the term of the Agreement, Provider is not properly licensed as described in this Section, Provider shall discontinue providing services to Covered Persons.

3.26 Quality; Utilization Management. Pursuant to any applicable provider manuals and related protocols, or as elsewhere specified under the Agreement, Provider agrees to cooperate with Subcontractor and Health Plan's quality improvement and utilization review and management activities. This shall include, but not be limited to, participation in any internal and external quality assurance, utilization review, peer review, and grievance procedures established by Subcontractor and Health Plan or as required under the State Contract to ensure that Covered Persons have due process for their complaints, grievances, appeals, fair hearings or requests for external review of adverse decisions made by Redacted or Provider. Provider shall adhere to the quality assurance and utilization review standards of the MississippiCAN Program and shall monitor quality and initiate corrective action to improve quality consistent with the generally accepted level of care.

3.27 Non-Discrimination. Covered Persons must be provided Covered Services without regard to race, color, creed, sex, religion, age, national origin, ancestry, marital status, sexual orientation, language, health status, disease or pre-existing condition (including genetic information), anticipated need for health care or physical or mental handicap, except where medically indicated. Examples of prohibited practices include, but are not limited to, the following:

(a) Denying or not providing a Covered Person any Medicaid Covered Service. Health care and treatment necessary to preserve life must be provided to all Covered Persons who are not terminally ill or permanently unconscious, except where a competent Covered Person objects to such care on his/her own behalf.

(b) Subjecting a Covered Person to segregated, separate, or different treatment, including a different place or time from that provided to other Covered Persons or public or private patients, in any manner related to the receipt of any Medicaid Covered Service, except where Medically Necessary.

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

3.28 Advance Directives. Provider shall comply with the advance directives requirements set forth in the Uniform Health-Care Decisions Act, Section 41-41-215 of the Mississippi Code.

3.29 National Provider ID (NPI). Provider shall obtain a National Provider Identification Number (NPI) and when filing claims with Redacted, the NPI used is the same NPI used when filing claims with DOM.

3.30 Termination. In the event of termination of the Agreement, Provider shall promptly supply to Subcontractor and Health Plan all information necessary for the reimbursement of any outstanding Medicaid claims.

3.31 Complaints; Grievances and Appeals. Information on how Provider or Provider's authorized representative can submit complaints and file grievances and appeals, and the resolution process, is contained in the applicable provider manual.

3.32 Health Care Acquired/Preventable Conditions. Provider agrees that no payment shall be made for the provision of medical assistance for health care acquired conditions and other provider preventable conditions as may be identified by the State. As a condition of payment, Provider shall identify and report to Subcontractor any provider preventable conditions in accordance with 42 CFR Part 438, including but not limited to 438.6(f)(2)(i).

3.33 Quality and Utilization Management Program. Provider shall cooperate with Subcontractor and Health Plan in meeting the Quality Management and Utilization Management Program standards outlined in the State Contract.

3.34 Referrals. Provider shall make referrals for social, vocational, education or human services when a need for such service is identified.

3.35 Insolvency. In the event Subcontractor and/or Health Plan becomes insolvent or unable to pay Provider, Provider shall not seek compensation for services rendered from the State, DOM, or their officers, Agents, or employees, or the Covered Persons or their eligible dependents.

3.36 Third Party Resources. Provider will report all third party resources to Subcontractor and Health Plan identified through the provision of medical services.

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

3.38 Capitated Providers. If Provider is capitated and terminates its agreement with Subcontractor, for any reason, Provider will provide services to Covered Persons assigned to Provider up to the end of the month in which the effective date of termination falls.

3.39 Certification on Relationship to State, DOM and CMS. Provider certifies that no officer, director, employee, subcontractor or agent of Provider, or person with an ownership or control interest in Provider, is also employed by, or is a public official of, the State of Mississippi or any of its agencies, DOM or CMS.

3.40 Funding. Provider recognizes that the obligation of DOM to proceed under its Contract with CCO is conditioned upon the appropriation of funds by the Mississippi State Legislature and the receipt of State and/or Federal funds. If the funds anticipated for the continuing fulfillment of the agreement are, at any time, not forthcoming or insufficient, either through the failure of the

Federal government to provide or the State of Mississippi to appropriate funds, or the discontinuance, or material alteration of the program under which the funds were provided or if funds are not otherwise available to DOM, DOM has the right upon ten (10) working days written notice to CCO to terminate the Contract.

3.41 Gratuities. Provider represents that it has not violated, is not violating, and promises that it will not violate the prohibitions against gratuities set forth in Section 6-204 (Gratuities) of the Mississippi Personal Service Contract Procurement Regulations.

3.42 Assignment/Delegation. Provider shall not assign or delegate the Agreement without the express written consent of CCO or DOM. The transfer of five percent (5%) or more of the beneficial ownership in Provider at any time during the term of this Agreement shall be deemed an assignment under this Agreement.

3.43 Notice of Legal Action. Immediately upon obtaining knowledge or receiving notice of any legal action or notice listed below, Provider shall provide to CCO written notice of such legal action or notice and, upon request by CCO, a complete copy of all filings and other documents generated in connection with any such legal action:

(a) Any action, suit or counterclaim filed against Provider;

(b) Any regulatory action, or proposed action, respecting Provider's business or operations;

(c) Any notice received by Provider from the Department of Insurance or the State Health Officer;

(d) The filing of a petition in bankruptcy by or against Provider, or the insolvency of Provider;

(e) The conviction of any person who has an ownership or control interest in Provider, or who is an agent or managing employee of Provider, of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or Title XX of the Social Security Act; or

(f) A malpractice action against any Provider delivering service under an agreement.

3.44 Federal and State Funds Liability. Providers acknowledges and agrees that payments made to Provider for services provided under the Agreement are derived from federal and State funds and that any false claim or statement in documents or any concealment of material fact related to such services may be a cause for sanctions and prosecution under applicable federal and State laws. Provider shall be subject to all laws applicable to individuals and entities receiving State and federal funds and may be held civilly or criminally liable to both CCO and DOM in the event of nonperformance, misrepresentation, fraud, or abuse related to services provided pursuant to the State Contract. Provider recognizes that payments made to the Provider are derived from federal and State funds, and are contingent upon and subject to availability and receipt of funds.

3.45 Insurance Requirements. As applicable, Provider shall secure and maintain during the term of the Agreement insurance appropriate to the services to be performed under the Agreement. Provider shall require that its providers secure and maintain during the term of the Agreement general liability insurance, professional liability insurance, and workers' compensation insurance for all employees connected with the provision of services under the Agreement. Such workers compensation insurance shall comply with Mississippi Workers' Compensation Laws. Such comprehensive general liability insurance and professional liability insurance shall provide coverage in an amount established by CCO pursuant to the Agreement or as required under the State Contract.

SECTION 4
ADDITIONAL PROVIDER REQUIREMENTS FOR SPECIFIC ACTIVITIES

4.1 Behavioral Health Providers. Behavioral health Providers shall ensure that all Covered Persons receiving inpatient psychiatric services are scheduled for outpatient follow-up and/or continuing treatment prior to discharge from the inpatient psychiatric hospital if the Provider is aware of the Covered Person's inpatient hospitalization status. Behavioral health Providers will be provided daily reports identifying Covered Persons known to be admitted to an inpatient facility.

4.2 PCP Responsibilities. Providers acting as PCPs shall meet the following requirements:

(a) PCPs who serve Covered Persons under the age of twenty-one (21) are responsible for conducting all EPSDT screens for individuals on their Panel under the age of twenty-one (21). Should the PCP be unable to conduct the necessary EPSDT screens, the PCP is responsible for arranging to have the necessary EPSDT screens conducted by another network Provider and ensure that all relevant medical information, including the results of the EPSDT screens, are incorporated into the Covered Person's PCP Medical Record.

(b) PCPs who serve Members under the age of twenty-one (21) report encounter data associated with EPSDT screens, using a format approved by DOM, to the Contractor within ninety (90) calendar days from the date of service.

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

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

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

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

4.3 Specialists as PCPs. Covered Persons with disabling conditions, chronic illnesses, or child(ren) with special health care needs may request that their PCP be a specialist. The designation of a specialist as a PCP must be pursuant to a treatment plan approved by Subcontractor and Health Plan, in consultation with the PCP to which the Covered Person is currently assigned, the Covered Person and, as appropriate, the specialist.

The specialist as a PCP shall provide or arrange for all primary care, including routine preventive care, and to provide those specialty medical services consistent with the Covered Person's disabling condition, chronic illness, or special health care need in accordance with Subcontractor and Health Plan's standards and within the scope of the specialty training and clinical expertise.

The specialist as a PCP shall have admitting privileges at a hospital in Health Plan's network.

SECTION 5
HEALTH PLAN AND SUBCONTRACTOR REQUIREMENTS

5.1 Prompt Payment. Subcontractor or Health Plan shall pay Provider pursuant to the State Contract and applicable State and federal law and regulations, including but not limited to Mississippi Code Section 83-9-5, 42 CFR 447.46, 42 CFR 447.45(d)(2), 42 CFR 447.45(d)(3), 42 CFR 447.45(d)(5) and 42 CFR 447.45(d)(6), as applicable and as may be amended from time to time. If a third party liability exists, payment of claims shall be determined in accordance with federal and/or State third party liability law and the terms of the State Contract. Unless Subcontractor or Health Plan otherwise requests assistance from Provider, Subcontractor or Health Plan will be responsible for third party collections in accordance with the terms of the State Contract.

5.2 No Incentives to Limit Medically Necessary Services. Subcontractor and Health Plan shall not structure compensation provided to individuals or entities that conduct utilization management and concurrent review activities so as to provide incentives for the individual or entity to deny, limit, or discontinue Medically Necessary services to any Covered Person.

5.3 Provider Discrimination Prohibition. Subcontractor and Health Plan shall not discriminate with respect to participation, reimbursement, or indemnification of a provider who is acting within the scope of the provider's license or certification under applicable State law, solely on the basis of such license or certification. Subcontractor and Health Plan shall not discriminate against Provider for serving high-risk Covered Persons or if Provider specializes in conditions requiring costly treatments. This provision shall not be construed as prohibiting Subcontractor and/or Health Plan from limiting a provider's participation to the extent necessary to meet the needs of Covered Persons. This provision also is not intended and shall not interfere with measures established by Redacted that are designed to maintain quality of care practice standards and control costs.

5.4 Communications with Covered Persons. Covered Persons are entitled to the full range of their Providers' opinions and counsel about the availability of Medically Necessary Services under the provisions of the State Contract. Any contractual provisions, including gag clauses or rules, that restrict a Provider's ability to advise Covered Persons about Medically Necessary treatment options violate federal law and regulations.

Subcontractor and Health Plan shall not prohibit or otherwise restrict Provider, when acting within the lawful scope of practice, from advising or advocating on behalf of a Covered Person for the following:

(a) The Covered Person's health status, medical care, or treatment options, including any alternative treatment that may be self-administered;

(b) Any information the Covered Person needs in order to decide among all relevant treatment options;

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

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

(e) Information regarding the nature of treatment options including those that may not reflect Redacted's position or may not be covered by Redacted.

Subcontractor and Health Plan also shall not prohibit a Provider from advocating on behalf of a Covered Person in any grievance system, utilization review process, or individual authorization process to obtain necessary health care services.

5.5 Termination, Revocation and Sanctions. In addition to its termination rights under the Agreement, Subcontractor and Health Plan shall have the right to revoke any functions or activities Subcontractor and/or Health Plan delegates to Provider under the Agreement or impose other sanctions consistent with the State Contract if in Subcontractor and/or Health Plan's reasonable judgment Provider's performance under the Agreement is inadequate. Subcontractor and Health Plan shall also have the right to suspend, deny, refuse to renew or terminate Provider in accordance with the terms of the State Contract and applicable law and regulation. However, Subcontractor and Health Plan shall not exclude or terminate a Provider from participation in Subcontractor and/or Health Plan's Provider Network due to the fact that the Provider has a practice that includes a substantial number of patients with expensive medical conditions, and shall not terminate a Provider for filing a Complaint, Grievance, or Appeal on a Covered Person's behalf.

5.6 Rights of DOM. DOM shall have the right to invoke against Provider any remedy set forth in the State Contract, including the right to require the termination of the Agreement, for each and every reason for which it may invoke such a remedy against CCO or require termination of the State Contract. Suspected Fraud and Abuse by Provider will be investigated by DOM.

SECTION 6
OTHER REQUIREMENTS

6.1 Compliance with State Contract. All tasks performed under the Agreement shall be performed in accordance with the requirements of the applicable State Contract, as set forth in this Appendix, applicable provider manuals, and protocols, policies and procedures that Subcontractor and/or Health Plan have provided or delivered to Provider. The applicable provisions of the State Contract are incorporated into the Agreement by reference. Nothing in the Agreement relieves Health Plan of its responsibility under the State Contract. If any provision of the Agreement is in conflict with provisions of the State Contract, the terms of the State Contract shall control and the terms of the Agreement in conflict with those of the State Contract will be considered waived.

6.2 Monitoring. Subcontractor and/or Health Plan shall perform ongoing monitoring (announced or unannounced) of services rendered by Provider under the Agreement and shall perform periodic formal reviews of Provider according to a schedule established by the State, consistent with industry standards or State managed care organization laws and regulations or requirements under the State Contract. As a result of such monitoring activities, Subcontractor and/or Health Plan shall identify to Provider any deficiencies or areas for improvement mandated under the State Contract and Provider and Subcontractor and/or Health Plan shall take appropriate corrective action. Provider shall comply with any corrective action plan initiated by Subcontractor and/or Health Plan and/or required by the MississippiCAN Program. In addition, Provider shall monitor and report the quality of services delivered under the Agreement and initiate a plan of correction where necessary to improve quality of care, in accordance with that level of care which is recognized as acceptable professional practice in the respective community in which Subcontractor, Health Plan and Provider practice and/or the performance standards established under the State Contract.

6.3 Enrollment. The parties acknowledge and agree that DOM is responsible for enrollment, reenrollment and disenrollment of Covered Persons.

6.4 No Exclusivity. Nothing in the Agreement or this Appendix shall be construed as prohibiting or penalizing Provider for contracting with a managed care organization other than Subcontractor and/or Health Plan or as prohibiting or penalizing Subcontractor and Health Plan for contracting with other providers. Redacted may not require Providers who agree to participate in the MississippiCAN Program to contract with Redacted's other lines of business.

6.5 Delegation. The parties agree that, prior to execution of the Agreement, Subcontractor and/or Health Plan evaluated Provider’s ability to perform any duties delegated to Provider under the Agreement. Any delegated duties and reporting responsibilities shall be set forth in the Agreement or other written delegation agreement or addendum between the parties. Subcontractor and Health Plan shall have the right to revoke any functions or activities Subcontractor and/or Health Plan delegates to Provider under the Agreement if in Subcontractor and/or Health Plan’s reasonable judgment Provider’s performance under the Agreement is inadequate.

Dental Vendor
Provider Agreement

DENTAL VENDOR, INC.
DENTAL PROVIDER
AGREEMENT

THIS AGREEMENT (this "Agreement") is made and entered into as of _____, 20 ("Commencement Date"), by and between DENTAL VENDOR. its subsidiaries, and its affiliated companies (collectively "DENTAL VENDOR"), and _____ (the "Practice").

The parties hereby agree as follows:

ARTICLE 1.
DEFINITIONS

Whenever used in this Agreement, the following terms shall have the definitions contained in this Article:

1.1 CoveredServices are those dental services, supplies and benefits for which an Enrollee is entitled to receive coverage under a Dental Plan. Once an Enrollee reaches his/her maximum allowable amount or frequency of Covered Services under the Dental Plan, those additional services shall not be considered Covered Services, and Enrollee shall be responsible for payment to the Practice for all such services.

1.2 DentalPlan is any one of the various dental plans under which a Payor is obligated to provide coverage of Covered Services for an Enrollee. Such Dental Plans are as set forth in Exhibit F.

1.3 DentalPractitionerManual is the manual provided to each Practice, as such document is updated, amended and/or renamed from time to time.

1.4 Enrollee is any individual who is eligible and enrolled in a Dental Plan to receive coverage for Covered Services.

1.5 EnrolleeExpenses are any amounts that are the Enrollee's responsibility to pay the Practice in accordance with the Dental Plan, including copayments, coinsurance and deductibles.

1.6 FeeScheduleAmount is the maximum amount the Practice may receive as payment for Covered Services, including Enrollee Expenses, as set forth in Exhibit A, B, and/or D, as appropriate.

1.7 GovernmentAgency means any local, state or federal government agency or entity with regulatory or other authority over DENTAL VENDOR, Payor, the Practice, Dental Plans, or this Agreement

1.8 ParticipatingDentist is any person who (a) is licensed as a Doctor of Dental Surgery (D.D.S.) or Doctor of Dental Medicine (D.M.D.) in accordance with applicable State and Federal Law and practices as a dentist in accordance with State law or, if applicable, is board certified or board eligible in a specialty of dental care, and practices as a dentist in accordance with applicable State and Federal Law in such specialty, (b) has successfully completed DENTAL VENDOR's credentialing process; and (c) is an employee or contractor of the Practice.

1.9 Payor is the entity or person, which may be DENTAL VENDOR or another entity that has the financial responsibility for payment of Covered Services.

1.10 Protocols are programs, protocols, standard operating procedures, Plan guidelines, and administrative procedures adopted by DENTAL VENDOR or a Payor to be followed by the Practice in providing services and doing business under this Agreement. Protocols may include, but are not limited to, credentialing and recredentialing processes, utilization management, processes, quality improvement, peer review, Enrollee grievance, inspection of Practice records or other similar programs or procedures.

1.11 StateandFederalLaw means the laws and regulations of a State or of the United States, which are applicable to DENTAL VENDOR, a Payor, the Practice, Dental Plans, or this Agreement.

ARTICLE 2. NETWORK PARTICIPATION

2.1 DentalNetworks. The Practice and the Participating Dentists shall participate in those Dental Plan-specific panels of providers designated by DENTAL VENDOR ("Provider Panels"). This Agreement applies to those facilities of the Practice and to those Participating Dentists listed in Exhibit G to this Agreement. If the Practice begins providing services at any other location for any reason, the Practice will provide written notice to DENTAL VENDOR within 30 days, and such location will be added to this Agreement unless DENTAL VENDOR objects within a reasonable period of time. Nothing in this Agreement shall be deemed to require DENTAL VENDOR to perform any specific marketing activities on behalf of the Practice or utilize the Practice for any Enrollees in a particular Provider Panel.

ARTICLE 3. DUTIES OF PRACTICE

3.1 CoveredServices. The Practice agrees to provide Covered Services to Enrollees in accordance with the applicable Dental Plan, State and Federal Law, the requirements of any Government Agency, and the terms of this Agreement.

3.2 EligibilityVerification. The Practice is responsible for determining whether an individual is an Enrollee and, therefore, entitled to receive Covered Services. The Practice shall comply with DENTAL VENDOR's procedures for prior verification of Enrollee eligibility and agrees that failure to follow such procedures may result in forfeiture of payment for Covered Services. If the Practice provides services to an individual who is later determined not to be an Enrollee at the time the services were provided, those services are not eligible for payment under this Agreement, and the Practice may then directly bill the responsible party for such services, if permitted by applicable law. DENTAL VENDOR retains the right of final verification of eligibility, and, where permitted by applicable State and Federal law, this verification supersedes any previous verification of eligibility and/or claims payment review.

3.3 Nondiscrimination. The Practice will accept Enrollees as new patients and provide Covered Services in the same manner as such services are provided to other patients of the Practice and Participating Dentists, except as required pursuant to this Agreement. The Practice shall not discriminate against any Enrollee on the basis of source of payment or in any manner in regard to access to, and the provision of, Covered Services. The Practice shall not unlawfully discriminate against any Enrollee, employee or applicant for employment on the basis of race, religion, color, national origin, ancestry, disability, medical condition, marital status, age, sexual orientation or gender.

3.4 ProfessionalStandards. All Covered Services shall be provided by duly licensed, certified or otherwise authorized professional personnel in accordance with: (a) generally accepted and professionally recognized practices and standards of dental practice, (b) State and Federal Law, (c) the Principles of Ethics of the American Dental Association, (d) applicable state dental board or Board of Dentistry; (e) Dental Practitioner Manual; and (f) this Agreement. To the extent feasible and permitted by law, the Practice will utilize duly licensed dental hygienists as are available and appropriate for effective and efficient delivery of care.

3.5 Licensure. The Practice and each Participating Dentist shall maintain in good standing at all times during the term of this Agreement any and all licenses, certificates and/or approvals required by State and Federal Law to provide Covered Services to Enrollees. The Practice shall immediately notify DENTAL VENDOR of any changes to the licensure status of the Practice or any Participating Dentists.

3.6 AccessibilityandAvailability. The Practice shall ensure that Enrollees have timely and reasonable access to Covered Services and shall at all times be reasonably available to Enrollees.

3.7 DentalPractitionerManual. The Practice and Participating Dentists shall comply with the Dental Practitioner Manual, which is incorporated herein by reference. The Practice shall make the Dental Practitioner Manual available to all Participating Dentists. The Dental Practitioner Manual may be amended, revised, supplemented or replaced from time to time by DENTAL VENDOR. DENTAL VENDOR will provide written notice of any material changes to the Dental Practitioner Manual. A breach of the Dental Practitioner Manual by the Practice or Participating Dentist shall be considered a breach of this Agreement

3.8 Protocols. The Practice and each Participating Dentist shall cooperate and comply with all DENTAL VENDOR and Payor Protocols, including DENTAL VENDOR's credentialing and re-credentialing processes. The Protocols will be made available to the Practice and may be included in the Dental Practitioner Manual or other similar document. DENTAL VENDOR may change the Protocols from time to time and will provide written notice of any material changes to the Dental Practitioner Manual.

a. If DENTAL VENDOR is delegating the credentialing function to the Practice for its Participating Dentists, then the Practice shall execute a Delegated Credentialing Agreement attached hereto as Exhibit H. In addition, such Practice shall:

(a) develop, implement, and maintain, written policies and procedures for the review, selection, and evaluation of Participating Dentists, including, minimum professional requirements for health care providers, a review of

any suspensions or revocations of the Participating Dentist's license, and any liability claims made against the Participating Dentist; and a formal process for re-evaluating each Participating Dentist on an ongoing basis; and

(b) ensure that each Participating Dentist is properly licensed under applicable federal and state law and regulation.

3.9 ParticipatingDentists. The Practice shall ensure that Participating Dentists comply with all applicable requirements set forth in this Agreement. The Practice shall compensate Participating Dentists for the provision of Covered Services to Enrollees and shall ensure that Participating Dentists look solely to the Practice for compensation for Covered Services. No Participating Dentist may treat an Enrollee unless and until he/she has completed DENTAL VENDOR's credentialing process. Prior to execution of this Agreement, the Practice shall provide DENTAL VENDOR with a complete list of Participating Dentists, together with any provider-specific information required by DENTAL VENDOR. During the term of this Agreement, the Practice shall provide at least 30
days' prior written notice to DENTAL VENDOR of the addition or termination of any Participating Dentists. Any new Participating Dentist will complete and submit a credentialing application (unless he/she is already credentialed by DENTAL VENDOR).

3.10 SuspensionofParticipatingDentists. The Practice shall suspend any Participating Dentist from providing Covered Services to Enrollees in the following circumstances and shall concurrently notify DENTAL VENDOR of such action: (a) Participating Dentist ceases to meet the licensing/certification or credentialing requirements or other professional standards described in this Agreement; (b) the Practice reasonably determines that there are serious deficiencies in the professional competence, conduct or quality of care of Participating Dentist; (c) Participating Dentist makes material omissions, misrepresentations, or falsifications in his/her application, credential attestation, claims, referral requests, or other submissions to DENTAL VENDOR; or (d) Participating Dentist submits fraudulent billing or claims information to DENTAL VENDOR, Enrollees or Enrollee's secondary insurance carriers.

3.11 DentalRecords. The Practice shall maintain adequate medical, financial and administrative records related to Covered Services in a manner consistent with the standards in the community and in accordance with all applicable State and Federal Law. Any such records shall be maintained for a period of at least six years or such longer period as is required by applicable law. Upon request, the Practice shall provide to DENTAL VENDOR, at the Practice's expense, copies of such information and records. The Practice will obtain any Enrollee consent required to authorize the Practice to provide access to such information and records.

3.12 Insurance. The Practice shall maintain throughout the term of this Agreement and for a period of four years thereafter, insurance, at a minimum, of the types and in the amounts as follows: (a) professional liability insurance in the amount of $1,000,000 per occurrence and $3,000,000 annual aggregate unless the particular state in which the Practice is located has set a lower minimum requirement (in which case the lower minimum requirement

would apply), and (b) general liability insurance in the amount of $1,000,000 per occurrence, combined single limit, bodily injury and property damage. Professional liability insurance shall either be occurrence or claims made with an extended period reporting option. The Practice shall ensure that all Participating Dentists procure and maintain insurance in the amounts set forth above, unless they are covered under the Practice's insurance policies. Prior to the Commencement Date and upon each policy renewal thereafter, the Practice will submit a certificate of insurance to DENTAL VENDOR. The Practice shall provide DENTAL VENDOR 30 days' prior written notice of cancellation or material reduction in the insurance coverage specified in this Section.

3.13 ContinuityofCare. The Practice shall furnish Covered Services in a manner providing continuity of care and ready referral of patients to other care providers at times as may be appropriate and consistent with standards of care in the community and applicable State or Federal Law. If the Practice cannot provide Covered Services relating to endodontics, periodontics, oral surgery, orthodontics and pedodontics, the Practice shall refer Enrollees in need of such services to providers who are qualified to provide such services. If an Enrollee requires additional services or evaluation, the Practice will refer Enrollee to his/her primary care physician or to the emergency room.

3.14 Non-CoveredServices. Should the Practice provide services that are not Covered Services to Enrollees, then the Practice agrees to (a) disclose to Enrollee that such services are not Covered Services, (b) inform the Enrollee of the fees or additional amounts Enrollee will be required to pay, and (c) look solely to the Enrollee for payment for such non-Covered Services.

3.15 InspectionandAudit. The Practice and Participating Dentists shall provide access at reasonable times upon demand by DENTAL VENDOR and/or Governmental Agencies to periodically audit or inspect the facilities, offices, equipment, books, documents and records of the Practice and Participating Dentists relating to the performance of this Agreement and the Covered Services provided to Enrollees. The Practice and Participating Dentists shall comply with any requirements or directives issued by DENTAL VENDOR and Government Agencies as a result of such evaluation, inspection or audit of the Practice and Participating Dentists. The provisions of this Section shall survive termination of this Agreement.

3.16 AppealsandGrievances. The Practice and the Participating Dentists shall participate and cooperate with DENTAL VENDOR and/or Payor in appeals and grievance activities.

ARTICLE 4. DUTIES OF DENTAL VENDOR AND PAYORS

4.1 PaymentofClaims. As described further in Article 5 below, Payors will pay the Practice for rendering Covered Services to Enrollees.

4.2 Administration. DENTAL VENDOR shall perform certain administrative, accounting, enrollment, eligibility verification, credentialing, quality management, utilization management, and other functions necessary for the administration and

operation of the Dental Plans. Payor shall be solely responsible for interpreting the terms of and making final coverage determinations under each Dental Plan.

4.3 Compliance. DENTAL VENDOR will perform all its obligations hereunder in compliance with applicable State and Federal Law, and will maintain such licensure, registration and permits necessary to lawfully perform this Agreement.

ARTICLE 5. PROCESSING AND PAYMENT OF CLAIMS

5.1 ClaimSubmission. The Practice shall submit all claims for Covered Services to DENTAL VENDOR in accordance with the Protocols, the Dental Practitioner Agreement, and applicable State and Federal Law. If the Practice does not submit claims electronically, the Practice shall submit only the CMS-1500 form, Standard ADA Claim Form, or other form permitted by DENTAL VENDOR. All claims must be submitted no later than 90 calendar days from the date Covered Services were provided to the Enrollee, unless otherwise specified by applicable law.

5.2 PaymentforCoveredServices. Payor will pay complete, valid claims for Covered Services at the lower of (a) the billed charges or (b) the Fee Schedule Amount less any applicable Enrollee Expenses, within the applicable time frames allowed for such payment under State and Federal Law. Payment will not be made if the Practice does not comply with a Protocol or does not file a timely claim under Section 5.1 above. Notwithstanding anything to the contrary, DENTAL VENDOR reserves the right, upon review of a claim, to recommend an alternate benefit and pay the claim up to the Fee Schedule Amount for that alternate benefit in lieu of paying
the claim as submitted.

5.3 CollectionofEnrolleeExpenses. The Practice shall collect Enrollee Expenses as set forth in the Dental Practitioner Manual or the Protocols, and will not charge or attempt to collect from Enrollees any amount in excess of the permitted Enrollee Expenses, except for Additional Services or uncovered services.

5.4 Payment in Full. The Practice agrees to accept the payment under this Article 5 and any Enrollee Expenses as payment in full for Covered Services. The Practice will not seek to recover, and will not accept any payment from Enrollee, DENTAL VENDOR, Payor or anyone acting on their behalf, in excess of payment in full as provided in this paragraph. The Practice shall not bill Enrollees for charges not paid due to inappropriate or inaccurate billing, or the Practice's failure to comply with Protocols, the Dental Practitioner Manual and/or this Agreement.

5.5 PaymentCorrections. Payor shall have the right to make, and the Practice shall have the right to request, corrective adjustments to a previous payment, except the Practice may not seek correction of a payment more than 12 months after it was made. In the event of an overpayment by Payor or other amount owed by the Practice to Payor, Payor may correct such overpayments or amounts owed by adjusting future claim payment to the extent permitted by applicable State and Federal Law and/or billing the Practice for the amount of the overpayment or amounts owed.

5.6 CapitationPlans. Terms and conditions specific to Capitation Plans (as defined in Exhibit D) are set forth in Exhibit D, attached hereto and incorporated herein by reference. To the extent that the terms and conditions of Exhibit D conflict with the terms and conditions of this Agreement, Exhibit D shall control.

5.7 NoBillingofEnrollees. With the exception of Enrollee Expenses and appropriate charges for non-Covered Services, the Practice shall in no event, including, without limitation, non-payment by Payor, insolvency of DENTAL VENDOR or breach of this Agreement, bill, charge, collect a deposit from, or attempt to bill, charge, collect or receive any form of payment from any Enrollee for Covered Services. The Practice agrees that this provision supersedes any oral or written agreement to the contrary now existing or hereafter entered into between the Practice and Enrollee or persons acting on the Enrollee's behalf that requires the Enrollee to pay for Covered Services. The Practice's obligations under this Section shall survive the termination of this Agreement for any reason with respect to Covered Services provided during or after the term of this Agreement.

ARTICLE 6. TERM AND TERMINATION

6.1 Term. This Agreement shall take effect on the Commencement Date and continue for an initial term of one year. Thereafter, this Agreement shall automatically renew for successive one-year terms, until terminated pursuant to Section 6.2.

6.2 Termination. This Agreement or a Participating Dentist, as appropriate, may be terminated

(a) The Agreement may be terminated by mutual written agreement of the parties.

(b) The Agreement may be terminated by either party, upon 30 days detailed written notice of a material breach of this Agreement by the other party, except that such a termination will not take effect if the breach is cured within 30 days after receipt of such termination notice. A Participating Dentist may be terminated upon a material breach of this Agreement by the Participating Dentist that is not cured within 30 days after DENTAL VENDOR provided notice of the breach.

(c) This Agreement may be terminated by DENTAL VENDOR immediately upon written notice to the Practice due to the Practice's loss, relinquishment, suspension, restriction or other adverse action against its license; the Practice's failure to maintain the insurance required hereunder; or if DENTAL VENDOR determines in its sole discretion that the health or safety of any Enrollee(s) is endangered by the actions of the Practice or any Participating Dentist or as a result of continuation of this Agreement. A
Participating Dentist may be terminated upon the loss, suspension, revocation, condition, limitation, qualification or other material restriction on Participating Dentist's licenses, certifications and permits by any Government Agency, or upon the failure of Participating Dentist to maintain the insurance required hereunder.

(d) This Agreement may be terminated by either party, without cause, by providing the other party with at least 90 days' prior written notice.

(e) A Participating Dentist may be terminated if such Participating Dentist does not meet DENTAL VENDOR credentialing or re-credentialing criteria, or DENTAL VENDOR may, in its sole discretion, terminate the Agreement.

(f) A Participating Dentist may be terminated upon an indictment, arrest or conviction for a felony, or for any criminal charge related to the practice of Participating Dentist's profession, or DENTAL VENDOR may, in its sole discretion, terminate the Agreement.

(g) This Agreement may be terminated upon imposition of any sanction by any Government Agency against the Practice.

(h) DENTAL VENDOR may terminate this Agreement in the following circumstances: (a) The Practice ceases to meet the licensing/certification or credentialing requirements or other professional standards described in this Agreement; (b) DENTAL VENDOR reasonably determines that there are serious deficiencies in the professional competence, conduct or quality of care of the Practice; (c) the Practice makes material omissions, misrepresentations, or falsifications in its application, credentialing attestation, claims, referral requests, or other submissions to DENTAL VENDOR; or (d) the Practice submits fraudulent billing or claims information to DENTAL VENDOR, Enrollees or Enrollee's secondary insurance carriers.

6.3 OngoingServices. Upon expiration or termination of this Agreement for any reason, except termination under paragraph 6.2(c) above, the Practice shall complete any Covered Services for Enrollees started prior to the date of such termination under the terms hereof. The Practice shall not be obligated to continue providing Covered Services to any Enrollee longer than 30 days from the effective date of termination, or as proscribed by applicable State or Federal Law. The provisions of this Section shall survive termination of this Agreement.

6.4 TransferofDentalRecords. Following expiration or termination of this Agreement for any reason, at DENTAL VENDOR's request, the Practice shall copy all requested Enrollee dental files and forward such files to another provider selected by Enrollee or DENTAL VENDOR, as appropriate, provided such copying and forwarding is not otherwise objected to by such Enrollees. The cost of copying the Enrollee dental files shall be borne equally by the Practice and DENTAL VENDOR.

ARTICLE 7. DISPUTE RESOLUTION

DENTAL VENDOR and the Practice will work together in good faith to resolve any disputes about their business relationship, including, but not limited to, all questions of arbitrability, the validity, scope or termination of this Agreement or any term hereof. If the parties are unable to resolve any such dispute within 60 days following the date one party sent written notice of the dispute to the other party, and if either party wishes to pursue the dispute it shall submit it to binding arbitration in accordance with the Commercial Dispute Procedures of the American Arbitration Association, as they may be amended from time to time. In no event may arbitration be initiated (or the dispute pursued in any other forum) more than one year following the sending of written notice of the dispute.

Any arbitration proceeding under this Agreement shall be conducted in such location as the parties may mutually agree. The arbitrator(s) may construe or interpret but shall not vary or ignore the terms of this Agreement and shall be bound by controlling law. The arbitrator(s) shall have no authority to award any punitive, indirect, special or exemplary damages, except in connection with a statutory claim that explicitly provides for such relief. The parties expressly

intend that any dispute between the parties be resolved on an individual basis so that no other dispute with any third party(ies) may be consolidated or joined with the dispute between the parties. The parties agree that any arbitration ruling allowing class arbitration or requiring consolidated arbitration would be contrary to the intent of this Agreement and would require immediate judicial review of such ruling.

If the dispute pertains to a matter that is generally administered by certain DENTAL VENDOR Protocols, such as claims payment, credentialing or quality improvement plan, the applicable procedures must be fully exhausted by the Practice before the Practice may invoke the right to arbitration under this Article.

The decision of the arbitrator(s) on the points in dispute will be binding, and judgment on the award may be entered in any court having jurisdiction thereof. The parties acknowledge that because this Agreement affects interstate commerce, the Federal Arbitration Act applies. In the event that any court determines this arbitration procedure is not binding or otherwise allows any litigation of a dispute to go forward notwithstanding the terms of this Agreement, the parties hereby waive any and all rights to a trial by jury, and such litigation would proceed with the judge as the finder of fact.

This Article is intended to govern any dispute between DENTAL VENDOR and the Practice regardless of whether the dispute arose before or after execution of this Agreement and shall survive and govern any termination of this Agreement.

ARTICLE 8. GENERAL PROVISIONS

8.1 IndependentContractor. The sole relationship between the parties is an independent contractor relationship. This Agreement does not create a joint venture, partnership agency, employment or other relationship between the parties.

8.2 Indemnification. The Practice shall defend, indemnify and hold harmless, and shall cause each Participating Dentist to defend, indemnify and hold harmless DENTAL VENDOR and its directors, officers, employees, affiliates and agents against any claim, loss, damage, cost, expense or liability arising out of or related to the performance or nonperformance by the Practice or Participating Dentists or their respective employees or agents of any Covered Services and any other services to be performed or arranged by the Practice and Participating Dentists under this Agreement. DENTAL VENDOR shall defend, indemnify and hold harmless the Practice and its directors, officers, employees, affiliates and agents against any claim, loss, damage, cost, expense or liability arising out of or related to the performance or nonperformance by DENTAL VENDOR, its employees or agents of any services to be performed by DENTAL VENDOR under this Agreement.

8.3 Dentist-EnrolleeRelationship. Nothing contained in this Agreement is intended to interfere with the dentist- patient relationship between the Practice and the Enrollees or to discourage the Practice and Participating Dentists from discussing treatment options or providing other medical advice or treatment deemed appropriate by the Practice or Participating Dentists. The Practice and Participating Dentists shall have the sole responsibility for the dental care and treatment of Enrollees.

8.4 Notice. All notices required or permitted by this Agreement shall be in writing, electronic and may be delivered in person, sent by U.S. First-Class Mail, delivered by Federal Express or other overnight courier. The addresses specified on the signature page of this Agreement shall be the party's address for notice purposes, which the parties may change through written notice in compliance with this Section.

8.5 Assignment. This Agreement may not be assigned by either party without the written consent of the other party, except that DENTAL VENDOR may assign this Agreement and its rights, interests and benefits hereunder to: (a) any entity controlling, controlled by or under common control with DENTAL VENDOR; or (b) any purchaser of all or substantially all of DENTAL VENDOR's business, in each case without the Practice's prior written consent.

8.6 Delegation. DENTAL VENDOR may delegate certain administrative duties under this Agreement to one or more other entities. No such delegation will relieve DENTAL VENDOR of its obligations under this Agreement.

8.7 Amendment. DENTAL VENDOR may amend this Agreement by sending a copy of the amendment (via regular first-class U.S. Mail) to the Practice at least 30 days prior to its effective date, so long as there is no written objection submitted by the Practice. The signature of the Practice will not be required. DENTAL VENDOR may also amend this Agreement to maintain compliance with State and Federal Law or comply with the requirements of Government Agencies and shall give written notice to the Practice of such amendment and its effective date. Unless such Government Agencies direct otherwise, the signature of the Practice will not be required.

8.8 Confidentiality. Neither party will disclose to a Enrollee, other dental care providers, or other third parties any of the following information (except as required by a Government Agency): (a) any proprietary business information, not available to the general public, obtained by the party from the other party; or (b) the specific Fee Schedule Amounts, except for purposes of administration of benefits as authorized by DENTAL VENDOR.

Each party shall maintain the confidentiality of all Enrollee records in accordance with any applicable State and Federal Law, including, but not limited to those promulgated under the Health Insurance Portability and Accountability Act of 1996, the Gramm-Leach-Bliley Act, and any state laws implementing either, as applicable. The Practice shall maintain all protected health information or personally identifiable information obtained pursuant to this Agreement at a secure environment under its control, and shall take reasonable steps to safeguard this information and to prevent disclosure to third parties without the express written authorization of Enrollee (unless such disclosure is required to comply with State and Federal Law).

8.9 Use of Names During the term of this Agreement, the Practice and DENTAL VENDOR shall have the right to use each other's name solely to make public reference to the Practice as a member of DENTAL VENDOR's provider network. The Practice shall not otherwise use DENTAL VENDOR's name, product names, logos and service marks without prior written approval. Neither party shall slander or libel the other party, either during the term of the Agreement or thereafter, and this provision shall survive the termination of this Agreement.

8.10 Non-Solicitation. During the term of this Agreement and for one year thereafter, neither the Practice nor Participating Dentists shall directly or indirectly solicit Enrollees, subscribers or subscriber groups to disenroll from any Dental Plan or discontinue their relationship with DENTAL VENDOR. Notwithstanding Article 7, DENTAL VENDOR shall, in addition to any other available remedies, have the right to seek an injunction or other equitable relief against the Practice and/or Participating Dentists to enforce its rights under this Section.

8.11 Severability. The unenforceability or invalidity of any paragraph or subparagraph of any section or subsection of this Agreement shall not affect the enforceability and validity of the balance of this Agreement.

8.12 Captions. Captions in this Agreement are descriptive only and do not affect the intent or interpretation of the Agreement.

8.13 Waiver. The waiver by either party of a breach of any provision of this Agreement shall not operate as or be construed to be a waiver of any subsequent breach of the same or any other provision hereof.

8.14 No Third Party Beneficiaries. This Agreement shall not create any rights in any third parties who have not entered into this Agreement, nor shall this Agreement entitle any such third party to enforce any rights or obligations that may be possessed by such third party.

8.15 EntireAgreement. This Agreement, including all exhibits, which are incorporated herein by reference, is the entire agreement of the parties regarding the subject matter herein, and supersedes any prior written or oral agreements, promises, negotiations or representations of or between the parties.

8.16 Unique Relationship. The parties agree that the relationship established through this Agreement is unique and specific to them. Consequently, any disputes that may arise between the parties relative to this Agreement shall be resolved exclusively between them pursuant to Section 8, Resolution of Disputes, of this Agreement.

8.17 DataOwnership. The Practice acknowledges and agrees that all information contained in submitted claims is the property of DENTAL VENDOR.

8.18 MedicarePatients. If a Medicare Appendix is attached to this Agreement as Exhibit E, the Practice agrees to provide Covered Services under this Agreement, to Patients who are enrolled in a Dental Plan for Medicare beneficiaries and to cooperate and comply with the provisions set forth in the attached Medicare Advantage Addendum. The Practice also

understands that DENTAL VENDOR's agreement with the Practice is subject to review and approval by the Centers for Medicare and Medicaid Services.

8.19 MedicaidPatients. If a Medicaid Appendix is attached to this Agreement as Exhibit E-1, the Practice agrees to provide Covered Services to Patients enrolled in a Dental Plan for Medicaid recipients and to comply with any additional requirements set forth in the Medicaid Appendix.

8.20 Dissolution. Subject to Section 6.3 of this Agreement, in the event of the dissolution of the Plan, the Practice agrees to continue to treat Patients within the compensation limitations of this Agreement for the conditions under treatment at the time of dissolution. This obligation to continue treatment under the payment terms of this Agreement does not require that long-term, nonrestorative therapies be completed if such non- completion would not constitute abandonment of the Patient.

8.21 Removal of the Practice. The Practice is hereby informed that Payors, DENTAL VENDOR's clients and third parties, including a Payor, with whom DENTAL VENDOR is contracting have the right to request removal of the Practice from the Provider Panel servicing its Enrollees. The Practice shall have no legal entitlement to continue treating such Enrollees. Removal of the Practice by DENTAL VENDOR from participating on specified Provider Panels shall not constitute termination or breach of this Agreement.

8.22 Lease of Provider Network and Claims Re-Pricing. DENTAL VENDOR shall be permitted to lease or rent its provider network to third parties and affiliated entities and shall be permitted to enter into claims re-pricing agreements with third parties without the Practice's consent.

ARTICLE 9. GOVERNING LAW AND REGULATORY REQUIREMENTS

9.1 GoverningLaw. This Agreement shall be governed by and construed in accordance with the law of the state in which the Practice renders Covered Services.

9.2 RegulatoryAddenda. One or more regulatory addenda may be attached to this Agreement as Exhibit C, setting forth additional provisions to satisfy regulatory requirements under applicable law. These regulatory addenda and any attachments thereto, are expressly incorporated into this Agreement. In the event of any inconsistency between a regulatory addendum and any other part of this Agreement, including but not limited to attachments, amendments, and exhibits, the provisions of the regulatory addenda will control to the extent it is applicable.

ARTICLE 10. REPRESENTATIONS AND WARRANTIES

The Practice, by virtue of its execution and delivery of this Agreement, represents and warrants that, at all times during the terms of this Agreement, is a duly organized and validly existing legal entity in good standing under the laws of its jurisdiction of organization; it has the unqualified authority to bind, and does bind, itself and the Participating Dentists to all of the terms and conditions of this Agreement, including any Appendices, Attachments and Exhibits, as applicable; has obtained and holds all registrations, permits, licenses, and other approvals and consents, and has made all filings, that it is required to obtain from or make with all Government Agencies

under applicable State and Federal Law in order to conduct its business as presently conducted and to enter into and perform its obligations under this Agreement; and each submission of a claim by the Practice pursuant to this Agreement shall be deemed to constitute the representation and warranty by it to DENTAL VENDOR that (i) the representations and warranties of it set forth in this Article and elsewhere in this Agreement are true and correct as of the date the claim is submitted, (ii) it has complied with the requirements of this Agreement with respect to the Covered Services involved and the submission of the claim submitted claim, and (iii) the claim is a valid claim.

THIS AGREEMENT CONTAINS A BINDING ARBITRATION PROVISION THAT MAY BE ENFORCED BY THE PARTIES.

[signatures on following page]

IN WITNESS WHEREOF, the parties hereto have executed this Agreement as of the Commencement Date.

DENTAL VENDOR, INC.

XXXX Address

Signed: _____

Print Name: _____

Print Title: _____

Date: _____

THE PRACTICE

Signed:

Print Name: _____

_____

Print Title: _____

Date: _____

Address: _____

City: _____

EXHIBIT A

PPO/MAC/INO/EPO FEE SCHEDULES (IF APPLICABLE)

EXHIBIT B

DISCOUNT AND REFERRAL FEE SCHEDULES

(IF APPLICABLE)

EXHIBIT C

STATE-SPECIFIC REGULATORY ADDENDUM

(IF APPLICABLE)

EXHIBIT D

CAPITATION PLAN ADDENDUM (IF APPLICABLE)

This Addendum and the relevant Attachments are only applicable to Capitation Plans, but not to preferred provider organization, indemnity or discount fee-for-service plans.

1 Definitions.

A. Capitation. The predetermined per Enrollee fee paid monthly by DENTAL VENDOR to the Practice as set forth in the Capitation Payment Schedule (Attachment 1) for providing Covered Services as prescribed in the Fee Schedules.

B. CapitationFeeSchedules. The listings of Covered Services which describe the services to be delivered to Enrollees of Capitation Plans designated by Payor (Attachment 2).

C. CapitationPlans. Those service contracts for which DENTAL VENDOR shall pay the Practice a Capitation amount in addition to any fees due to the Practice as listed on the appropriate Capitation Fee Schedule.

2 For Capitation Plans, services that do not require a payment from DENTAL VENDOR shall be reported on a Standard ADA Claim Form, utilizing appropriate coding as described in the Dental Practitioner Manual. All services for which a fee is due from DENTAL VENDOR shall be reported on a Standard ADA Form.
All forms shall be completed and submitted to DENTAL VENDOR no less frequently than once a month.

3 For Capitation Plans, DENTAL VENDOR shall pay the Practice a monthly Capitation amount based on the
number of Enrollees who have elected to be treated at the Practice's site as of the first day of that month. The Practice agrees not to charge or collect from any Enrollee any amount whatsoever for services listed as "no charge" on the attached fee schedules. The Practice is solely responsible for collecting from Enrollees the fees according to the attached fee schedules and in no event seek to collect such fees from DENTAL VENDOR unless the plan design specifically provides for DENTAL VENDOR payments. The Practice is responsible for collecting all fees for services not specifically listed on the appropriate Capitation Fee Schedules.

ATTACHMENT D-1

CAPITATION/DHMO REIMBURSEMENT SCHEDULES (IF APPLICABLE)

EXHIBIT E-1

MEDICAID ADDENDUM

(IF APPLICABLE)

EXHIBIT F

(SEE EXHIBIT F IN

PACKET)

EXHIBIT G

NAMES AND ADDRESSES OF ADDITIONAL DENTAL OFFICES OR PARTICIPATING DENTISTS

Instructions: Include below the address and telephone number of the Practice's dental offices and/or Participating Dentists as it should appear in DENTAL VENDOR's or Payor's Provider Directory.
Additionalsheetsmay be attached if necessary

Address 1		**Participating Dentist(s) Who Should be at** locations, simply list once and indicate "all" next to their name)
Street		
City, State Zip		
Phone #		
Fax		
Office Hours		
Handicapped Accessible?		
Languages Spoken?		
Address 2		**Participating Dentist(s) Who Should be Listed at this Location**
Street		
City, State Zip		
Phone #:		
Fax:		
Office Hours		
Handicapped Accessible?		
Languages Spoken?		
Address 3		**Participating Dentist(s) Who Should be Listed at this Location**
Street		
City, State Zip		
Phone #:		
Fax:		
Office Hours		
Handicapped Accessible?		
Languages Spoken?		

Dental Vendor
Mississippi Medicaid Program
Regulatory Requirements Appendix

MISSISSIPPI MEDICAID PROGRAM

REGULATORY REQUIREMENTS APPENDIX

DOWNSTREAM PROVIDER

THIS MISSISSIPPI MEDICAID PROGRAM REGULATORY REQUIREMENTS APPENDIX (this "Appendix") supplements and is made part of the provider agreement (the "Agreement") between Vendor, ("Subcontractor") and the provider named in the Agreement ("Provider").

SECTION 1
APPLICABILITY

This Appendix applies with respect to the provision of health care services that Provider provides directly to Covered Persons through Health Plan's (as defined herein) products or benefit plans including Mississippi Coordinated Access Network Program (the "MississippiCAN Program") as governed by the State's designated regulatory agencies. Provider has agreed to provide Covered Services to Covered Persons who receive their coverage pursuant to a contract between the State and Health Plan (the "State Contract" as defined herein). The State Contract and applicable State and federal law require that the provisions contained in this Appendix be part of the Agreement. In the event of a conflict between this Appendix and other appendices or any provision of the Agreement, the provisions of this Appendix shall control except with regard to benefit contracts outside the scope of this Appendix or unless otherwise required by law. In the event Subcontractor is required to amend or supplement this Appendix as required or requested by the State and requested by Health Plan, Provider agrees that Subcontractor shall be permitted to unilaterally initiate such additions, deletions or modifications.

SECTION 2
DEFINITIONS

Unless otherwise defined in this Appendix, all capitalized terms shall be as defined in the Agreement. For purposes of this Appendix, the following terms shall have the meanings set forth below; provided, however, in the event any definition set forth in this Appendix or the Agreement is inconsistent with any definitions under the MississippiCAN Program, the definitions shall have the meaning set forth under the MississippiCAN Program.

2.1 Action: Health Plan's decision to deny or limit authorization or payment (in whole or in part) for health care services, including new authorizations and previously authorized services; the reduction, suspension, or termination of a previously authorized service; or Health Plan's failure to provide services in a timely manner; failure to resolve Complaints, Grievances, or Appeals within the specified time frames.

2.2 Appeal: A request for review by Health Plan of an Action related to a Covered Person or Provider. In the case of a Covered Person, an Action may include determinations on the health care services a Covered Person believes he or she is entitled to receive, including delay in providing, arranging for, or approving the health care services (such that a delay would adversely

affect the health of the Covered Person). In the case of a Provider, the Action may include, but is not limited to, delay or non-payment for covered services.

2.3 Behavioral Health Services: Mental health and/or drug and alcohol abuse treatment services that are provided by the county mental health/mental retardation programs, the single county authority administrators, or other appropriately licensed health care practitioners.

2.4 Complaint: An expression of dissatisfaction received orally or in writing that is of a less serious or formal nature that is resolved within one (1) business day of receipt.

2.5 Covered Person: An individual who is currently enrolled with Health Plan for the provision of services under a MississippiCAN Program. A Covered Person may also be referred to as an Enrollee, Member or Customer under the Agreement.

2.6 Covered Services: Health care services or products for which a Covered Person is enrolled with Health Plan to receive coverage under the State Contract.

2.7 Division: Division of Medicaid, Office of the Governor, State of Mississippi.

2.8 Early, Periodic, Screening, Diagnosis, and Treatment (EPSDT) Services: Defined by the Division to include:

a. Age appropriate, comprehensive health and development history that includes physician and mental health assessments along with counseling and anticipatory guidance and risk factor reduction interventions;
b. Calculation of Body Mass Index;
c. Growth measurements and head circumference;
d. Nutritional counseling;
e. Developmental surveillance and Developmental and autism Spectrum Disorders Screenings as appropriate;
f. Comprehensive unclothed exam;
g. Appropriate laboratory tests (including blood level assessment appropriate to age and risk);
h. Appropriate immunizations in accordance with Recommended Childhood and Adolescent Immunization Schedule adopted by the Division;
i. A vision assessment;
j. A hearing assessment;
k. A dental screening and/or referral to dental care;
l. Health education; and
m. Referrals for identified abnormalities.

2.9 Fraud and Abuse: Fraud is any type of intentional deception or misrepresentation made by an entity or person with the knowledge that the deception could result in some unauthorized benefit to the entity, him or herself, or some other person. The Fraud can be committed by many entities, including a vendor, a subcontractor, a provider, a State employee, or a Covered Person, among others. Abuse is any practice that is inconsistent with sound fiscal, business, or medical practices, and results in an unnecessary cost to the Medicaid program, a vendor, a subcontractor

or Provider or in reimbursement for services that are not Medically Necessary or that fail to meet professionally recognized standards for health care.

2.10 Grievance: An expression of dissatisfaction about any matter or aspect of Health Plan or its operation, other than an Action as defined herein.

2.11 Health Plan: An appropriately licensed entity that has entered into a contract with Subcontractor, either directly or indirectly, under which Subcontractor provides certain administrative services for Health Plan pursuant to the State Contract. For purposes of this Appendix, Health Plan refers to Vendor of Mississippi, Inc.

2.12 Marketing: The activities that promote visibility and awareness for the MississippiCAN Program and Health Plan's participating in the program. All activities are subject to prior review and approval by the Division.

2.13 Medical Record: A single complete record, which documents the entire treatment plan developed for, and medical services received by, the Covered Person including inpatient, outpatient, referral services and emergency medical services whether provided by contracted Providers or non-contracted providers.

2.14 Mississippi Coordinated Access Network (MississippiCAN) Program: Mississippi Medicaid's coordinated care program.

2.15 Primary Care Provider (PCP): Any physician or health care practitioner or group operating within the scope of his or her licensure who is responsible for supervising, prescribing and providing primary care and primary case management services in the MississippiCAN Program, whose practice is limited to the general practice of medicine or who is an Internist, Pediatrician, Obstetrician, Gynecologist, Family Practitioner, General Practitioner, Certified Nurse Practitioners whose specialty is pediatrics, adult, family, certified nurse midwife, obstetrics/gynecology, or a physician assistant.

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

2.17 Provider: A hospital, ancillary provider, physician group, individual physician or other healthcare provider who has entered into an Agreement.

2.18 Provider Network: The Panel of health service Providers with which Subcontractor and/or Health Plan contracts for the provision of covered services to Covered Persons and Non-Contracted Providers administering services to Covered Persons.

2.19 State: The State of Mississippi or its designated regulatory agencies.

2.20 State Contract: Health Plan's contract with the State for the purpose of providing and paying for Covered Services to Covered Persons enrolled in the MississippiCAN Program.

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

SECTION 3
PROVIDER REQUIREMENTS

The MississippiCAN Program, through the State Contract and federal and State statutes and regulations, requires the Agreement to contain certain conditions that Health Plan, Subcontractor and Provider agree to undertake, which include the following:

3.1 Definitions Related to the Provision of Covered Services. Provider shall follow the applicable State Contract's requirements for the provision of Covered Services. Provider's decisions affecting the delivery of acute or chronic care services to Covered Persons shall be made on an individualized basis and in accordance with the following definitions:

(a) Emergency Medical Condition: A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in any of the following: (1) 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; (2) serious impairment to body functions; or (3) serious dysfunction of any body organ or part.

(b) Emergency Services: Covered inpatient and outpatient services furnished by a provider qualified to furnish those health services and that are needed to evaluate or stabilize an Emergency Medical Condition.

(c) Medically Necessary Services: As set forth in the Social Security Act, Section 1905 (42 USC 1396d(a)), Medically Necessary Services are defined as services, supplies, or equipment provided by a licensed health care professional that are:

a. Appropriate and consistent with the diagnosis or treatment of the Covered Person's condition, illness, or injury;

b. In accordance with the standards of good medical practice consistent with the individual Covered Person's condition(s);

c. Not primarily for the personal comfort or convenience of the Member, family, or Provider;

d. The most appropriate services, supplies, equipment, or levels of care that can be safely and efficiently provided to the Covered Person;

e. Furnished in a setting appropriate to the Covered Person's medical need and condition and, when applied to the care of an inpatient, further mean that the Covered Person's medical symptoms or conditions require that the services cannot be safely provided to the Covered Person as an outpatient;

f. Not experimental or investigational or for research or education;

g. Provided by an appropriately licensed practitioner; and

h. Documented in the patient's record in a reasonable manner, including the relationship of the diagnosis to the service.

Medically Necessary Services may also be those services for children that are necessary to correct or ameliorate defects and physical and mental illnesses and conditions discovered during an interperiodic or periodic EPSDT screen, whether such services are covered or exceed the benefit limits in the Medicaid State Plan and Title 23 of Mississippi Administrative Code.

3.2 Medicaid Eligibility. Provider must be enrolled in the Mississippi Medicaid program and must use the same National Provider Identifier (NPI) number. Health Plan and Subcontractor will exclude from its network any provider who has been terminated or suspended from the Medicare or Medicaid program in any state.

3.3 Accessibility Standards. Provider shall provide for timely access for Covered Person appointments in accordance with the appointment availability requirements established under the State Contract, as further described in the applicable provider manual.

3.4 Hours of Operation; Appointments. Provider shall offer hours of operation that are no less than the hours of operation offered to commercial beneficiaries or comparable to Medicaid fee-for-service if Provider serves only Medicaid beneficiaries.

3.5 Hold Harmless. Except for any applicable cost-sharing requirements under the State Contract, Provider shall look solely to Subcontractor and Health Plan for payment of Covered Services provided to Covered Persons pursuant to the Agreement and the State Contract and hold the State, the Division, the U.S. Department of Health and Human Services and Covered Persons harmless in the event that Subcontractor and/or Health Plan cannot or will not pay for such Covered Services. In accordance with 42 CFR 447.15, as may be amended from time to time, the Covered Person is not liable to Provider for any services for which Subcontractor and/or Health Plan is liable and as specified under the State's relevant health insurance or managed care statutes, rules or administrative agency guidance. Provider shall not require any copayment or cost sharing for Covered Services provided under the Agreement unless expressly permitted under the State Contract. Provider shall also be prohibited from charging Covered Persons for missed appointments if such practice is prohibited under the State Contract or applicable law. Neither the State, the Division nor Covered Persons shall be in any manner liable for the debts and obligations of Subcontractor and/or Health Plan and under no circumstances shall Subcontractor, Health Plan, or any providers used to deliver services covered under the terms of the State Contract, charge Covered Persons for Covered Services.

Covered Person may be responsible for non-covered item(s) and/or service(s), only if the Provider ensures that written documentation in compliance with the Advance Beneficiary Notification (ABN) is received from the Covered Person that an item(s) or service(s) rendered is a non-covered item and/or service(s) and that the Covered Person will be financially responsible for the item(s) and/or service(s). If Subcontractor and/or Health Plan determines a Covered Person was charged for Covered Services inappropriately, such payment may be recovered, as applicable.

This provision shall survive any termination of the Agreement, including breach of the Agreement due to insolvency.

3.6 Indemnification. To the extent applicable to Provider in performance of the Agreement, Provider shall indemnify, defend and hold the Division and its employees harmless from and against all injuries, deaths, losses, damages, claims, suits, liabilities, judgments, costs and expenses, including court costs and attorney fees, to the extent proximately caused by any negligent act or other intentional misconduct or omission of Provider, its agents, officers, employees or contractors arising from the Agreement. The Division may waive this requirement for public entities if Provider is a state agency or sub-unit as defined by the State or a public health entity with statutory immunity. This clause shall survive the termination of the Agreement for any reason, including breach due to insolvency.

3.7 Provider Selection. To the extent applicable to Provider in performance of the Agreement, Provider shall comply with 42 CFR 438.214, as may be amended from time to time, which includes, but is not limited to the selection and retention of providers, credentialing and recredentialing requirements and nondiscrimination. If Subcontractor and/or Health Plan delegates credentialing to Provider, Subcontractor and Health Plan will provide monitoring and oversight and Provider shall ensure that all licensed medical professionals are credentialed in accordance with Health Plan's and the State Contract's credentialing requirements.

3.8 Restrictions on Referrals. Provider shall not make inappropriate referrals for designated health services to health care entities with which Provider or a member of Provider's family has a financial relationship, pursuant to federal anti-kickback and physician self-referral laws that prohibit such referrals.

3.9 Records Retention. As required under State or federal law or the State Contract, Provider shall maintain an adequate record keeping system for recording services, charges, dates and all other commonly accepted information elements for services rendered to Covered Persons. All financial records shall follow generally accepted accounting principles. Medical records and supporting management systems shall include all pertinent information related to the medical management of each Covered Person. Other records shall be maintained as necessary to clearly reflect all actions taken by Provider related to services provided under the State Contract. Such records shall be maintained for a period of not less than ten (10) years from the close of the Agreement, or such other period as required by law. If records are under review or audit, they must be retained for a minimum of ten (10) years following resolution of such action. Prior

approval for the disposal of records must be requested and approved by Health Plan if the Agreement is continuous.

3.10 Records Access. Provider acknowledges and agrees that the State, the Division, the U.S. Department of Health and Human Services and other authorized federal and state personnel shall have complete access to all records pertaining to services provided to Covered Persons. Provider shall provide immediate access to facilities, records and supportive materials pertinent to the State Contract for State or Federal fraud investigators. Copies of requested documents shall be provided to the State, the Division, the U.S. Department of Health and Human Services and other authorized federal and state personnel or their designees free of charge.

3.11 Government Audit; Investigations. Provider acknowledges and agrees that the State and the U.S. Department of Health and Human Services or their authorized representatives shall have the right to inspect or otherwise evaluate the quality, appropriateness, and timeliness of services provided under the terms of the State Contract and any other applicable rules. There shall be no restrictions on the right of the State or federal government to conduct whatever inspections and audits are necessary to assure quality, appropriateness or timeliness of services provided pursuant to the State Contract and the reasonableness of their costs.

3.12 Privacy; HIPAA. Provider shall comply with all applicable privacy rule and security rule provisions of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), and associated implementing regulations, as may be amended from time to time, and shall safeguard information about Covered Persons in accordance with applicable federal and State privacy laws and rules including 42 CFR 438.224 and 42 CFR Part 431, Subpart F, as may be amended from time to time.

3.13 Compliance with Law. Provider shall comply with all applicable federal and State laws and regulations that pertain to a Covered Person's rights, including but not limited to the following to the extent applicable to Provider in performance of the Agreement:

(a) 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; and Americans with Disabilities Act, and their implementing regulations, as may be amended from time to time.

(b) 42 CFR 434 and 42 CFR 438.6, as may be amended from time to time.

(c) All relevant federal and State statutes, regulations and orders related to equal opportunity in employment, including but not limited to compliance with E.O. 11246, "Equal Employment Opportunity," as amended by E.O. 11375, "Amending Executive Order 11246 Relating to Equal Employment Opportunity," and as supplemented by regulations at 41 CFR part 60, "Office of Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor."

(d) If the Agreement is for an amount in excess of $100,000, Provider shall comply with all applicable standards, orders or regulations issued pursuant to the Clean Air Act,

42 U.S.C. 7401 et seq., and the Federal Water Pollution Control Act, as amended, 33 U.S.C. 1251 et seq. Any violations shall be reported to DHHS and the appropriate Regional Office of the Environmental Protection Agency.

3.14 Physician Incentive Plans. In the event Provider participates in a physician incentive plan ("PIP") under the Agreement, Provider agrees that such PIPs must comply with 42 CFR 417.479, 42 CFR 438.6(h), 42 CFR 422.208, and 42 CFR 422.210, as may be amended from time to time. Subcontractor, Health Plan nor Provider may make a specific payment directly or indirectly under a PIP to a physician or physician group as an inducement to reduce or limit Medically Necessary services furnished to an individual Covered Person. PIPs must not contain provisions that provide incentives, monetary or otherwise, for the withholding of services that meet the definition of Medical Necessity.

3.15 Lobbying. Provider agrees to comply with the following requirements related to lobbying:

(a) Prohibition on Use of Federal Funds for Lobbying: By signing the Agreement, Provider certifies to the best of Provider's knowledge and belief, pursuant to 31 U.S.C. Section 1352 and 45 CFR Part 93, as may be amended from time to time, that no federally appropriated funds have been paid or will be paid to any person by or on Provider's behalf for the purpose of influencing or attempting to influence an officer or employee of any agency, a member of Congress, an officer or employee of Congress, or an employee of a member of Congress in connection with the award of any federal contract, the making of any federal grant, the making of any federal loan, the entering into of any cooperative agreement, or the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan, or cooperative agreement.

(b) Disclosure Form to Report Lobbying: If any funds other than federally appropriated funds have been paid or will be paid to any person for the purpose of influencing or attempting to influence an officer or employee of any agency, a member of Congress, an officer or employee of Congress, or an employee of a member of Congress in connection with the award of any federal contract, the making of any federal grant, the making of any federal loan, the entering into of any cooperative agreement, or the extension, continuation, renewal, amendment or modification of any federal contract, grant, loan, or cooperative agreement and the value of the Agreement exceeds $100,000, Provider shall complete and submit Standard Form-LLL, "Disclosure Form to Report Lobbying," in accordance with its instructions.

3.16 Excluded Individuals and Entities. By signing the Agreement, Provider certifies to the best of Provider's knowledge and belief that neither it nor any of its employees, principals, nor any providers, subcontractors or consultants or persons with an ownership or controlling interest in the Provider (an owner including the Provider himself or herself), or an agent or managing employee of the Provider, with whom Provider contracts and who are providing items or services that are significant and material to Provider's obligations under the Agreement is:

(a) excluded from participation in federal health care programs under either Section 1128 or section 1128A of the Social Security Act; or

(b) debarred, suspended or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in nonprocurement activities under regulations issued under Executive Order no. 12549 or under guidelines implementing Executive Order No. 12549; or an affiliate, as defined in the Federal Acquisition Regulation, of such a person.

Provider acknowledges and agrees that payment will not be made for any items or Covered Services provided by an excluded individual pursuant to 42 CFR 1001.1901(b) and is obligated to screen all employees, contractors, and subcontractors for exclusion as required under applicable State and Federal laws. Additionally, Provider acknowledges that pursuant to 42 CFR 1003.102(a)(2) civil monetary penalties may be imposed against Provider if he or she employs or enters into contracts with excluded individuals or entities to provide items or Covered Services to Covered Persons under this Agreement. Provider agrees not to employ or subcontract with individuals or entities whose owner, those with a controlling interest, or managing employees are on a State or Federal exclusion list to provide items or Covered Services under this Agreement. Provider shall immediately report to Subcontractor and/or Health Plan any exclusion information discovered. Provider can search the HHS-OIG website, at no cost, by the names of any individuals or entities. The database is called LEIE and can be accessed at http://www.oig.hhs.gov/fraud/exclusions.asp. The GSA EPLS/SAM database can be accessed at https://www.sam.gov. Applicable state exclusion databases can be accessed through the State's Medicaid website. Subcontractor and Health Plan will terminate the Agreement immediately and exclude from its network any provider who has been excluded from federal health care programs or terminated from the Medicare or the Medicaid program in any state. Subcontractor and Health Plan may also terminate the Agreement if Provider's owners, agents, or managing employees are found to be excluded on a State or Federal exclusion list.

3.17 Disclosure. Provider shall cooperate with Subcontractor and Health Plan in disclosing information the Division may require related to ownership and control, significant business transactions, and persons convicted of crimes in accordance with 42 CFR Part 455 and shall provide information upon request. Provider shall submit information related to ownership and control of subcontractors or wholly owned suppliers within thirty-five (35) calendar days of a request for such information.

By executing this Agreement, Provider certifies that neither Provider nor any of its principals is presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in any State or federal health care program or from participating in transactions by any State or federal department or agency. Subcontractor and/or Health Plan will terminate the Agreement upon becoming aware or receiving notice from the Division, whichever is earlier, that Provider is or has been excluded from participation in any State or federal health care program or by any State or federal agency.

3.18 Cultural Competency. Provider shall participate in Subcontractor and Health Plan's and the State's efforts to promote the delivery of services in a culturally competent manner to all

Covered Persons, including those with limited English proficiency and diverse cultural and ethnic backgrounds and shall provide interpreter services in a Covered Person's primary language and for the hearing impaired for all appointments and emergency services. Provider shall provide information to Covered Persons regarding treatment options and alternatives, as well as information on complaints and appeals, in a manner appropriate to the Covered Person's condition and ability to understand.

3.19 Marketing. As required under State or federal law or the applicable State Contract, any marketing materials developed and distributed by Provider as related to the performance of the Agreement must be submitted to Health Plan to submit to the Division for prior approval.

3.20 Fraud, Waste and Abuse Prevention. Provider shall cooperate fully with Subcontractor and Health Plan's policies and procedures designed to protect program integrity and prevent and detect potential or suspected fraud, waste, and abuse in the administration and delivery of services under the State Contract and shall cooperate and assist the Division and any other State or federal agency charged with the duty of preventing, identifying, investigating, sanctioning or prosecuting suspected fraud, waste, and abuse in state and/or federal health care programs.

In accordance with Health Plan's policies and the Deficit Reduction Act of 2005 (DRA), Provider shall have written policies for its employees, contractors or agents that: (a) provide detailed information about the federal False Claims Act (established under sections 3729 through 3733 of title 31, United States Code); (b) cite administrative remedies for false claims and statements (established under chapter 38 of title 31, United States Code) and whistleblower protections under federal and state laws; (c) reference state laws pertaining to civil or criminal penalties for false claims and statements; and (d) with respect to the role of such laws in preventing and detecting fraud, waste, and abuse in federal health care programs (as defined in section 1128B(f)), include as part of such written policies, detailed provisions regarding Provider's policies and procedures for detecting and preventing fraud, waste, and abuse. Provider agrees to train its staff on the aforesaid policies and procedures.

3.21 Data; Reports. Provider shall cooperate with and release to Subcontractor and Health Plan any information necessary for Subcontractor and Health Plan to perform its obligations under the State Contract to the extent applicable to Provider in performance of the Agreement, including the timely submission of reports and information required by Subcontractor and Health Plan. Such reports shall include child health check-up reporting, if applicable, as well as complete and accurate encounter data in accordance with the requirements of Subcontractor and Health Plan and the State.

3.22 Encounter Data. Provider agrees to cooperate with Subcontractor and Health Plan to comply with Subcontractor and Health Plan's obligation to prepare encounter data submissions, reports, and clinical information including, without limitation, child and adolescent health check-up reporting, EPSDT encounters, and cancer screening encounters, as applicable, and such other reporting regarding Covered Services as may be required under the State Contract.

3.23 Claims Information. Provider shall promptly submit to Subcontractor or Health Plan the information needed to make payment and shall identify third party liability coverage, including Medicare and other insurance, and if applicable seek such third party liability payment before submitting claims to Subcontractor or Health Plan. Provider understands and agrees that each claim Provider submits to Subcontractor constitutes a certification that the claim is true and accurate to the best of Provider's knowledge and belief and that the Covered Services are 1) Medically Necessary and 2) have been provided to the Covered Person prior to submitting the claim.

Effective July 1, 2014, Provider must submit claims within six (6) months from the date of service. Claims filed within the appropriate time frame but denied may be resubmitted to the Contractor within ninety (90) calendar days from the date of denial

3.24 Insurance Requirements. As applicable, Provider shall secure and maintain during the term of the Agreement insurance appropriate to the services to be performed under the Agreement.

3.25 Licensure. Provider represents that it is currently licensed and/or certified under applicable State and federal statutes and regulations and by the appropriate State licensing body or standard-setting agency, as applicable. Provider represents that it is in compliance with all applicable State and federal statutory and regulatory requirements of the Medicaid program and that it is eligible to participate in the Medicaid program. Provider represents that it does not have a Medicaid provider agreement with the Division that is terminated, suspended, denied, or not renewed as a result of any action of the Division, CMS, HHS, or the Medicaid Fraud Control Unit of the State's Attorney General. Provider shall maintain at all times throughout the term of the Agreement all necessary licenses, certifications, registrations and permits as are required to provide the health care services and/or other related activities delegated to Provider by Vendor under the Agreement. If at any time during the term of the Agreement, Provider is not properly licensed as described in this Section, Provider shall discontinue providing services to Covered Persons.

3.26 Quality; Utilization Management. Pursuant to any applicable provider manuals and related protocols, or as elsewhere specified under the Agreement, Provider agrees to cooperate with Subcontractor and Health Plan's quality improvement and utilization review and management activities. This shall include, but not be limited to, participation in any internal and external quality assurance, utilization review, peer review, and grievance procedures established by Subcontractor and Health Plan or as required under the State Contract to ensure that Covered Persons have due process for their complaints, grievances, appeals, fair hearings or requests for external review of adverse decisions made by Vendor or Provider. Provider shall adhere to the quality assurance and utilization review standards of the MississippiCAN Program and shall monitor quality and initiate corrective action to improve quality consistent with the generally accepted level of care.

3.27 Non-Discrimination. Covered Persons must be provided Covered Services without regard to race, color, creed, sex, religion, age, national origin, ancestry, marital status, sexual orientation, language, health status, disease or pre-existing condition (including genetic

information), anticipated need for health care or physical or mental handicap, except where medically indicated. Examples of prohibited practices include, but are not limited to, the following:

(a) Denying or not providing a Covered Person any Medicaid Covered Service. Health care and treatment necessary to preserve life must be provided to all Covered Persons who are not terminally ill or permanently unconscious, except where a competent Covered Person objects to such care on his/her own behalf.

(b) Subjecting a Covered Person to segregated, separate, or different treatment, including a different place or time from that provided to other Covered Persons or public or private patients, in any manner related to the receipt of any Medicaid Covered Service, except where Medically Necessary.

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

3.28 Advance Directives. Provider shall comply with the advance directives requirements set forth in the Uniform Health-Care Decisions Act, Section 41-41-215 of the Mississippi Code.

3.29 National Provider ID (NPI). Provider shall obtain a National Provider Identification Number (NPI).

3.30 Termination. In the event of termination of the Agreement, Provider shall promptly supply to Subcontractor and Health Plan all information necessary for the reimbursement of any outstanding Medicaid claims.

3.31 Complaints; Grievances and Appeals. Information on how Provider or Provider's authorized representative can submit complaints and file grievances and appeals, and the resolution process, is contained in the applicable provider manual.

3.32 Health Care Acquired/Preventable Conditions. Provider agrees that no payment shall be made for the provision of medical assistance for health care acquired conditions and other provider preventable conditions as may be identified by the State. As a condition of payment, Provider shall identify and report to Subcontractor any provider preventable conditions in accordance with 42 CFR Part 438, including but not limited to 438.6(f)(2)(i).

3.33 Quality and Utilization Management Program. Provider shall cooperate with Subcontractor and Health Plan in meeting the Quality Management and Utilization Management Program standards outlined in the State Contract.

3.34 Referrals. Provider shall make referrals for social, vocational, education or human services when a need for such service is identified.

3.35 Insolvency. In the event Subcontractor and/or Health Plan becomes insolvent or unable to pay Provider, Provider shall not seek compensation for services rendered from the State, the Division, or their officers, Agents, or employees, or the Covered Persons or their eligible dependents.

3.36 Third Party Resources. Provider will report all third party resources to Subcontractor and Health Plan identified through the provision of medical services.

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

3.38 Capitated Providers. If Provider is capitated and terminates its agreement with Subcontractor, for any reason, Provider will provide services to Covered Persons assigned to Provider up to the end of the month in which the effective date of termination falls.

SECTION 4
ADDITIONAL PROVIDER REQUIREMENTS FOR SPECIFIC ACTIVITIES

4.1 Behavioral Health Providers. Behavioral health Providers shall ensure that all Covered Persons receiving inpatient psychiatric services are scheduled for outpatient follow-up and/or continuing treatment prior to discharge from the inpatient psychiatric hospital if the Provider is aware of the Covered Person's inpatient hospitalization status. Behavioral health Providers will be provided daily reports identifying Covered Persons known to be admitted to an inpatient facility.

4.2 PCP Responsibilities. Providers acting as PCPs shall meet the following requirements:

(a) PCPs who serve Covered Persons under the age of twenty-one (21) are responsible for conducting all EPSDT screens for individuals on their Panel under the age

of twenty-one (21). Should the PCP be unable to conduct the necessary EPSDT screens, the PCP is responsible for arranging to have the necessary EPSDT screens conducted by another network Provider and ensure that all relevant medical information, including the results of the EPSDT screens, are incorporated into the Covered Person's PCP Medical Record.

(b) PCPs who serve Members under the age of twenty-one (21) report encounter data associated with EPSDT screens, using a format approved by the Division, to the Contractor within ninety (90) calendar days from the date of service.

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

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

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

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

4.3 Specialists as PCPs. Covered Persons with disabling conditions, chronic illnesses, or child(ren) with special health care needs may request that their PCP be a specialist. The designation of a specialist as a PCP must be pursuant to a treatment plan approved by Subcontractor and Health Plan, in consultation with the PCP to which the Covered Person is currently assigned, the Covered Person and, as appropriate, the specialist.

The specialist as a PCP shall provide or arrange for all primary care, including routine preventive care, and to provide those specialty medical services consistent with the Covered Person's disabling condition, chronic illness, or special health care need in accordance with Subcontractor and Health Plan's standards and within the scope of the specialty training and clinical expertise.

The specialist as a PCP shall have admitting privileges at a hospital in Health Plan's network.

SECTION 5
HEALTH PLAN AND SUBCONTRACTOR REQUIREMENTS

5.1 Prompt Payment. Subcontractor or Health Plan shall pay Provider pursuant to the State Contract and applicable State and federal law and regulations, including but not limited to Mississippi Code Section 83-9-5, 42 CFR 447.46, 42 CFR 447.45(d)(2), 42 CFR 447.45(d)(3), 42 CFR 447.45(d)(5) and 42 CFR 447.45(d)(6), as applicable and as may be amended from time to time. If a third party liability exists, payment of claims shall be determined in accordance

with federal and/or State third party liability law and the terms of the State Contract. Unless Subcontractor or Health Plan otherwise requests assistance from Provider, Subcontractor or Health Plan will be responsible for third party collections in accordance with the terms of the State Contract.

5.2 No Incentives to Limit Medically Necessary Services. Subcontractor and Health Plan shall not structure compensation provided to individuals or entities that conduct utilization management and concurrent review activities so as to provide incentives for the individual or entity to deny, limit, or discontinue Medically Necessary services to any Covered Person.

5.3 Provider Discrimination Prohibition. Subcontractor and Health Plan shall not discriminate with respect to participation, reimbursement, or indemnification of a provider who is acting within the scope of the provider's license or certification under applicable State law, solely on the basis of such license or certification. Subcontractor and Health Plan shall not discriminate against Provider for serving high-risk Covered Persons or if Provider specializes in conditions requiring costly treatments. This provision shall not be construed as prohibiting Subcontractor and/or Health Plan from limiting a provider's participation to the extent necessary to meet the needs of Covered Persons. This provision also is not intended and shall not interfere with measures established by Vendor that are designed to maintain quality of care practice standards and control costs.

5.4 Communications with Covered Persons. Covered Persons are entitled to the full range of their Providers' opinions and counsel about the availability of Medically Necessary Services under the provisions of the State Contract. Any contractual provisions, including gag clauses or rules, that restrict a Provider's ability to advise Covered Persons about Medically Necessary treatment options violate federal law and regulations.

Subcontractor and Health Plan shall not prohibit or otherwise restrict Provider, when acting within the lawful scope of practice, from advising or advocating on behalf of a Covered Person for the following:

(a) The Covered Person's health status, medical care, or treatment options, including any alternative treatment that may be self-administered;

(b) Any information the Covered Person needs in order to decide among all relevant treatment options;

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

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

Subcontractor and Health Plan also shall not prohibit a Provider from advocating on behalf of a Covered Person in any grievance system, utilization review process, or individual authorization process to obtain necessary health care services.

5.5 Termination, Revocation and Sanctions. In addition to its termination rights under the Agreement, Subcontractor and Health Plan shall have the right to revoke any functions or activities Subcontractor and/or Health Plan delegates to Provider under the Agreement or impose other sanctions consistent with the State Contract if in Subcontractor and/or Health Plan's reasonable judgment Provider's performance under the Agreement is inadequate. Subcontractor and Health Plan shall also have the right to suspend, deny, refuse to renew or terminate Provider in accordance with the terms of the State Contract and applicable law and regulation. However, Subcontractor and Health Plan shall not exclude or terminate a Provider from participation in Subcontractor and/or Health Plan's Provider Network due to the fact that the Provider has a practice that includes a substantial number of patients with expensive medical conditions, and shall not terminate a Provider for filing a Complaint, Grievance, or Appeal on a Covered Person's behalf.

SECTION 6
OTHER REQUIREMENTS

6.1 Compliance with State Contract. All tasks performed under the Agreement shall be performed in accordance with the requirements of the applicable State Contract, as set forth in this Appendix, applicable provider manuals, and protocols, policies and procedures that Subcontractor and/or Health Plan have provided or delivered to Provider. The applicable provisions of the State Contract are incorporated into the Agreement by reference. Nothing in the Agreement relieves Health Plan of its responsibility under the State Contract. If any provision of the Agreement is in conflict with provisions of the State Contract, the terms of the State Contract shall control and the terms of the Agreement in conflict with those of the State Contract will be considered waived.

6.2 Monitoring. Subcontractor and/or Health Plan shall perform ongoing monitoring (announced or unannounced) of services rendered by Provider under the Agreement and shall perform periodic formal reviews of Provider according to a schedule established by the State, consistent with industry standards or State managed care organization laws and regulations or requirements under the State Contract. As a result of such monitoring activities, Subcontractor and/or Health Plan shall identify to Provider any deficiencies or areas for improvement mandated under the State Contract and Provider and Subcontractor and/or Health Plan shall take appropriate corrective action. Provider shall comply with any corrective action plan initiated by Subcontractor and/or Health Plan and/or required by the MississippiCAN Program. In addition, Provider shall monitor and report the quality of services delivered under the Agreement and initiate a plan of correction where necessary to improve quality of care, in accordance with that level of care which is recognized as acceptable professional practice in the respective community in which Subcontractor, Health Plan and Provider practice and/or the performance standards established under the State Contract.

6.3 Enrollment. The parties acknowledge and agree that the Division is responsible for enrollment, reenrollment and disenrollment of Covered Persons.

6.4 No Exclusivity. Nothing in the Agreement or this Appendix shall be construed as prohibiting or penalizing Provider for contracting with a managed care organization other than Subcontractor and/or Health Plan or as prohibiting or penalizing Subcontractor and Health Plan for contracting with other providers.

6.5 Delegation. The parties agree that, prior to execution of the Agreement, Subcontractor and/or Health Plan evaluated Provider's ability to perform any duties delegated to Provider under the Agreement. Any delegated duties and reporting responsibilities shall be set forth in the Agreement or other written delegation agreement or addendum between the parties. Subcontractor and Health Plan shall have the right to revoke any functions or activities Subcontractor and/or Health Plan delegates to Provider under the Agreement if in Subcontractor and/or Health Plan's reasonable judgment Provider's performance under the Agreement is inadequate.

Vision Vendor
Provider Services Agreement

PROVIDER SERVICES AGREEMENT

THIS PROVIDER SERVICES AGREEMENT (this "**Agreement**") is entered into by and between VISION VENDOR, INCORPORATED, a California corporation ("**Vision Vendor**") and the entity or individual identified as "Provider" on the signature page of this Agreement ("**Provider**") for the purposes of setting forth the terms and conditions under which Provider will participate as a provider of Eye Health Care Services for Vision Vendor.

RECITALS

A. Provider is duly registered, fully licensed, and in good standing, with no restriction against its licenses under the laws of the States in which Eye Health Care Services are provided under the terms of this Agreement (collectively, "**State(s)**"). By this Agreement, and subject to the terms and conditions which follow, Provider agrees to, and shall cause each of its contracting providers to agree to provide Eye Health Care Services in accordance with this Agreement on behalf of Vision Vendor, its affiliates, and its Plans. Provider conducts its practice at the office location(s) listed on the Provider Demographic Form.

B. Vision Vendor desires to engage Provider to provide Eye Health Care Services, and Provider hereby accepts such engagement, under the terms and conditions specified herein.

AGREEMENT

NOW, THEREFORE, in consideration of the foregoing recitals, which are incorporated herein by this reference, and for other good and valuable consideration, the receipt and sufficiency of which is hereby acknowledged, the parties hereto, intending to be legally bound, hereby agree as follows:

ARTICLE I
DEFINITIONS

In addition to the terms defined elsewhere in this Agreement, the following terms are defined as follows:

1.1 "**Allowable Fee**" means the amount payable to a Provider for Eye Health Care Services pursuant to **Exhibit A** of this Agreement.

1.2 "**Contracting Provider**" means each licensed health care provider that is employed by or otherwise under contract with Provider to provide Eye Health Care Services to Enrollees hereunder.

1.3 "**Copayment**" means a portion of the Allowable Fee for a given Eye Health Care Service which, under the terms of the applicable Plan, is required to be paid by the Enrollee directly to the Provider.

1.4 "**Deductible**" means the amount required, under the terms of the applicable Plan, to be paid by the Enrollee for Eye Health Care Services provided under this Agreement before the Enrollee is entitled to benefits under a Plan.

1.5 "**Effective Date**" means the date set forth on the signature page to this Agreement by Vision Vendor.

1.6 "**Enrollee**" means any individual entitled to receive Eye Health Care Services pursuant to a Plan.

1.7 "**Eye Health Care Services**" means the Medically Necessary services and materials that are covered benefits under the applicable Plan.

1.8 "**Emergency Medical Condition**" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: (i) serious jeopardy to the health of the individual or, in the case of a pregnant woman, the health of the woman or her unborn child; (ii) serious impairment to bodily functions; or (iii) serious dysfunction of any bodily organ or part.

1.9 "**Intermediary**" is a person or entity authorized to negotiate and execute the Agreement on behalf of Provider or on behalf of a network through which Provider elects to participate.

1.10 "**Medically Necessary**" means those Eye Health Care Services provided by Provider or a Contracting Provider which an Enrollee requires, as determined by Provider or Vision Vendor in accordance with generally accepted medical practice standards in effect at the time of treatment and in conformity with the professional and technical standards adopted by Vision Vendor's UM/QA committee, and not solely for the convenience of the Enrollee, Provider or Contracting Provider.

1.11 "**Plan**" means a health maintenance organization, a preferred provider organization, a physician hospital organization, an insurance company, an employer, a self-funded health benefit plan, a third party administrator, or any other source of funding for Eye Health Care Services, whether Medicare, Medicare Advantage, a State's Medicaid or Medicaid managed care program, commercial, or otherwise, that enters or has entered into an agreement with Vision Vendor to obtain the services called for under this Agreement, whether such agreement is entered into now or in the future.

1.12 **"Provider Demographic Form"** means the form provided by Vision Vendor to be completed by Provider setting forth Provider's information including but not limited to the office locations, office hours, languages spoken, billing and mailing addresses, telephone and fax numbers and the list of Contracting Providers. The Provider Demographic Form shall be updated from time to time by Provider upon a change to the information provided by Provider.

1.13 "**Provider Policies**" means any Vision Vendor or Plan policies, procedures, reference guides, manuals and other governing documents referred to in this Agreement or required by any agreement with a Plan. Vision Vendor shall make available to Provider the Provider Policies in effect as of the date hereof. Additionally, Provider may obtain access to the most current Provider Policies via the portal or other electronic means.

1.14 "**UM/QA Program**" means the utilization management and quality assurance program administered by Vision Vendor's UM/QA committee and its governing board to assure that Eye Health Care Services are necessary and that they are being provided in a manner consistent with accepted standards of service and with applicable laws, regulations and standards.

ARTICLE II
PROVIDER DUTIES

Provider agrees that:

2.1 Provider shall accept (and shall cause each Contracting Provider to accept) as patients all Enrollees referred by Vision Vendor without discrimination. Provider shall provide Vision Vendor with a minimum of sixty (60) days' advance written notice of Provider's inability to accept new patients hereunder. Eye Health Care Services provided under this Agreement shall be of the same type and quality, and provided in the same manner, as said services provided to all other patients of Provider.

2.2 Provider shall provide Eye Health Care Services to Enrollees at a level of care and competence that equals or exceeds the generally accepted and professionally recognized standard of practice at the time of treatment in accordance with applicable law and rules and/or standards of professional conduct, and any controlling governmental licensing requirements. Provider shall cause every Contracting Provider to, at all times during the term of the Agreement, maintain a license to practice his or her profession in the applicable State(s). In the event of any suspension, restriction or revocation of any license required to be maintained by a Contracting Provider, Provider shall: (a) immediately cause such Contracting Provider to stop providing Eye Health Care Services under this Agreement; (b) immediately provide notice of such suspension, restriction, or revocation to Vision Vendor by both telephone and in writing; and (c) shall not resume performance under this Agreement unless and until his or her license is restored and he or she has received written notice of reinstatement from Vision Vendor.

2.3 Provider warrants and represents that it has not been convicted of crimes as specified in Section 1128 of the Social Security Act (42 U.S.C. 1320a-7), excluded from participation in the Medicare or Medicaid program, assessed a civil penalty under the provisions of Section 1128, entered into a contractual relationship with an entity convicted of a crime specified in Section 1128, or taken any other action that would prohibit it from participation in Medicare, Medicaid or any state health care programs. Provider agrees to notify Vision Vendor immediately in the event it or any Contracting Provider is or becomes disbarred, excluded, suspended, or is otherwise determined to be ineligible to participate in any federal or state health care program(s). Provider shall not employ or contract with, with or without compensation, any individual or entity that has been disbarred, excluded, suspended or otherwise determined to be ineligible to participate in federal health care programs. Provider shall screen their employees and contractors initially and on an ongoing monthly basis to determine whether any of them has been excluded from participation in Medicare, Medicaid, SCHIP, or any Federal health care programs (as defined in Section 1128B(f) of the Social Security Act) and not employ or contract with an individual or entity that has been excluded or debarred. Provider will conduct monthly checks to screen their employees and contractors for exclusion, using the Social Security Administration's Death Master File, the National Plan and Provider Enumeration System (NPPES), the List of Excluded Individuals/Entities (LEIE), the System for Award Management (SAM), and any other databases a State may prescribe.

2.4 Provider shall, and shall cause each Contracting Provider, to comply with each applicable Plan. Vision Vendor shall give Provider access via the portal or other electronic means to the Eye Health Care Services, compensation and any other additional or modified terms and conditions applicable to existing or new Plans offered through Vision Vendor ("**New Plan Information**"). Provider shall regularly access and provide New Plan Information to each

Contracting Provider. Provider agrees to comply with and be bound by such amendments or modifications.

2.5 Provider shall cause each Contracting Provider to provide Eye Health Care Services to Enrollees in accordance and compliance with the terms and conditions hereof and with the Provider Policies, as they may be amended from time to time unilaterally by Vision Vendor. Provider shall cause each Contracting Provider to provide services hereunder in accordance with all applicable CMS, Medicaid and other laws, regulations, guidelines, instructions and model contracts, including, without limitation, applicable statutes and regulations promulgated by the regulators of the applicable Federal or State(s) who supervise, regulate and license the provision of Eye Health Care Services by Provider or any Contracting Provider (such regulators are collectively referred to herein as the "**Regulator**"), applicable statutes, regulations and guidelines (from Plan, Vision Vendor, or otherwise) regarding privacy and confidentiality or Enrollees' health information and medical records, and any anti-fraud activities. It is expressly acknowledged and agreed to that Plans contracting with Vision Vendor may be subject to various state and federal law, regulation and policies, and contractual obligations, and any provision required to be incorporated herein by any such law, regulation, policy or contractual obligation and any amendments thereto shall be deemed automatically incorporated herein without any further action or notice by the parties hereto.

2.6 Provider shall maintain, and shall cause each Contracting Provider to maintain, written records of Eye Health Care Services (including but not limited to tests, services, products and procedures) provided to patients and Enrollees in accordance with Plan requirements and the applicable requirements of each Regulator and agency of the State(s), including, without limitation, licensing authorities and Provider shall make such written records of the tests and procedures available to Vision Vendor or a Plan from time to time upon request, subject to applicable patient record confidentiality requirements, as well as to such applicable authorities in accordance with this Agreement.

2.7 Provider shall cause its Contracting Providers to make available Eye Health Care Services to Enrollees during each Contracting Provider's customary service hours at each facility of Provider that are customarily open to patients (collectively, "**Office(s)**"). If a Contracting Provider offers services on weeknights or weekends, Provider shall cause such Contracting Provider to extend such hours to Enrollees to receive Eye Health Care Services, and shall accept referrals of Enrollees from other Offices (as applicable). If an Enrollee desires Eye Health Care Services after-hours when such Enrollee's customary Contracting Provider is unavailable, Provider shall refer the Enrollee to the nearest Contracting Provider who offers Eye Health Care Services during such hours. Provider shall monitor each Contracting Provider's Office hours to ensure that Enrollees have adequate access to Eye Health Care Services at convenient times. At all times during business hours, Provider shall cause its Contracting Provider(s) or another Vision Vendor-approved provider to be available to furnish Eye Health Care Services at the Office(s). Each Office(s) shall be listed on the Provider Demographic Form and shall be adequately equipped and staffed to provide complete Eye Health Care Services as agreed upon in this Agreement.

2.8 Provider shall, and shall cause each Contracting Provider, to comply with availability and accessibility standards as are promulgated by Vision Vendor from time to time, including, without limitation, waiting times and appointments. Provider agrees to submit to periodic audits of each Office to ensure compliance with Vision Vendor's standards. Provider acknowledges that Provider has access to Vision Vendor's availability and accessibility

standards prior to the execution of this Agreement. Vision Vendor shall give Provider access via the portal or other means to any amendments or modifications to such standards which may be adopted by Vision Vendor from time to time during the term hereof. Provider shall regularly access and provide such standards to each Contracting Provider. Provider agrees to comply with and be bound by such changes.

2.9 If a Contracting Provider determines that an Enrollee requires Eye Health Care Services that are beyond the scope of the Contracting Provider's scope of training and license, the Contracting Provider shall refer Enrollee to another Contracting Provider or other Vision Vendor-approved provider who is licensed and trained to provide such services, using a referral form provided by Vision Vendor. Provider shall cause each Contracting Provider to notify Enrollees whether or not such services are a covered benefit under the Plan.

2.10 In the event an Enrollee at an Office requires services to treat an Emergency Medical Condition or urgent care services beyond the scope of his/her Contracting Provider's training or licensure, or an Enrollee contacts Provider or a Contracting Provider requiring such emergency or urgent care services during business hours, the following shall apply: In no event shall Provider or any Contracting Provider provide services to any Enrollee beyond the scope of Provider's or such Contracting Provider's license. Provider shall cause each Contracting Provider to treat all Emergency Medical Conditions within the Contracting Provider's scope of training and license. In the event any Enrollee presents with any other type of Emergency Medical Condition, Provider shall contact the local ambulance or paramedic services. Provider shall ensure that Enrollees are informed of the appropriate agencies or resources to contact in the event of an Emergency Medical Condition or urgent care condition after hours.

2.11 Provider and each Contracting Provider acknowledges that it is a "Covered Entity" as that term is defined in the HIPAA Standards for Privacy of Individually Identifiable Health Information adopted by the United States Department of Health and Human Services on December 28, 2000, as amended (the "**Privacy Rule**"). Provider shall adequately protect the confidentiality of individually identifiable health information and shall comply with the Privacy Rule and all state and federal laws governing the confidentiality of Enrollee medical information.

2.12 Medicare Advantage Compliance. For Eye Health Care Services covered under a Medicare Advantage Plan, each Contracting Provider agrees to render such Eye Health Care Services to Enrollees in accordance with applicable Medicare Advantage regulations and Center for Medicare and Medicaid Services ("**CMS**") guidelines With respect to any Medicare Advantage Plan, applicable regulatory requirements shall survive the termination of the Agreement regardless of the reason for termination and shall supersede any contrary provision in this Agreement and any oral or written contrary agreement between Provider/Contracting Provider and an Enrollee (or his/her representative) if such other agreement is inconsistent with these requirements.

2.13 Record Audit and Inspection. Provider agrees to give the Department of Health and Human Services ("**HHS**"), the Comptroller General, State Medicaid officials or their respective designee(s) the right to inspect, evaluate, and audit any pertinent contracts, books, documents, papers, and records involving transactions related to the Agreement for a period of ten (10) years from the final date of a contract period or from the date of completion of any audit, whichever is later, or longer if required under applicable regulations. Provider shall make available its premises, physical facilities, equipment and records relating to Medicare Enrollees, and any additional relevant information that such departments may require.

2.14 Confidentiality and Accuracy of Enrollee Records. Each Contracting Provider shall safeguard the privacy of any and all protected health information that identifies Enrollees, and shall abide by all applicable federal and state laws regarding privacy, confidentiality and disclosure of medical records and other health and Enrollee information. Each Contracting Provider shall maintain medical records in an accurate and timely manner, and shall ensure that Enrollees have timely access to their medical records.

2.15 Reporting Requirements. Provider shall cooperate with Vision Vendor in its compliance with CMS or Medicaid reporting and data submission requirements.

2.16 Accountability. Vision Vendor shall only delegate activities or functions (if any) to Provider if such delegation is in writing and is not inconsistent with the Agreement or applicable regulations. Such delegation arrangement, if made, shall include any reporting requirements, a right of revocation, ongoing review and performance monitoring by Vision Vendor, approval and auditing of credentialing processes (if applicable), and compliance with all applicable laws, regulations and CMS or Medicaid instructions.

2.17 Suspension or Termination of Agreement. If Vision Vendor suspends or terminates the Agreement, Vision Vendor shall give prior written notice to Provider of the following: (i) the reasons for the action, including, if relevant, the standards and profiling data used to evaluate Provider and the numbers and mix of providers needed by Vision Vendor; and (ii) Provider's right to appeal the action and the process and timing for requesting a hearing. If Vision Vendor suspends or terminates the Agreement because of deficiencies in the quality of care, Vision Vendor will give written notice of such action to licensing or disciplinary bodies or to other appropriate authorities.

2.18 Subcontracts. If Provider subcontracts with another provider to deliver Eye Health Care Services to Enrollees, Provider shall receive prior written consent from Vision Vendor, shall ensure that its contract with such provider contains all of the regulatory provisions herein including those contained in any Medicare or Medicaid addenda to this Agreement, and Provider shall provide proof of the same to Vision Vendor upon request.

2.19 Fraud, Waste and Abuse Prevention. Provider shall promptly report any suspected fraud and abuse by to Vision Vendor. Provider shall also cooperate fully with Vision Vendor's policies and procedures designed to protect program integrity and prevent and detect potential or suspected fraud, waste, and abuse in the administration and delivery of services and shall cooperate and assist Vision Vendor, a plan, and any agency charged with the duty of preventing, identifying, investigating, sanctioning or prosecuting suspected fraud, waste, and abuse in state and/or federal health care program

2.20 Disclosure Forms. Provider shall cooperate with Vision Vendor and/or a Plan in disclosing information required related to ownership and control, significant business transactions, and persons convicted of crimes, including any required criminal background checks, in accordance with 42 CFR Part 455 and shall provide information upon request.

2.21 Required Training. Provider shall participate, and shall cause its Participating Providers to participate, in such trainings as are required by Medicare or Medicaid regulations or rules and communicated by Vision Vendor, including but not limited to limited English proficiency and cultural sensitivity.

2.22 Demographic Information and Surveys. Providers shall cooperate with Vision Vendor survey efforts, including but not limited to, querying Americans with Disabilities Act compliance and the validity of Provider demographic information, as required by State or Federal laws, regulations or rules. Provider will attest to the validity of such information as requested by Vision Vendor.

2.23 New Regulatory Provisions. If any applicable Medicare or Medicaid regulations are amended during the term of the Agreement, then those associated provision shall be deemed automatically amended to ensure compliance therewith.

ARTICLE III
UTILIZATION REVIEW AND QUALITY ASSURANCE

3.1 Provider shall, and shall cause each Contracting Provider to, actively participate in, support, and cooperate with any applicable utilization management and quality assurance ("**UM/QA**") programs designated and approved by Vision Vendor or the Plan. Vision Vendor may establish one or more committees comprised of Contracting Providers and other individuals licensed to practice optometry and/or ophthalmology for purposes of carrying out the UM/QA programs designated and approved by Vision Vendor under this Agreement. Vision Vendor shall give Provider access via the portal or other means to any applicable documentation of such programs and any amendments or modifications.

3.2 Provider shall (and shall cause each Contracting Provider to) cooperate with and abide by and adhere to rulings of the Vision Vendor committees, and further agrees that upon request, Provider will furnish case records of Vision Vendor patients for whom claims have been submitted, and that Vision Vendor may use any information so obtained for statistical, actuarial, scientific, peer review or other reasonable purposes, provided that the committee shall maintain the confidentiality of such information in accordance with applicable State and federal laws and regulations.

ARTICLE IV
COMPENSATION; BILLING AND PAYMENT

4.1 In exchange for Eye Health Care Services provided to and/or arranged and paid for on behalf of eligible Enrollees covered under the Plan(s), Vision Vendor agrees to pay Provider the Allowable Fees for services rendered to an Enrollee hereunder, less (i) any applicable Copayments and/or Deductibles, and (ii) any withheld amounts as may be determined by the Vision Vendor and included herein as an amendment to **Exhibit A** attached hereto; (iii) subject to **Exhibit B** hereof, any adjustments charged to the account of Provider for monies owing to Vision Vendor or an Enrollee (as determined by Vision Vendor) as a result of Provider being paid incorrectly or incorrectly billing Vision Vendor or an Enrollee and (iv) amounts set forth in an uncontested notice of overpayment of a claim. Provider specifically authorizes Vision Vendor to offset an uncontested notice of overpayment of a claim directly from Provider's current claims submission. Provider shall be entitled to collect from an Enrollee directly for all applicable Copayment or Deductible amounts. Provider shall report to Vision Vendor in writing all Copayments or Deductible amounts paid by Vision Vendor Enrollees directly to Provider and/or its Contracting Providers.

4.2 If an Enrollee requests services or items that are not covered by the Plan (i.e., optional optical procedures or higher priced frames), Provider shall (i) inform the Enrollee of

his/her responsibility to pay for such non-Eye Health Care Services, (ii) inform the Enrollee that neither Vision Vendor nor any Plan shall be responsible for payment for such services, and (iii) obtain a written consent from such Enrollee evidencing his/her obligation to pay for such services prior to rendering any such non-covered services. Provider and each Contracting Provider shall be entitled to require any Enrollee to pay for such non-Eye Health Care Services directly to Provider or the Contracting Provider, as applicable, subject in all cases to applicable provisions of **Exhibit A**. Provider shall not and shall not allow Contracting Providers to charge Enrollees for non-Eye Health Care Services in excess of rates normally charged to non-Vision Vendor patients. Provider and its Contracting Providers shall not bill Vision Vendor for non-Eye Health Care Services rendered to Enrollees.

4.3 Provider shall use all commercially reasonable efforts to submit claims to Vision Vendor for Eye Health Care Services rendered by Provider and/or its Contracting Providers within ninety (90) days after the rendering of such services or such timeframe as required by State guidelines. Any claims for Eye Health Care Services not submitted to Vision Vendor within ninety (90) days from the date of service, or such other timeframe as required by State guidelines, shall be deemed waived and Provider shall not (and shall cause the Contracting Providers not to) bill Vision Vendor, Enrollees or any third party for such services. However, if Vision Vendor denies a claim because it was filed beyond the claim filing deadline, upon Provider's submission of a provider dispute, as such procedure is set forth at **Exhibit B** attached hereto, and upon Provider's demonstration of good cause for the delay, Vision Vendor shall accept and adjudicate the claim. Provider shall bill Vision Vendor on electronic or other forms designated by Vision Vendor, which forms shall be substantially similar to a CMS-1500 claim form and shall be completed with all requested billing and patient information. Failure to provide all requested billing and patient information on the proper designated form may result in nonpayment or downward adjustment of amounts payable to Provider pursuant to a process set forth in the Provider Policies. Provider shall employ current HCPCS, ICD-9, or CPT-4 coding, as appropriate.

4.4 Provider retains the right to seek additional reimbursement from other third party payors pursuant to applicable coordination of benefits provisions or policies. If Vision Vendor is the primary payor, Vision Vendor will pay Provider as provided herein. If Vision Vendor is not the primary payor, Vision Vendor shall be responsible for the difference between Provider's usual and customary fees and the amount payable by the primary payor, not to exceed the applicable rates set forth in **Exhibit A** attached hereto, less any applicable Copayments and Deductibles.

4.5 Except as otherwise provided in Section 4.3, Provider and each Contracting Provider agrees to accept the Allowable Fee, less any applicable Copayments and Deductibles, as payment in full for Eye Health Care Services provided hereunder. In no event, including, without limitation (i) non-payment by Vision Vendor, the primary payor or an ~~intermediary,~~ (ii) insolvency of Vision Vendor, the primary payor or an ~~intermediary,~~ or (iii) a breach by Vision Vendor of the Agreement, shall such Contracting Provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against any Enrollee or person (other than Vision Vendor, the primary payor or ~~intermediary~~) acting on behalf of the Enrollee for Eye Health Care Services provided pursuant to the Agreement. Provider shall not (and shall cause its Contracting Providers not to) invoice or balance bill Enrollees for the difference between Provider's billed charges and the reimbursement paid by Vision Vendor for any Eye Health Care Services, and agrees not to bill or to assess any charge to

Enrollees regardless of whether or not payment is received from Vision Vendor. Provider acknowledges that attempting to charge for or collect from an Enrollee any such charge may result in termination of this Agreement or other appropriate action by Vision Vendor. Neither Provider nor any Contracting Provider or their respective agents, trustees or assignees may maintain any action at law against a Vision Vendor Enrollee for sums owed to Provider or any Contracting Provider by Vision Vendor, and Enrollees shall not be liable to Provider or any Contracting Provider for such sums.

ARTICLE V
ELIGIBILITY AND AUTHORIZATION VERIFICATION

5.1 Enrollee may be furnished with an identification card, and Provider shall cause each Contracting Provider to make a photocopy of such card. Provider shall also contact, and shall cause each Contracting Provider to contact, Vision Vendor's telephone verification service during regular business hours to verify (i) whether a person seeking services pursuant to this Agreement is eligible for Eye Health Care Services, (ii) that the services sought are Eye Health Care Services covered under the Enrollee's Plan, and (iii) the amount of applicable Copayments and Deductibles, if any. Provider may also access the portal to verify (i) whether a person seeking services pursuant to this Agreement is eligible for Eye Health Care Services. If Provider or any Contracting Provider obtains a copy of the identification card and obtains verification in the manner set forth in this Section 5.1, such verification shall be conclusive as to Vision Vendor for the date of such verification, unless and until Vision Vendor notifies Provider to the contrary in writing electronically or otherwise.

ARTICLE VI
TERM AND TERMINATION

6.1 Term. Unless sooner terminated in accordance with this Agreement, the initial term of this Agreement shall be one (1) year from and after the Effective Date. Upon the expiration of the initial and each subsequent term, this Agreement shall automatically renew for additional terms of one (1) year each, unless sooner terminated in accordance with this Agreement.

6.2 Termination.

6.2.1 Termination Without Cause. This Agreement may be terminated at any time by the mutual written agreement of Provider and Vision Vendor. This Agreement may be terminated without cause at any time, upon not less than ninety (90) days' prior written notice to the other party.

6.2.2 Termination for Cause. This Agreement may be terminated for cause only on the following grounds:

(a) In the event that either party substantially fails to perform any of its material obligations under this Agreement, the other party may give written notice to the non-performing party specifying the obligation(s) not performed and demanding performance within thirty (30) days. If at the end of the thirty (30) day period the non-performing party has not performed the specified obligation(s), the party giving notice

may terminate this Agreement immediately upon additional written notice to the non-performing party.

(b) Vision Vendor may terminate this Agreement (i) upon thirty (30) days' prior written notice in the event that Provider or any Contracting Provider fails to provide Vision Vendor with any information reasonably requested by Vision Vendor in the form so requested for the purposes of this Agreement, and during such thirty (30) day notice period Provider (or such Contracting Provider) does not cure such default; or (ii) immediately if Provider or any Contracting Provider provides Vision Vendor with any misleading or false information (including but not limited to information regarding claims, services provided, patients treated, premises where treatment was provided, status of licensure or ownership of practice or dispensing facility).

(c) Vision Vendor shall be entitled to suspend Provider and any Contracting Provider from participation under this Agreement immediately upon written notice in the event that, in the judgment of Vision Vendor, the health, safety, or welfare of patients will be jeopardized by Provider or such Contracting Provider continuing to provide services under this Agreement. The effect of suspension from participation under this Agreement shall be that, for the term of the suspension, the suspended Provider (or Contracting Provider, as applicable) shall not perform any Eye Health Care Services under this Agreement. All other provisions of this Agreement shall remain in full force and effect during the term of any such suspension, unless and until this Agreement is terminated according to its terms. Any such suspension shall continue until notice of reinstatement is issued in writing by Vision Vendor. Any suspension under this Section 6.2.2(c) that continues for an uninterrupted ninety (90) day period shall result in the automatic termination of this Agreement.

6.3 Effect of Expiration or Termination. Upon the expiration or earlier termination of this Agreement for any reason, Provider and each Contracting Provider shall continue to provide Eye Health Care Services to Enrollees who retain eligibility and who are under the care of Provider at the time of such expiration or termination until the services are completed, or until Vision Vendor makes reasonable and appropriate provision for the assumption of such services by another Vision Vendor-approved provider. Provider shall be entitled to compensation (less applicable Deductibles and Copayments, if any) pursuant to Section 4.1 for Eye Health Care Services provided pursuant to this Section 6.3.

ARTICLE VII
INSURANCE AND INDEMNIFICATION

7.1 Provider and each Contracting Provider shall maintain, throughout the term of this Agreement and for a period of not less than three (3) years thereafter, at Provider's own expense, professional and comprehensive general liability insurance coverage. Provider and each Contracting Provider shall maintain throughout the term of this Agreement and for a period of not less than three (3) years thereafter at Provider's expense minimum professional liability insurance coverage of at least One Million Dollars ($1,000,000) per occurrence, Three Million Dollars ($3,000,000) annual aggregate or such other amount that is specified in the Vision Vendor Provider Policies, and shall maintain minimum general liability insurance coverage in the amount of at least One Million Dollars ($1,000,000.00) combined single limit. Provider and each Contracting Provider shall maintain workers' compensation coverage to the extent and in the amounts required by applicable law. In the event of any reduction, lapse, discontinuation, or

other loss of any insurance coverage required to be maintained by Provider or any Contracting Provider, Provider: (a) shall immediately provide notice of such event to Vision Vendor both by telephone and in writing; (b) shall be subject to suspension from providing services under this Agreement in the sole discretion of Vision Vendor upon oral or written notice; and (c) in the event of such suspension, shall not resume performance under this Agreement unless and until such insurance coverage is restored and he or she has received written notice of reinstatement from Vision Vendor. Upon request, Provider shall provide Vision Vendor with certificates evidencing the insurance coverages required herein. Provider shall, at least thirty (30) days prior to the expiration of such policy or policies, furnish Vision Vendor with renewals or binders thereof.

7.2 Provider and each Contracting Provider agrees to indemnify, defend and hold harmless Vision Vendor from and against any and all claims, liability, cost or expense (including, without limitation, litigation costs and attorneys' fees) arising out of or resulting from any act or failure to act by Provider, to the extent the claim, liability, cost or expense is not otherwise covered by insurance.

ARTICLE VIII
RECORDKEEPING AND ACCESS TO RECORDS

8.1 Provider and/or each Contracting Provider shall maintain patient visit records and billing and payment records for all Enrollees treated by Provider and its Contracting Providers in accordance with prudent recordkeeping practices and as required by law.

8.2 Any request by Vision Vendor for supporting medical record Documentation shall be provided to Vision Vendor by Provider without cost to Vision Vendor.

8.3 Without limiting any of the foregoing, Provider and each Contracting Provider agrees to maintain such records (including patient care records) and provide such information to Vision Vendor or any Regulator, government agency, HHS, Plan, or any of their designees as may be required by law, regulation, or Vision Vendor's contractual obligations, and to permit the foregoing and their representatives at all reasonable times to have access upon demand to Provider's and each Contracting Provider's books, records and papers relating to Eye Health Care Services provided to Enrollees hereunder, to the cost thereof, to the payments received by Provider and/or its Contracting Providers from or on behalf of Enrollees, and, as otherwise may be necessary for compliance by Vision Vendor with, and/or to inspect all facilities maintained or utilized by Provider and its Contracting Providers in the performance of services hereunder. Provider and each Contracting Provider shall retain such books and records for at least ten (10) years from and after termination of this Agreement, whether by rescission or otherwise or longer as may be required by law.

ARTICLE IX
DISPUTES AND GRIEVANCES

9.1 Provider may submit information regarding disputes, on its own behalf or on behalf of Contracting Providers, to Vision Vendor at the address or telephone number designated on the signature page of this Agreement, which address or telephone number may be modified from time to time by written notice hereunder. Such disputes shall be resolved in accordance with Vision Vendor's provider dispute resolution mechanism. If the parties are unable to resolve the dispute in accordance with the provider dispute resolution mechanism, then any matters

remaining in controversy shall be subject to binding arbitration in accordance with Section 10.12 of this Agreement.

9.2 Vision Vendor shall notify Provider in writing of the grievance procedures established by Vision Vendor for redress of concerns of Enrollees regarding Provider and of Provider regarding Enrollees, including, without limitation, disputes as to services, materials, or payment for same. Vision Vendor shall provide forty-five (45) business days' notice to Provider of any changes to such grievance procedures, and Provider shall have the right to negotiate and agree to the change(s). If Provider decides not to agree, Provider has the right to terminate this Agreement prior to the implementation of the change. Otherwise, following forty-five (45) business days from receipt of the notice of any grievance procedure changes, Provider agrees to comply with and be bound by such grievance procedures. Further, Provider and each Contracting Provider shall participate in and abide by the decisions of Vision Vendor's or Plan's enrollee complaint and grievance systems and agree to be bound by any arbitration decision resulting from the disposition of any grievance involving an Enrollee to the same extent as would apply if Provider were a party to an arbitration agreement.

ARTICLE X
MISCELLANEOUS

10.1 Nondiscrimination. Provider shall not discriminate against any individual on the basis of race, color, sex, age, religion, national origin, disability, veteran's status, ancestry, marital status, sexual orientation, physical, sensory or mental handicap, socioeconomic status, or participation in publicly financed programs of health care in providing Eye Health Care Services under this Agreement.

10.2 Negation of Agency, Partnership, Joint Venture or Employment Relationship. In the performance of the work, duties and obligations of the parties to this Agreement, the parties shall be, and at all times are, independent contractors, and neither party shall consider itself or act as the agent of the other party. No relationship of employer and employee, or of partners or of joint venturers is created by this Agreement. No party shall have nor exercise any control or direction over the performance of services of any other party to this Agreement. Without limiting the foregoing, nothing contained herein shall be construed to interfere with the ordinary relationship that exists between provider and patient. Furthermore, no Provider or Contracting Provider shall be penalized for discussing Medically Necessary or appropriate patient care, for filing a grievance on behalf of a Member, or protesting a Plan decision, policy or practice which a Provider or Contracting Provider believes interferes with its ability to provide Medically Necessary and appropriate health care. Nothing contained in this Agreement shall create any rights or remedies in any third party including, but not limited to, any Enrollee.

10.3 Assignment; Binding Effect. Vision Vendor may at any time assign its rights and obligations under this Agreement to any entity that: (a) controls, is controlled by, or is under common control with, Vision Vendor; (b) purchases substantially all of the assets of Vision Vendor; or (c) is a Plan referred to in Section 1.10 of this Agreement, and Provider and each Contracting Provider hereby agrees to such assignment (the acceptance of any payment by Vision Vendor or its successor after such assignment also shall constitute evidence of consent by Provider to such assignment). No other assignment of the rights or obligations of either party under this Agreement shall be made without the express written consent of the other party, which consent shall not be unreasonably withheld. Any attempted assignment in violation of this

provision shall be void. Subject to the foregoing restrictions on assignment, this Agreement shall be binding upon the successors and assigns of the parties hereto.

10.4 Amendment. Except as otherwise provided herein, no amendment or modification of this Agreement shall be valid, binding or effective unless it is in writing and signed by Provider and Vision Vendor. Notwithstanding the foregoing, Vision Vendor shall, at any time and without any obligation to provide prior notice to, or obtain the consent of, Provider, have the right to unilaterally modify or amend this Agreement for the purpose of complying with applicable federal, state and local law. Vision Vendor shall notify Provider in writing of any such amendment(s) and such amendment(s) shall become effective as stated therein.

10.5 Notices. Any and all notices or other communications required or permitted by this Agreement shall be in writing and shall be delivered personally or by United States mail, first class, postage prepaid, addressed to the receiving party at the address for notices set forth on the signature page in the case of Vision Vendor or the Provider Demographic Form for Provider. Notice or access to Provider and, if applicable, each Contracting Provider, also may be by email, the portal, or other electronic means. Subject to the provisions of this Agreement, any such notices shall be effective on the later of delivery or the date indicated in the notice. Either party may change its notice address by giving written notice of the change to the other party.

10.6 Waiver of Breach; Entire Agreement. The waiver of any breach of this Agreement shall not be deemed to be a waiver of any other breach of either the same or any different provision. This Agreement, including without limitation, **Exhibits A, B, B-1,** and **B-2,** and the Provider Policies contain the entire agreement between the parties relating to the subject matter hereof and supersede any and all other agreements, negotiations, or representations, whether oral or written, between the parties with respect to the subject matter of this Agreement. In the event a Provider or Contracting Provider is directly or indirectly contracted with Vision Vendor under more than one agreement, Vision Vendor shall solely determine the governing agreement with respect to the provision of Eye Health Care Services to an Enrollee.

10.7 Governing Law. This Agreement shall be construed in accordance with and governed by the internal laws of the State of California without regard to its conflict of law provisions.

10.8 Headings. Headings contained in the Agreement are inserted only as a matter of convenience and in no way define, limit or extend the scope or intent of this Agreement or any provision thereof.

10.9 Severability. In the event any provision of this Agreement is rendered invalid or unenforceable by the enactment of any applicable statute, ordinance or regulation, or is made unenforceable by any court of competent jurisdiction, the remainder of this Agreement shall remain in full force and effect.

10.10 Nondisclosure. Without the other party's prior written consent, neither party shall disclose any term or condition hereunder to any third party, except as required by law, regulations or by applicable agencies, or as necessary to administer this Agreement.

10.11 Provider List; Marks. Vision Vendor has the right to list Provider and each Contracting Provider as a participating provider on Vision Vendor's participating provider lists. In addition to any other indemnification provided hereunder, Provider hereby releases Vision

Vendor, its officers, employees and agents from any and all liability for errors or omissions in preparation and dissemination of such provider lists. Provider and its Contracting Providers shall not at any time use any trademarks, service marks, trade names, or other marks or names of Vision Vendor, whether registered or common law marks (collectively, "**Marks**"), or prepare or distribute any forms, documents or materials of any kind using any Marks of Vision Vendor.

10.12 Arbitration. Any controversy or claim arising out of or relating to this Agreement, or the breach thereof, shall be settled by compulsory and binding arbitration in accordance with the Commercial Arbitration Rules of the American Arbitration Association, and judgment on the award rendered may be entered in any court having jurisdiction thereof. Such arbitration shall be held in the County of Los Angeles, California. If either party to this Agreement initiates arbitration or any other legal proceedings against the other party, the prevailing party shall be allowed such costs and reasonable attorneys' fees as the court may allow. If the parties are unable to agree on a single arbitrator, each party shall appoint an arbitrator and the two appointed arbitrators shall select a third arbitrator who shall conduct the arbitration. All fees and expenses of the arbitrator(s) and the arbitration shall be shared equally by the parties, subject to the terms of Section 10.15 hereof.

10.13 Counterparts. This Agreement may be executed in any number of counterpart copies, all of which shall constitute one and the same Agreement and each of which shall constitute an original, and shall become effective upon execution and delivery to both parties hereto. A facsimile or other digital copy of a signature shall be valid as an original.

10.14 Confidentiality; Non-Solicitation. Provider and each Contracting Provider acknowledges and agrees that the business relationship between Vision Vendor and its Enrollees and/or with subscriber groups, as applicable, and all lists of Enrollees accepted by Provider and the Contracting Provider(s) hereunder shall all be deemed valuable proprietary and confidential information of Vision Vendor. Accordingly, during the entire term of this Agreement and for a period of one (1) year after this Agreement expires or terminates for any reason, Provider and each Contracting Provider agrees that he/she/it shall not, without the prior written consent of Vision Vendor, directly or indirectly within the service area of Vision Vendor: (a) interfere with Vision Vendor's contract and/or property rights; (b) solicit such Enrollee to become enrolled with any other managed care organization; or (c) to disclose any proprietary information of Vision Vendor.

10.15 Fees. In the event of any litigation or other action involving a dispute or determination of rights or obligations under this Agreement, the prevailing party, as determined by the judge or arbitrator or arbitration panel, shall be entitled to court or arbitrator fees and reasonable attorneys' fees from the other party(ies) to the litigation or action.

10.16 Not Contingent on Referrals. The parties hereby acknowledge and agree that the terms and conditions hereunder neither require nor are in any way contingent upon the recommendation or referral by or to, or the provision of any item or service by or to, any party hereto or any patient. This Agreement shall not be construed to be an exclusive Agreement between Vision Vendor and Provider.

10.17 Location Change or Severance of Contracting Providers. Provider agrees to provide Vision Vendor with written notice at least one hundred (100) days in advance of any office location change of address or addition or severance of any Contracting Provider.

[SIGNATURE PAGE FOLLOWS]

IN WITNESS WHEREOF, the parties have executed this Agreement effective as of the Effective Date.

→ ***PROVIDER TO COMPLETE THIS SECTION***

Attestation: The individual signing below on behalf of Provider acknowledges, warrants, and represents that said individual has the authority and proper authorization to execute this Agreement on behalf of Provider and its Contracting Providers, if any, and does so freely with the intent to fully bind Provider, and its Contracting Providers, if any, to the provisions of this Agreement.

PROVIDER, on behalf of each Contracting Provider

Name: _____
(Contracting Provider/Entity, Line 1 from the W-9)

DBA: _____
(Business Name, Line 2 from the W-9)

Signature: _____
(Signature of Provider, Designee or Owner)

Name: _____
(Name of Person Signing)

Title: _____
(Title of Person Signing)

Date: _____

Tax ID Number: _____
(EIN or Social Security number from W-9)

Address to be used for giving notice to Provider under this Agreement:

Address: _____

City: _____

State: _____ Zip: _____

→ ***VISION VENDOR USE ONLY***

VISION VENDOR:

Vision Vendor, Incorporated,
a California corporation

By: _____

Name:

Title: Chief Operating Officer

Date: _____

Effective Date: _____

Address for Notices:

Vision Vendor
Attn: Contracting - Vision

EXHIBIT A

ALLOWABLE FEES

Subject in all cases to the terms and conditions of the applicable Plan, the maximum amount Provider shall receive for rendering services to an Enrollee shall be the lesser of billed charges or the applicable fees set forth in this **Exhibit A**.

MEDICAID PRODUCTS:

Reimbursement will be at [redacted] of the then current applicable Medicaid fee schedule. The applicable Medicaid fee schedule is determined by the State of the Member's health plan. For any service code without a specific dollar amount in such fee schedule, Provider will be paid at [redacted] of billed charges up to a maximum of [redacted]

Notwithstanding the foregoing, the following fittings will be reimbursed as follows:

Description:	CPT:	Medicaid
Fitting of spectacles except for aphakia; monofocal	92340	[redacted]
Fitting of spectacles except for aphakia; bifocal	92341	
Fitting of spectacles except for aphakia; multifocal, other than bifocal	92342	
Fitting of spectacles prosthesis for aphakia; monofocal	92352	

EXHIBIT B

DISPUTE RESOLUTION MECHANISM

This Exhibit sets forth Provider's rights, responsibilities, and related procedures as they relate to claim settlement practices and claim disputes. This Exhibit is modified by, and incorporates, any State laws, regulations and policies relating to this subject matter to the extent required by law.

I. Dispute Resolution Process for Contracting Providers

A. Definition of Contracted Provider Dispute. A "contracted provider dispute" is a provider's written notice to Vision Vendor and/or the Enrollee's applicable health plan challenging, appealing or requesting reconsideration of a claim (or a bundled group of substantially similar multiple claims that are individually numbered) that has been denied, adjusted or contested or seeking resolution of a billing determination or other contract dispute (or bundled group of substantially similar multiple billing or other contractual disputes that are individually numbered) or disputing a request for reimbursement of an overpayment of a claim.

Each contracted provider dispute must contain, at a minimum the following information:

1. provider's name;
2. provider's identification number;
3. provider's contact information;
4. if the contracted provider dispute concerns a claim or a request for reimbursement of an overpayment of a claim from Vision Vendor to a provider the following must be provided: a clear identification of the disputed item, the date of service and a clear explanation of the basis upon which the provider believes the payment amount, request for additional information, request for reimbursement for the overpayment of a claim, contest, denial, adjustment or other action is incorrect; if the contracted provider dispute is not about a claim, a clear explanation of the issue and the provider's position on such issue; and
5. if the contracted provider dispute involves an Enrollee or group of Enrollees, the name and identification number(s) of the Enrollee or Enrollees, a clear explanation of the disputed item, including the date of service and provider's position on the dispute, and written authorization from the Enrollee or Enrollee for provider to represent said Enrollee or Enrollee.

B. Sending a Contracted Provider Dispute to Vision Vendor. Contracted provider disputes submitted to Vision Vendor must include the information listed above for each contracted provider dispute (*see* **Exhibit B-1** attached hereto). All contracted provider disputes must be sent to the attention of *Provider Dispute Resolution/Claims Department* as follows:

Via Mail: 6601 Center Drive West, Suite 200
Los Angeles, CA 90045

Via Physical Delivery: 6601 Center Drive West, Suite 200
Los Angeles, CA 90045

Via fax: (877) 627-2488

C. Time Period for Submission of Provider Disputes.

1. Contracted provider disputes must be received by Vision Vendor within three hundred sixty-five (365) days from the later of the date: (a) of Vision Vendor's action that led to the dispute (or the most recent action if there are multiple actions) that led to the dispute; or (b) that the provider's time for contesting or denying a claim (or most recent claim if there are multiple claims) has expired.

2. Contracted provider disputes that do not include all required information as set forth above in Section I.A. may be returned to the submitter for completion. An amended contracted provider dispute which includes the missing information may be submitted to Vision Vendor within thirty (30) business days of the provider's receipt of a returned contracted provider dispute.

D. Contact Vision Vendor Regarding Contracted Provider Disputes. All inquiries regarding the status of a contracted provider dispute or about filing a contracted provider dispute must be directed to Vision Vendor at (866) 376-6780.

E. Instructions for Filing Substantially Similar Contracted Provider Disputes. Substantially similar multiple claims, billing or contractual disputes, may be filed in batches as a single dispute, provided that such disputes are submitted in the following format (*see* **Exhibit B-2** attached hereto):

1. Sort provider disputes by similar issue.
2. Submit Provider Dispute Resolution Request (for use with multiple "LIKE" claims) form with each batch.
3. Number each batch cover sheet.
4. Provide a cover letter for the entire submission describing each provider dispute with references to the numbered batches.

F. Past Due Payments. If the contracted provider dispute or amended contracted provider dispute involves a claim and is determined in whole or in part in favor of the provider, Vision Vendor will pay any outstanding monies determined to be due, and all interest and penalties required by law or regulation.

II. Claim Overpayments

A. Notice of Overpayment of a Claim. If Vision Vendor determines that it has overpaid a claim, Vision Vendor will notify the provider in writing through a separate notice clearly identifying the claim, the name of the Enrollee, the date of service(s) and a clear explanation of the basis upon which Vision Vendor believes the amount paid on the claim was in excess of the amount due, including interest and penalties on the claim.

B. Contested Notice. If the provider contests Vision Vendor's notice of overpayment of a claim, the provider, within thirty (30) business days of the receipt of the notice of overpayment of a claim, must send written notice to Vision Vendor stating the basis upon which the provider believes that the claim was not overpaid. Vision Vendor will process the contested notice in accordance with Vision Vendor's contracted provider dispute resolution process described in Section II above.

C. No Contest. If the provider does not contest Vision Vendor's notice of overpayment of a claim, the provider must reimburse Vision Vendor within thirty (30) Business days of the provider's receipt of the notice of overpayment of a claim.

D. Offsets to Payments. Vision Vendor may only offset an uncontested notice of overpayment of a claim against provider's then current claim submission when: (i) the provider fails to reimburse Vision Vendor within the time frame set forth in Section II(C) and (ii) Vision Vendor's contract with the provider specifically authorizes Vision Vendor to offset an uncontested notice of overpayment of a claim from the provider's current claims submissions. In the event that an overpayment of a claim or claims is offset against the provider's then current claim or claims pursuant to this section, Vision Vendor will provide the provider with a detailed written explanation identifying the specific overpayment or payments that have been offset against the specific claim or claims.

EXHIBIT B-1
PROVIDER DISPUTE RESOLUTION REQUEST

INSTRUCTIONS

- Please complete the below form. Fields with an asterisk (*) are required.
- Be specific when completing the DESCRIPTION OF DISPUTE and EXPECTED OUTCOME.
- Provide additional information to support the description of the dispute. Do not include a copy of a claim that was previously processed.
- For routine follow-up, please contact Vision Vendor at (XXX) XXX-XXXX.
- Mail the completed form to: Vision Vendor, ADDRESS

***PROVIDER NAME:**	***PROVIDER TAX ID # / Medicare ID #:**
PROVIDER ADDRESS:	

PROVIDER TYPE ☐ OD ☐ MD ☐ DO ☐ Mental Health Professional ☐ Mental Health Institution ☐ Hospital ☐ ASC ☐ SNF ☐ DME ☐ Rehab ☐ Home Health ☐ Ambulance ☐ Other _____

(please specify type of "other")

CLAIM INFORMATION ☐ Single ☐ Multiple "**LIKE**" Claims (complete attached spreadsheet)
Number of claims:____

*** Patient Name:**		**Date of Birth:**
*** Health Plan ID Number:**	**Patient Account Number:**	**Original Claim ID Number:** (If multiple claims, use attached spreadsheet)

Service "From/To" Date: (* Required for Claim, Billing, and Reimbursement Of Overpayment Disputes)	**Original Claim Amount Billed:**	**Original Claim Amount Paid:**

DISPUTE TYPE	
☐ Claim ☐ Appeal of Medical Necessity / Utilization Management Decision ☐ Disputing Request For Reimbursement Of Overpayment	☐ Seeking Resolution Of A Billing Determination ☐ Contract Dispute ☐ Other:

*** DESCRIPTION OF DISPUTE:**
EXPECTED OUTCOME:

Contact Name (please print)	**Title**	**( ) Phone Number**
Signature	**Date**	**( ) Fax Number**

[ ] CHECK HERE IF ADDITIONAL INFORMATION IS ATTACHED
(Please do not staple)

Vendor Vision Use Only

TRACKING NUMBER _____ PROV ID# _____

CONTRACTED _____ NON-CONTRACTED _____

EXHIBIT B-2
PROVIDER DISPUTE RESOLUTION REQUEST
(For use with multiple "LIKE" claims)

Number	* Patient Name		Date of Birth	* Health Plan ID Number	Original Claim ID Number	* Service From/To Date	Original Claim Amount Billed	Original Claim Amount Paid	Expected Outcome
	Last	First							
1									
2									
3									
4									
5									
6									
7									
8									
9									
10									

Page _____ of _____

[ ] **CHECK HERE IF ADDITIONAL INFORMATION IS ATTACHED**
(Please do not staple)

MississippiCHIP Regulatory Requirements Appendix

Downstream Provider

THIS MISSISSIPPICHIP PROGRAM REGULATORY REQUIREMENTS APPENDIX (this "Appendix") supplements and is made part of the provider agreement (the "Agreement") between Vision Vendor ("Subcontractor") and the party named in the Agreement ("Provider").

SECTION 1
APPLICABILITY

This Appendix applies with respect to the provision of direct or health care related services that Provider directly provides to Members through CCO's (as defined herein) products or benefit plans under the Mississippi Children's Health Insurance Program (the "MississippiCHIP Program") as governed by the State's designated regulatory agencies. Provider has agreed to provide Covered Services to Members who receive their coverage pursuant to a contract between the State and CCO (the "MississippiChip Program Contract" as defined herein). The MississippiChip Program Contract and applicable State and federal law require that the provisions contained in this Appendix be part of the Agreement. In the event of a conflict between this Appendix and other appendices or any provision of the Agreement, the provisions of this Appendix shall control except with regard to benefit plans outside the scope of this Appendix or unless otherwise required by law. In the event Subcontractor is required to amend or supplement this Appendix as required or requested by the State to comply with federal or State regulations, Subcontractor will unilaterally initiate such additions, deletions or modifications. All provider agreements must be in writing and must include all specific activities and report responsibilities delegated to the Provider by Subcontractor.

SECTION 2
DEFINITIONS

Unless otherwise defined in this Appendix, all capitalized terms shall be as defined in the Agreement. For purposes of this Appendix, the following terms shall have the meanings set forth below; provided, however, in the event any definition set forth in this Appendix or the Agreement is inconsistent with any definition under the MississippiCHIP Program Contract, the definition shall have the meaning set forth under the MississippiCHIP Program Contract.

2.1 Abuse: Any Practice that is inconsistent with sound fiscal, business, or medical practices, and results in an unnecessary cost to CHIP, Contractor, a Provider or in reimbursement for services that are not Medically Necessary or that fail to meet professionally recognized standards for healthcare.

2.2 Action: Subcontractor's or CCO's decision to deny or limit authorization or payment (in whole or in part) for health care services, including new authorizations and previously authorized services; the reduction, suspension, or termination of a previously authorized service; or CCO's or Subcontractor's failure to provide services in a timely manner; failure to resolve Complaints, Grievances, or Appeals within the specified time frames.

2.3 Agreement: An agreement between the Subcontractor or CCO and an individual, business, university, government entity, affiliate, or nonprofit organization to perform part or all of

Subcontractor's or CCO's responsibilities under the MississippiCHIP Program Contract. Agreements must be approved in writing by DOM prior to the start date of the Agreement.

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

2.5 Auto Enrollment: The process by which Members who have not voluntarily selected a CHIP Contractor are assigned to a CHIP Contractor.

2.6 Behavioral Health Services: Mental health and/or drug and alcohol abuse treatment services that are provided by the county mental health/Intellectually Delayed/Developmentally Delayed programs, the single county authority administrators, or other appropriately licensed health care practitioners.

2.7 Benchmark Plan: The State School Employee's Health Insurance Plan.

2.8 Child: An individual who is under nineteen (19) years of age who is not eligible for Medicaid benefits and is not covered by other health insurance. Child is also referred to as Member.

2.9 CHIP: The Children's Health Insurance Program as defined in Title XXI of the Social Security Act.

2.10 Complaint: An expression of dissatisfaction received orally or in writing that is of a less serious or formal nature that is resolved within one (1) business day of receipt.

2.11 Coordinated Care Organization (CCO): An organization that meets the requirements for participation as a Contractor in CHIP and manages the purchase and provision of health care services under CHIP. For purposes of this Appendix, CCO refers to Vision Vendorcare of Mississippi, Inc.

2.12 Co-Payment: The fixed amount certain CHIP Members pay for a covered health care service. The amount may vary based on healthcare service being provided.

2.13 Cost Sharing: In accordance with 42 C.F.R. §457.10, premium charges, enrollment fees, deductibles, coinsurance, Co-Payments, or other similar fees that the Member has responsibility for paying.

2.14 Covered Services: Health care services or products for which a Member is enrolled with CCO to receive coverage under the MississippiCHIP Program Contract.

2.15 Disenrollment: Action taken by DOM, or its Agent, to remove a Member's name from the monthly Member Listing Report following DOM's receipt and approval of a request for Disenrollment or a determination that the Member is no longer eligible for Enrollment in Contractor.

2.16 DOM: The Division of Medicaid, Office of the Governor, State of Mississippi.

2.17 Fraud: Fraud is any type of intentional deception or misrepresentation made by an entity or person with the knowledge that the deception could result in some unauthorized benefit to the entity, him or herself, or some other person. The Fraud can be committed by many entities, including a vendor, a subcontractor, a provider, a State employee, or a Member among others.

2.18 Grievance: An expression of dissatisfaction about any matter or aspect of Subcontractor or CCO or its operation, other than an Action as defined herein.

2.19 Marketing: The activities that promote visibility and awareness for the MississippiCHIP Program and Subcontractor's or CCO's participation in the program. All activities are subject to prior review and approval by DOM.

2.20 Medical Record: A single complete record, which documents the entire treatment plan developed for, and medical services received by, the Member including inpatient, outpatient, referral services and emergency medical services whether provided by Contracted Providers or Non-Contracted Providers.

2.21 Member: An individual who meets all of the eligibility requirements for CHIP, enrolls in a CCO under CHIP, and receives health benefits coverage through CHIP.

2.22 MississippiCHIP Program: The Mississippi Medicaid child health program for select individuals under the age of nineteen (19) years of age who are not eligible for Medicaid benefits and are not covered by other health insurances.

2.23 MississippiCHIP Program Contract: The DOM contract with CCO, for the purpose of providing and paying for Covered Services to Members enrolled in the MississippiCHIP Program.

2.24 Primary Care Provider (PCP): Any physician or health care practitioner or group operating within the scope of his or her licensure who is responsible for supervising, prescribing and providing primary care and primary case management services in the MississippiCHIP Program, whose practice is limited to the general practice of medicine or who is an Internist, Pediatrician, Obstetrician, Gynecologist, Family Practitioner, General Practitioner, Certified Nurse Practitioners whose specialty is pediatrics, adult, family, certified nurse midwife, obstetrics/gynecology, or a physician assistant.

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

2.26 Provider Network: The Panel of health service Providers with which the Subcontractor or CCO contracts for the provision of covered services to Members and Non-Contracted Providers administering services to Member.

2.27 State: The State of Mississippi or its designated regulatory agencies.

2.28 State Child Health Plan: The State of Mississippi's plan submitted to HHS for the administration of CHIP.

2.29 Third Party Liability/Resource: Any resource available to a Member for the payment of medical expenses associated with the provision of covered services, including but not limited to, insurers and workers' compensation plan.

2.30 Well-Baby and Well-Child Care Services: Regular or preventive diagnostic and treatment services necessary to ensure the health of babies, children, and adolescents as defined by DOM in the State Child Health Plan. For the purposes of Cost Sharing, the term has the meaning assigned at 42 C.F.R. § 457.520.

SECTION 3
PROVIDER REQUIREMENTS

The MississippiCHIP Program, through contractual requirements and federal and State statutes and regulations, requires that providers who provide services to Members enrolled in the MississippiCHIP Program comply with certain requirements as set forth below and elsewhere in this Appendix.

3.1 Definitions Related to the Provision of Covered Services. Provider shall follow the applicable MississippiCHIP Program Contract's requirements for the provision of Covered Services. Provider's decisions affecting the delivery of acute or chronic care services to Members shall be made on an individualized basis and in accordance with the following definitions:

(a) Emergency Medical Condition: In accordance with Section 1932(b) of the Act and 42 CFR §457.10, a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in any of the following: (1) 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; (2) serious impairment to body functions; or (3) serious dysfunction of any body organ or part.

(b) Emergency Services: Healthcare services that are (1) furnished by a provider who is qualified to furnish those health services and (2) needed to evaluate or stabilize an Emergency Medical Condition.

(c) Medically Necessary Services: As set forth in the Social Security Act, Section 1905 (42 U.S.C. 1396d(a)), Medically Necessary Services are defined as services, supplies, or equipment provided by a licensed health care professional that are:

1. Appropriate and consistent with the diagnosis or treatment of the patient's condition, illness, or injury;

2. In accordance with the standards of good medical practice consistent with the individual patient's condition(s);
3. Not primarily for the personal comfort or convenience of the Member, family, or Provider;

4. The most appropriate services, supplies, equipment, or levels of care that can be safely and efficiently provided to the Member;

5. Furnished in a setting appropriate to the patient's medical need and condition and, when applied to the care of an inpatient, further mean that the Member's medical symptoms or conditions require that the services cannot be safely provided to the Member as an outpatient;

6. Not experimental or investigational or for research or education;

7. Provided by an appropriatelylicensed practitioner; and

8. Documented in the patient's record in a reasonable manner, including the relationship of the diagnosis to the service.

Medically Necessary Services may also be those services for children that are necessary to correct or ameliorate defects and physical and mental illnesses and conditions discovered during an interperiodic or Well-Baby and Well-Child Care Services, whether such services are covered or exceed the benefit limits in the Medicaid State Plan and Title 23 of Mississippi Administrative Code.

3.2 Accessibility Standards. Provider shall provide for timely access for Member appointments in accordance with the appointment availability requirements established under the MississippiCHIP Program Contract, as further described in the applicable provider manual.

Type	Appointment Scheduling Time Frames
PCP (well care visit)	Not to exceed thirty (30) calendar days
PCP (routine sick visit)	Not to exceed seven (7) calendar days
PCP (urgent care visit)	Not to exceed twenty-four (24) hours
Specialists	Not to exceed forty-five (45) calendar days
Dental Providers (routine visits)	Not to exceed forty-five (45) calendar days
Dental Providers (urgent Care)	Not to exceed forty-eight (48) hours
Behavioral Health Providers (routine visit)	Not to exceed fourteen (14) calendar days
Behavioral Health Providers (urgent visit)	Not to exceed twenty-four (24) hours
Behavioral Health Providers (post-discharge from an acute psychiatric hospital when the Contractor is aware of the Member's discharge)	Not to exceed seven (7) calendar days
Urgent Care Providers	Not to exceed twenty-four (24) hours
Emergency Providers	Immediately (twenty-four (24) hours a day, seven (7) days a week) and without Prior Authorization

3.3 Hours of Operation; Appointments. Provider shall offer hours of operation that are no less than the hours of operation offered to commercial beneficiaries.

3.4 PCP Responsibilities. If applicable, and Provider is a PCP, Provider shall comply with the following:

3.4.1 PCPs who serve Members under the age of nineteen (19) are responsible for conducting all Well-Baby and Well-Child Care services. Should the PCP be unable to conduct the necessary Well-Baby and Well-Child Care services screens, the PCP is responsible for arranging to have the necessary Well-Baby and Well-Child Care services screens conducted by another network provider and ensure that all relevant medical information, including the results of the Well-Baby and Well-Child Care services screens, are incorporated into the Member's PCP Medical Record.

3.4.2 PCPs who serve Members under the age of nineteen (19) report encounter data associated with Well-Baby and Well-Child Care services, using a format approved by DOM, to Contractor within one hundred and eighty (180) calendar days from the date of service.

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

3.4.3.1 Contact Members identified in the quarterly Encounter lists as not complying with Well-Baby, Well-Child Care, and immunization schedules for Children;

3.4.3.2 Identify to Contractor any such Members who have not come into compliance with Well-Baby, Well-Child Care, and immunization schedules within one (1) month of such notification to the site by Contractor; and

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

3.4.4 PCP shall provide the full range of Well-Baby, Well-Child Care, well-adolescent care and childhood and adolescent immunization services recommended by the Advisory Committee on Immunization Practices (ACIP) for all Members under the age of nineteen (19) as defined in, and in accordance with, the State Child Health Plan, 42 C.F.R. §457.495 and the provisions of Mississippi CHIP Contract, including periodic examinations for vision, dental, and hearing and all Medically Necessary services. The following minimum elements must be included in the periodic health screening assessment of children:

a. Comprehensive health and development history (including assessment of both physical and mental development);

b. Measurements (including head circumference for infants);

c. Comprehensive unclothed physical examination;

d. Immunizations appropriate to age and health history;

e. Assessment of nutritional status;

f. Laboratory tests (including tuberculosis screening and Federally required blood lead screenings);

g. Vision Screening;

h. Hearing Screening;

i. Dental and Oral Health Assessment;

j. Development Assessment; and,

k. Health education and anticipatory guidance.

If a suspected problem is detected by a screening examination, the child must be evaluated as necessary for further diagnosis. This diagnosis is used to determine treatment needs.

3.4.5 Specialists as PCPs. Members with disabling conditions, chronic conditions, or with special health care needs may request that their PCP be a specialist. The designation of a specialist as a PCP must be pursuant to a treatment plan approved by Contractor; in consultation with the PCP to which the Member is currently assigned, the Member and, as appropriate, the specialist. When possible, the specialist must be a provider participating in Contractor's network. The specialist as a PCP must agree to provide or arrange for all primary care, including routine preventive care, and to provide those specialty medical services consistent with the Member's disabling condition, chronic illness, or special health care need in accordance with Contractor's standards and within the scope of the specialty training and clinical expertise. To accommodate the full spectrum of care, the specialist as a PCP must also have admitting privileges at a hospital in Contractor's network.

3.5 **Provider Selection.** To the extent applicable to Provider in performance under the Agreement, Provider shall comply with 42 CFR §438.214, as may be amended from time to time, which includes, but is not limited to the selection and retention of providers, credentialing and re-credentialing requirements and nondiscrimination. If Subcontractor or CCO delegates credentialing to Provider, Subcontractor or CCO will provide monitoring and oversight and Provider shall ensure that all licensed medical professionals are credentialed in accordance with Subcontractor's or CCO's and the MississippiCHIP Program Contract's credentialing requirements.

3.6 **Records Retention.** As required under State or federal law or the MississippiCHIP Program Contract, Provider shall maintain a record keeping system of current, detailed, and organized records for recording services, charges, dates and all other commonly accepted information elements sufficient to disclose the quality, quantity, appropriateness and timeliness of services rendered to Members. All financial records shall follow generally accepted accounting principles. Medical records and supporting management systems shall include all pertinent information related to the medical management of each Member. Other records shall be maintained as necessary to clearly reflect all actions taken by Provider related to services provided under the MississippiCHIP Program Contract. Such records shall be maintained for a period of not less than five (5) years from the close of the Agreement, or such other period as required by law. If records are under review or audit or are the subject of litigation they must be retained for a minimum of five (5) years following resolution of such action. Prior approval for the disposal of records must be requested and approved by Subcontractor or CCO if the Agreement is continuous. Provider shall have written records retention policies and procedures and will make such

policies and procedures available to Subcontractor, CCO or DOM upon request. DOM requires ready access to any and all documents and records of transactions pertaining to the provisions of services provided by Provider and those copies of requested documents/records will be provided to DOM or its designee free of charge.

3.7 **Records Access.** Provider acknowledges and agrees and shall require Provider to acknowledge and agree that DOM, the U.S. Department of Health and Human Services and other authorized federal and state personnel shall have complete access to all records pertaining to services provided to Members. Provider shall provide immediate access to facilities, records and supportive materials pertinent to the MississippiCHIP Program Contract for State or Federal fraud investigators.

3.8 **Government Audit; Investigations.** Provider acknowledges and agrees and shall require Provider to acknowledge and agree that the State or any of its duly authorized representatives, DOM, the U.S. Department of Health and Human Services, the Centers for Medicare & Medicaid Services, the Office of Inspector General, the General Accounting Office, or any other auditing agency or their authorized representatives, with prior approval by DOM, at any time during the term of the Agreement, shall, at all reasonable time and within regular business hours, with or without notice, have the right to inspect or otherwise evaluate the quality, appropriateness, and timeliness of services provided under the terms of the MississippiCHIP Program Contract and any other applicable federal and State law and regulation..

This shall include, but not be limited to, the right to enter onto Provider's premises, access to and the right to audit, inspect, monitor, and examine any pertinent books, documents, papers, medical records, financial records, surveys and computer databases and/or to otherwise evaluate the performance of Provider related to Provider's performance under the Agreement. Such monitoring activities may also include, without limitation, on-site inspections of all service locations and facilities; auditing and/or review of all records developed under the MississippiCHIP Program Contract or the Agreement; reviewing management systems and procedures developed under the MississippiCHIP Program Contract or the Agreement; and review of any other areas of materials relevant or pertaining to the MississippiCHIP Program Contract or the Agreement. All reviews and audits shall be performed in such a manner as will not unduly delay the work of Provider. There will be no restrictions on the right of the State or federal authorities to conduct inspections and audits as necessary.
The Provider must fully cooperate with any and all reviews and/or audits by state or federal agencies, such as the Department of Audit, Department of Health and Human Services, Centers for Medicare and Medicaid Services, Office of Inspector General, General Accounting Office, or any other auditing agency approved by DOM, by assuring that appropriate employees and involved parties are available for interviews relating to the reviews or audits.

All records shall be maintained and available for review by authorized federal and state agencies during the entire term of the MississippiCHIP Program Contract and for a period of five (5) years thereafter, unless an audit, litigation, or other legal action is in progress. When an audit or litigation is in progress or audit findings are unresolved, records shall be kept for a period of five (5) years or until all issues are finally resolved, whichever is later. The Provider must have written policies and procedures for storing this information. Records must be kept in an original paper state or preserved on micro media or electronic format.

3.9 **Data; Reports.** Provider shall and shall require that Provider cooperate with and release to

Subcontractor or CCO any information necessary for Subcontractor or CCO to perform its obligations under the MississippiCHIP Program Contract to the extent applicable to Provider in performance of the Agreement, including the timely submission of reports and information required by Subcontractor or CCO. Such reports shall include well-baby/well-child reporting, as well as complete and accurate encounter and utilization management data in accordance with the requirements of Subcontractor, CCO and DOM.

3.10 **Encounter Data.** Provider shall agree to cooperate with Subcontractor or CCO to comply with Subcontractor's or CCO's obligation to prepare encounter data submissions, reports, and clinical information including, without limitation, and well-baby/well-child reporting and encounters, as applicable, and such other reporting regarding Covered Services as may be required under the MississippiCHIP Program Contract.

3.11 **Claims Information.** Provider shall promptly submit to Subcontractor or CCO the information needed to make payment and shall identify third party liability coverage, including Medicare and other insurance, and if applicable seek such third party liability payment before submitting claims to Subcontractor or CCO. Provider understands and agrees that each claim Provider submits to Subcontractor or CCO constitutes a certification that the claim is true and accurate to the best of Provider's knowledge and belief and that the Covered Services are 1) Medically Necessary and 2) have been provided to the Member prior to submitting the claim.

Provider must submit claims within six (6) months from the date of service. Claims filed within the appropriate time frame but denied may be resubmitted to Subcontractor or CCO within ninety (90) calendar days from the date of denial.

3.12 **Third Party Resources.** Provider shall report all Third Party Resources to Subcontractor or CCO identified through the provision of medical services.

3.13 **Privacy; HIPAA.** Provider shall comply with all applicable privacy rule and security rule provisions of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), and associated implementing regulations, as may be amended from time to time, and shall safeguard information about Members in accordance with applicable federal and State privacy laws and rules including 42 CFR §438.224 and 42 CFR Part 431, Subpart F, as may be amended from time to time. Provider agrees that confidential information, including but not limited to, medical and other pertinent information relative to Members, shall not be disclosed to any person or organization for any purpose without the expressed, written authority of DOM or as otherwise required by law and that all such disclosures shall fully comply with HIPAA privacy and security standards.

3.14 **Cultural Competency.** Provider shall participate in Subcontractor's, CCO's and DOM's efforts to promote the delivery of services in a culturally competent manner to all Members, including those with limited English proficiency and diverse cultural and ethnic backgrounds and shall provide interpreter services in a Member's primary language and for the hearing impaired for all appointments and emergency services. Provider shall provide information to Members regarding treatment options and alternatives, as well as information on complaints and appeals, in a manner appropriate to the Member's condition and ability to understand.

3.15 **Approval of Marketing Materials.** As required under State or federal law or the applicable

MississippiCHIP Program Contract, any marketing materials developed and distributed by Provider as related to the performance of the Agreement must be submitted to CCO for submission to DOM for prior approval.

3.16 **Independent Contractor Relationship.** Provider expressly agrees that Provider is acting in an independent capacity in the performance of the Agreement and not as an officer, agent or employee of DOM, CMS or the State. Provider further expressly agrees that the Agreement shall not be construed as a partnership or joint venture between Provider and DOM, CMS or the State. Nothing in the Agreement shall be construed, nor shall it be deemed to create, any right or remedy in any third party.

3.17 **Certification on Relationship to State, DOM and CMS**. Provider certifies that no officer, director, employee, subcontractor or agent of Provider, or person with an ownership or control interest in Provider, is also employed by, or is a public official of, the State of Mississippi or any of its agencies, DOM or CMS.

3.18 **Ownership and Control Information.** If applicable, Provider shall cooperate with Subcontractor and/or CCO in obtaining and providing information to DOM related to ownership and control, significant business transactions, and persons convicted of a criminal offense in compliance with§1128 of the Social Security Act, 42 USC §1320a-7 and 42 CFR Part 455, as amended and shall provide information upon request. Provider shall submit information related to ownership and control of subcontractors or wholly owned supplier within thirty-five (35) calendar days of a request for such information.

By executing the Agreement, Provider certifies that neither Provider nor any of its principals is presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in any State or federal health care program or from participating in transactions by any State or federal department or agency. Subcontractor will terminate the Agreement upon becoming aware or receiving notice from DOM, whichever is earlier, that Provider is or has been excluded from participation in any State or federal health care program or by any State or federal agency.

3.19 **Excluded Individuals and Entities.** Provider certifies that neither it nor any of its employees, principals, nor any providers, subcontractors or consultants or persons with an ownership or controlling interest in the Provider (an owner including the Provider himself or herself), or an agent or managing employee of the Provider, with whom Provider contracts and who are providing items or services that are significant and material to Provider's obligations under the Agreement is:

(a) excluded from participation in federal health care programs under either Section 1128 or section 1128A of the Social Security Act; or

(b) debarred, suspended, proposed for debarment, declared ineligible, or otherwise voluntarily excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549; or an affiliate, as defined in the Federal Acquisition Regulation, of such a person.

Provider acknowledges and agrees and shall require that Provider acknowledge and agree that payment will not be made for any items or Covered Services provided by an excluded individual pursuant to 42

CFR §1001.1901(b) and is obligated to screen all employees, contractors, and subcontractors for exclusion as required under applicable State and Federal laws. Additionally, Provider acknowledges that pursuant to 42 CFR §1003.102(a)(2) civil monetary penalties may be imposed against Provider if he or she employs or enters into contracts with excluded individuals or entities to provide items or Covered Services to Member under the Agreement. Provider agrees not to employ or subcontract with individuals or entities whose owner, those with a controlling interest, or managing employees are on a State or Federal exclusion list to provide items or Covered Services under the Agreement. Provider shall immediately report to Subcontractor and/or CCO any exclusion information discovered. Provider can search the HHS-OIG website, at no cost, by the names of any individuals or entities. The database is called LEIE and can be accessed at http://www.oig.hhs.gov/fraud/exclusions.asp. The GSA EPLS/SAM database can be accessed at https://www.sam.gov. Applicable state exclusion databases can be accessed through the State's Medicaid website. Subcontractor will terminate the Agreement immediately upon becoming aware or receiving notice from DOM, whichever is earlier, that Provider's owners, agents, managing employees, or any provider is or has been excluded from federal health care programs or terminated from the Medicare or the Medicaid program in any state.

3.20 **Licensure.** Provider represents that it is currently licensed and/or certified under applicable State and federal statutes and regulations and by the appropriate State licensing body or standard-setting agency, as applicable. Provider represents that it does not have a Medicaid provider agreement with DOM that is terminated, suspended, denied, or not renewed as a result of any action of DOM, CMS, HHS, or the Medicaid Fraud Control Unit of the State's Attorney General. Provider shall maintain at all times throughout the term of the Agreement all necessary licenses, certifications, registrations and permits as are required to provide the health care services and/or other related activities delegated to Provider by Subcontractor and/or CCO under the Agreement. If at any time during the term of the Agreement, Provider is not properly licensed as described in this Section, Provider shall discontinue providing services to Members.

3.21 **National Provider ID (NPI).** If applicable, Provider shall and shall require that Providers obtain a National Provider Identification Number (NPI) and when filing claims with Provider, the NPI number used is the same NPI number used when filing claims with DOM.

3.22 **Funding.** Provider recognizes that the obligation of DOM to proceed under its MississippiCHIP Program Contract with Subcontractor and/or CCO is conditioned upon the appropriation of funds by the Mississippi State Legislature and the receipt of State and/or Federal funds. If the funds anticipated for the continuing fulfillment of the agreement are, at any time, not forthcoming or insufficient, either through the failure of the Federal government to provide or the State of Mississippi to appropriate funds, or the discontinuance, or material alteration of the program under which the funds were provided or if funds are not otherwise available to DOM, DOM has the right upon ten (10) working days written notice to Subcontractor and/or CCO to terminate the MississippiCHIP Program Contract.

3.23 **Federal and State Funds Liability.** Providers acknowledges and agrees that payments made to Provider for services provided under the Agreement are derived from federal and State funds and that any false claim or statement in documents or any concealment of material fact related to such services may be a cause for sanctions and prosecution under applicable federal and State laws. Provider shall be subject to all laws applicable to individuals and entities receiving State and federal funds and may be held civilly or criminally liable to Subcontractor, CCO and DOM in the event of nonperformance, misrepresentation, fraud, or abuse related to services provided pursuant to the MississippiCHIP Program

Contract. Provider recognizes that payments made to the Provider are derived from federal and State funds, and are contingent upon and subject to availability and receipt of funds.

3.24 **Insolvency**. In the event Subcontractor and/or CCO becomes insolvent or unable to pay Provider, Provider shall not seek compensation for services rendered from DOM, its officers, Agents, or employees, or the Members or their eligible dependents.

3.25 **Termination.** In the event of termination of the Agreement, Provider shall promptly supply to Subcontractor or CCO all information necessary for the reimbursement of any outstanding MississippiCHIP Program claims.

3.26 **Capitated Providers.** If a Provider that is capitated terminates its agreement with Subcontractor or CCO, for any reason, Provider will provide services to Members assigned to Provider up to the end of the month in which the effective date of termination falls.

3.27 **Fraud, Waste, and Abuse Prevention.** Provider shall cooperate fully with the Subcontractor's and/or CCO's policies and procedures designed to protect program integrity and prevent and detect potential or suspected fraud, waste, and abuse in the administration and delivery of services under the MississippiCHIP Program Contract and shall cooperate and assist DOM and any other State or federal agency charged with the duty of preventing, identifying, investigating, sanctioning or prosecuting suspected fraud, waste, and abuse in state and/or federal health care programs. Provider, Subcontractor and CCO are responsible for reporting suspected fraud and abuse by participating and non-participating providers, as well as Members, when detected.

In accordance with Subcontractor's and/or CCO's policies and the Deficit Reduction Act of 2005 (DRA), Provider shall have written policies for its employees, contractors or agents that: (a) provide detailed information about the federal False Claims Act (established under sections 3729 through 3733 of title 31, United States Code); (b) cite administrative remedies for false claims and statements (established under chapter 38 of title 31, United States Code) and whistleblower protections under federal and state laws; (c) reference state laws pertaining to civil or criminal penalties for false claims and statements; and (d) with respect to the role of such laws in preventing and detecting fraud, waste, and abuse in federal health care programs (as defined in section 1128B(f)), include as part of such written policies, detailed provisions regarding Provider's policies and procedures for detecting and preventing fraud, waste, and abuse. Provider agrees to train its staff on the aforesaid policies and procedures.

3.28 **Quality Utilization Management.** Pursuant to any applicable provider manuals and related protocols, or as elsewhere specified under the Agreement, Provider agrees to cooperate with Subcontractor's and CCO's quality improvement and utilization review and management activities. This shall include, but not be limited to, participation in any internal and external quality assurance, utilization review, peer review, and grievance procedures established by Subcontractor and CCO or as required under the MississippiCHIP Program Contract to ensure that Members have due process for their complaints, grievances, appeals, fair hearings or requests for external review of adverse decisions made by Subcontractor, CCO or Provider. Provider shall adhere to the quality assurance and utilization review standards of the MississippiCHIP Program and shall monitor quality and initiate corrective action to improve quality consistent with the generally accepted level of care.

3.29 **Quality and Utilization Management Program.** Provider shall cooperate with Subcontractor and CCO in meeting the Quality Management and Utilization Management Program standards outlined

in the MississippiCHIP Program Contract.

3.30 **Referrals.** Provider shall make referrals for social, vocational, education or human services when a need for such service is identified.

3.31 **Restrictions on Referrals.** Provider shall not make inappropriate referrals for designated health services to health care entities with which Provider or a member of Provider's family has a financial relationship, pursuant to federal anti-kickback and physician self-referral laws that prohibit such referrals.

3.32 **Complaints, Grievances and Appeals.** Information on how Provider or Provider's authorized representative shall submit complaints and file grievances and appeals, and the resolution process, is contained in the Subcontractor or CCO MississippiCHIP Provider Manual.

3.33 **Health Care Acquired/Preventable Conditions.** Provider agrees that no payment shall be made for the provision of medical assistance for health care acquired conditions and other provider preventable conditions as may be identified by the State. As a condition of payment, Provider shall identify and report to Subcontractor and/or CCO any provider preventable conditions in accordance with 42 CFR Part 438, including but not limited to, 42 CFR § 438.6(f)(2)(i).

3.34 **Compliance with Laws.** Provider shall comply with all applicable federal and State laws and regulations and all provisions of the MississippiCHIP Program Contract that pertain to a Member's rights, including but not limited to the following, to the extent applicable to Provider in performance of the Agreement:

(a) Title VI of the Civil Rights Act of 1964; (b) Title XIX of the Social Security Act;

(c) Title IX of the Education Amendments of1972 (regarding education programs and activities); the Age Discrimination Act of 1975; the Rehabilitation Act of 1973; and The Genetic Information Non-Discrimination Act of 2008 (GINA), and their implementing regulations, as may be amended from time to time.

(d) 42 CFR Part 434 and 42 CFR § 438.6, as may be amended from time to time.

(e) All federal and State professional and facility licensing and accreditation requirements/standards that apply to the services Provider perform pursuant to the Agreement, including but not limited to:

(i) All applicable standards, orders or requirements issued under Section 306 of the Clean Air Act (42 USC 1857 (h)). Section 508 of the Clean Water Act (33 USC 1368), Executive Order 11738, and Environmental Protection Agency (EPA) regulations (40) CFR Part 15), which prohibit the use of facilities included on the EPA list of violating facilities. Any violations must be reported to DSHS, DHHS, and the EPA;

(ii) Any applicable mandatory standards and policies relating to energy efficiency that are contained in the State Energy Conservation Plan, including the Energy Policy & conservation Act (Pub. L. 94-165), and issued in compliance with the Federal Energy Policy & Conservation Act.

(f) All relevant federal and State statutes, regulations and orders related to equal opportunity in employment, including but not limited to compliance with E.O. 11246, "Equal Employment Opportunity," as amended by E.O. 11375, "Amending Executive Order 11246 Relating to Equal Employment Opportunity," and as supplemented by regulations at 41 CFR Part 60, "Office of Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor."

(g) If the Agreement is for an amount in excess of $100,000, Provider shall comply with all applicable standards, orders or regulations issued pursuant to the Clean Air Act, 42 U.S.C. 7401 et seq., and the Federal Water Pollution Control Act, as amended, 33 U.S.C. 1251 et seq. Any violations shall be reported to DHHS and the appropriate Regional Office of the Environmental Protection Agency.

(h) Those specified for laboratory services in the Clinical Laboratory Improvement Amendments (CLIA). All laboratory service sites must have a CLIA certificate of registration or waiver, and a CLIA identification number.

(i) The American with Disabilities Act (ADA). Provider shall make reasonable accommodation for Members with disabilities in accord with the ADA for all Covered Services and shall assure physical and communication barriers do not inhibit Members with disabilities from obtaining Covered Services;

(j) Section 1128B(d)(1) of the Balanced Budget Act of 1997; and,

(k) Any other requirements associated with the receipt of federal funds.

3.35 **Non-Discrimination.** Members must be provided Covered Services without regard to race, color, creed, sex, religion, age, national origin, ancestry, marital status, sexual orientation, language, health status, disease or pre-existing condition (including genetic information), anticipated need for health care or physical or mental handicap, except where medically indicated. Examples of prohibited practices include, but are not limited to, the following:

(a) Denying or not providing a Member any MississippiCHIP Covered Service. Health care and treatment necessary to preserve life must be provided to all Members who are not terminally ill or permanently unconscious, except where a competent Member objects to such care on his/her own behalf.

(b) Subjecting a Member to segregated, separate, or different treatment, including a different place or time from that provided to other Members or public or private patients, in any manner related to the receipt of any MississippiCHIP Covered Service, except where Medically Necessary.

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

3.36 **Advance Directives.** Provider shall comply with the advance directives requirements with 42 C.F.R §422.128 and with the Uniform Health-Care Decisions Act (Miss. Code Ann. § 41-41-201, *et. seq*.).

3.37 **Physician Incentive Plans.** In the event Provider participates in a physician incentive plan ("PIP") under the Agreement, Provider agrees that such PIPs must comply with 42 CFR § 417.479, 42 CFR § 438.6(h), 42 CFR § 422.208, and 42 CFR § 422.210, as may be amended from time to time. Subcontractor, CCO and Provider may not make a specific payment directly or indirectly under a PIP to a physician or physician group as an inducement to reduce or limit Medically Necessary services furnished to an individual Member. PIPs must not contain provisions that provide incentives, monetary or otherwise, for the withholding of services that meet the definition of Medical Necessity. Provider shall disclose annually to Subcontractor and/or CCO any PIP arrangement Provider may have with any physicians even if there is not substantial financial risk between Subcontractor and/or CCO and such physicians.

3.38 **Lobbying.** Provider agrees to comply with the following requirements related to lobbying:

(a) Prohibition on Use of Federal Funds for Lobbying: By signing the Agreement, Provider certifies to the best of Provider's knowledge and belief, pursuant to 31 U.S.C. § 1352 and 45 CFR Part 93, as may be amended from time to time, that no federally appropriated funds have been paid or will be paid to any person by or on Provider's behalf for the purpose of influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the award of any federal contract, the making of any federal grant, the making of any federal loan, the entering into of any cooperative agreement, or the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan, or cooperative agreement.

(b) Disclosure Form to Report Lobbying: If any funds other than federally appropriated funds have been paid or will be paid to any person for the purpose of influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the award of any federal contract, the making of any federal grant, the making of any federal loan, the entering into of any cooperative agreement, or the extension, continuation, renewal, amendment or modification of any federal contract, grant, loan, or cooperative agreement and the value of the Agreement exceeds $100,000, Provider shall complete and submit Standard Form-LLL, "Disclosure Form to Report Lobbying," in accordance with its instructions.

(c) Contractor shall abide by lobbying laws of the State of Mississippi.

3.39 **Gratuities.** Provider represents that it has not violated, is not violating, and promises that it will not violate the prohibitions against gratuities set forth in Section 6-204 (Gratuities) of the Mississippi Personal Service Contract Procurement Regulations.

3.40 **Compliance with Mississippi Employment Protection Act (MEPA).** Represents and warrants and shall require that Provider represent and warrant that it will ensure its compliance with the

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

3.41 **Insurance Requirements.** As applicable, Provider shall and shall require that Provider secure and maintain during the term of the Agreement general liability insurance, professional liability insurance, and workers' compensation insurance for all employees connected with the provision of services under the Agreement. Such workers compensation insurance shall comply with Mississippi Workers' Compensation Laws. Such comprehensive general liability insurance and professional liability insurance shall provide coverage in an amount established by Subcontractor and/or CCO pursuant to the Agreement or as required under the MississippiCHIP Program Contract.

3.42 **Indemnification.** To the extent applicable to Provider in performance under the Agreement, Provider shall indemnify, defend, protect, save and hold DOM and its employees and Members harmless from and against all injuries, deaths, losses, damages, claims, suits, demands, actions, recovery, liabilities, judgments, costs and expenses, including without limitation, court costs, investigative fees and expenses, and attorney fees, to the extent proximately caused by any negligent act or other intentional misconduct or omission of Provider, its agents, officers, employees or contractors arising from the Agreement. DOM may waive this requirement for public entities if Provider is a state agency or sub-unit as defined by the State or a public health entity with statutory immunity. This clause shall survive the termination of the Agreement for any reason, including breach due to insolvency.

3.43 **Notice of Legal Action.** Immediately upon obtaining knowledge or receiving notice of any legal action or notice listed below, Provider shall provide to Subcontractor and/or CCO written notice of such legal action or notice and, upon request by Subcontractor and/or CCO, a complete copy of all filings and other documents generated in connection with any such legal action:

(a) Any action, suit or counterclaim filed against Provider;

(b) Any regulatory action, or proposed action, respecting Provider's business or operations;

(c) Any notice received by Provider from the Department of Insurance or the State Health Officer;

(d) The filing of a petition in bankruptcy by or against Provider, or the insolvency of Provider;

(e) The conviction of any person who has an ownership or control interest in Provider, or who is an agent or managing employee of Provider, of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or Title XX of the Social Security Act; or

(f) A malpractice action against any Provider delivering service under an agreement.

3.44 **Hold Harmless.** Except for any applicable cost-sharing requirements under the MississippiCHIP Program Contract, Provider shall look solely to Subcontractor and/or CCO for payment of Covered Services provided to Members pursuant to the Agreement and the MississippiCHIP Program Contract and hold DOM, the State, the U.S. Department of Health and Human Services and Members harmless in the event that Subcontractor and/or CCO cannot or will not pay for such Covered Services. In accordance with 42 CFR § 447.15, as may be amended from time to time, the Member is not liable to Provider for any services for which Subcontractor and/or CCO is liable and as specified under the State's relevant health insurance or managed care statutes, rules or administrative agency guidance. Provider shall not require any copayment or cost sharing for Covered Services provided under the Agreement unless expressly permitted under the MississippiCHIP Program Contract. Provider shall also be prohibited from charging Members for missed appointments if such practice is prohibited under the MississippiCHIP Program Contract or applicable law. Neither the State, DOM, nor Member shall be in any manner liable for the debts and obligations of Subcontractor and/or CCO and under no circumstances shall Subcontractor, CCO, or any providers used to deliver services covered under the terms of the MississippiCHIP Program Contract, charge Members for Covered Services.

3.45 **Assignment/Delegation.** Provider shall not assign or delegate the Agreement without the express written consent of Subcontractor, CCO or DOM. The transfer of five percent (5%) or more of the beneficial ownership in Provider at any time during the term of this Agreement shall be deemed an assignment under this Agreement.

3.46 **Behavioral Health Providers.** Behavioral Health Providers shall ensure that all Covered Persons receiving inpatient psychiatric services are scheduled for outpatient follow-up and/or continuing treatment prior to discharge from the inpatient psychiatric hospital if the Provider is aware of the Covered Person's inpatient hospitalization status. Behavioral Health Providers will be provided daily reports identifying Covered Persons known to be admitted to an inpatient facility.

SECTION 4
SUBCONTRACTOR AND CCO REQUIREMENTS

41 Communications with Members. Members are entitled to the full range of their Providers' opinions and counsel about the availability of Medically Necessary Services under the provisions of the MississippiCHIP Program Contract. Any contractual provisions, including gag clauses or rules, that restrict a Provider's ability to advise Members about Medically Necessary treatment options violate federal law and regulations. Subcontractor and CCO shall not prohibit or otherwise restrict Provider, when acting within the lawful scope of practice, from advising or advocating on behalf of a Member for

the following:

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

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

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

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

(e) Information regarding the nature of treatment options including those that may not reflect Subcontractor's or CCO's position or may not covered by Subcontractor or CCO.

Subcontractor and CCO shall not prohibit a Provider from advocating on behalf of a Member in any grievance system, utilization review process, or individual authorization process to obtain necessary health care services.

4.2 Prompt Payment. Subcontractor and/or CCO shall pay Provider pursuant to the MississippiCHIP Program Contract and applicable State and federal law and regulations, including but not limited to Miss. Code Ann. §83-9-5, 42 CFR §447.46, 42 CFR §447.45(d)(2), 42 CFR §447.45(d)(3), 42 CFR §447.45(d)(5) and 42 CFR §447.45(d)(6), as applicable and as may be amended from time to time. If a third party liability exists, payment of claims shall be determined in accordance with federal and/or State third party liability law and the terms of the MississippiCHIP Program Contract. Unless Subcontractor or CCO otherwise requests assistance from Provider, Subcontractor or CCO will be responsible for third party collections in accordance with the terms of the MississippiCHIP Program Contract.

4.3 No Incentives to Limit Medically Necessary Services. Neither Subcontractor nor CCO shall structure compensation provided to individuals or entities that conduct utilization management and concurrent review activities so as to provide incentives for the individual or entity to deny, limit, or discontinue Medically Necessary services to any Member.

4.4 Provider Discrimination Prohibition. Subcontractor and CCO shall not discriminate with respect to participation, reimbursement, or indemnification of a provider who is acting within the scope of the provider's license or certification under applicable State law, solely on the basis of such license or certification. Subcontractor and CCO shall not discriminate against Provider for serving high-risk Members or if Provider specializes in conditions requiring costly treatments. This provision shall not be construed as prohibiting Subcontractor or CCO from limiting a provider's participation to the extent necessary to meet the needs of Members. This provision also is not intended and shall not interfere with measures established by Subcontractor or CCO that are designed to maintain quality of care practice standards and control costs. Subcontractor and CCO shall not provide false or misleading information to any person or entity in an attempt to recruit Providers for Subcontractor's or CCO's network.

4.5 Termination, Revocation and Sanctions. In addition to its termination rights under the Agreement, Subcontractor and/or CCO shall have the right to revoke any functions or activities Subcontractor and/or CCO delegates to Provider under the Agreement or impose other sanctions consistent with the MississippiCHIP Program Contract if in Subcontractor's or CCO's reasonable judgment Provider's performance under the Agreement is inadequate. Subcontractor or CCO shall also have the right to suspend, deny, refuse to renew or terminate the subcontract in accordance with the terms of the MississippiCHIP Program Contract and applicable law and regulation. However, Subcontractor and CCO shall not exclude or terminate a Provider from participation in Subcontractor's or CCO's Provider Network due to the fact that the Provider has a practice that includes a substantial number of patients with expensive medical conditions, and shall not terminate a Provider for filing a Complaint, Grievance, or Appeal on a Member's behalf.

SECTION 5
OTHER REQUIREMENTS

5.1 Compliance with MississippiCHIP Program Contract. All tasks performed under the Agreement shall be performed in accordance with the requirements of the MississippiCHIP Program Contract, as applicable, as set forth in this Appendix, applicable provider manuals, and protocols, policies and procedures that Subcontractor or CCO has provided or delivered to Provider. The applicable provisions of the MississippiCHIP Program Contract are incorporated into the Agreement by reference. Nothing in the Agreement or this Appendix relieves CCO of its responsibility under the MississippiCHIP Program Contract. If any provision of the Agreement is in conflict with provisions of the MississippiCHIP Program Contract, the terms of the MississippiCHIP Program Contract shall control and the terms of the Agreement in conflict with those of the MississippiCHIP Program Contract will be considered waived.

5.2 Monitoring. In accordance with 42CFR § 457.950, Subcontractor and/or CCO shall perform ongoing monitoring (announced or unannounced) of services rendered by Provider under the Agreement and shall perform periodic formal reviews of Provider according to a schedule established by the State, consistent with industry standards or State managed care organization laws and regulations or requirements under the MississippiCHIP Program Contract. As a result of such monitoring activities, and/or as a result of the inspecting, auditing and monitoring activities of DOM or other authorities pursuant to section 4.4 above, Subcontractor and/or CCO shall identify to Provider any deficiencies or areas for improvement mandated under the MississippiCHIP Program Contract and Provider and Subcontractor and/or CCO shall take appropriate corrective action within the relevant timeframe permitted, as applicable. Provider shall comply with any corrective action plan initiated by Subcontractor, CCO and/or required by the MississippiCHIP Program. In addition, Provider shall monitor and report the quality of services delivered under the Agreement and initiate a plan of correction where necessary to improve quality of care, in accordance with that level of care which is recognized as acceptable professional practice in the respective community in which Subcontractor, CCO and Provider practice and/or the performance standards established under the MississippiCHIP Program Contract.

5.3 Enrollment. The parties acknowledge and agree that DOM is responsible for enrollment, reenrollment and disenrollment of Members.

5.4 No Exclusivity. Nothing in the Agreement or this Appendix shall be construed as prohibiting

or penalizing Provider for contracting with a managed care organization other than Subcontractor or CCO or as prohibiting or penalizing Subcontractor or CCO for contracting with other providers. The Subcontractor or CCO may not require Providers who agree to participate in the MississippiCHIP Program to contract with the Contractor's other lines of business.

55 Revoking Delegation. The parties agree that, prior to execution of the Agreement, Subcontractor and/or CCO evaluated Provider's ability to perform any duties delegated to Provider under the Agreement. Any delegated duties and reporting responsibilities shall be set forth in the Agreement or other written delegation agreement or addendum between the parties. In addition to its termination rights under the Agreement, Subcontractor and/or CCO shall have the right to revoke any functions, assignment authority, or activities Subcontractor and/or CCO delegates to Provider under the Agreement or impose other sanctions if in Subcontractor's and/or CCO's reasonable judgment Provider's performance under the Agreement is inadequate or untimely.

56 Rights of DOM. DOM shall have the right to invoke against Provider any remedy set forth in the MississippiCHIP Program Contract, including the right to require the termination of the Agreement, for each and every reason for which it may invoke such a remedy against Subcontractor or CCO or require termination of the MississippiCHIP Program Contract. Suspected Fraud and Abuse by Provider will be investigated by DOM.

MISSISSIPPI MEDICAID PROGRAM

REGULATORY REQUIREMENTS APPENDIX

DOWNSTREAM PROVIDER

THIS MISSISSIPPI MEDICAID PROGRAM REGULATORY REQUIREMENTS APPENDIX (this "Appendix") supplements and is made part of the provider agreement (the "Agreement") between Vision Vendor, Inc. ("Subcontractor") and the provider named in the Agreement ("Provider").

SECTION 1
APPLICABILITY

This Appendix applies with respect to the provision of health care services that Provider provides directly to Covered Persons through Health Plan's (as defined herein) products or benefit plans including Mississippi Coordinated Access Network Program (the "MississippiCAN Program") as governed by the State's designated regulatory agencies. Provider has agreed to provide Covered Services to Covered Persons who receive their coverage pursuant to a contract between the State and Health Plan (the "State Contract" as defined herein). The State Contract and applicable State and federal law require that the provisions contained in this Appendix be part of the Agreement. In the event of a conflict between this Appendix and other appendices or any provision of the Agreement, the provisions of this Appendix shall control except with regard to benefit contracts outside the scope of this Appendix or unless otherwise required by law. In the event Subcontractor is required to amend or supplement this Appendix as required or requested by the State and requested by Health Plan, Provider agrees that Subcontractor shall be permitted to unilaterally initiate such additions, deletions or modifications. All provider agreements must be in writing and must include all specific activities and report responsibilities delegated to the Provider by Subcontractor.

SECTION 2
DEFINITIONS

Unless otherwise defined in this Appendix, all capitalized terms shall be as defined in the Agreement. For purposes of this Appendix, the following terms shall have the meanings set forth below; provided, however, in the event any definition set forth in this Appendix or the Agreement is inconsistent with any definitions under the MississippiCAN Program, the definitions shall have the meaning set forth under the MississippiCAN Program.

2.1 Action: Health Plan's decision to deny or limit authorization or payment (in whole or in part) for health care services, including new authorizations and previously authorized services; the reduction, suspension, or termination of a previously authorized service; or Health Plan's failure to provide services in a timely manner; failure to resolve Complaints, Grievances, or Appeals within the specified time frames.

2.2 Appeal: A request for review by Health Plan of an Action related to a Covered Person or Provider. In the case of a Covered Person, an Action may include determinations on the health care services a Covered Person believes he or she is entitled to receive, including delay in

providing, arranging for, or approving the health care services (such that a delay would adversely affect the health of the Covered Person). In the case of a Provider, the Action may include, but is not limited to, delay or non-payment for covered services.

23 Behavioral Health Services: Mental health and/or drug and alcohol abuse treatment services that are provided by the county intellectually delayed/developmentally delayed programs, the single county authority administrators, or other appropriately licensed health care practitioners.

24 CMS: Center for Medicare and Medicaid Services is an agency within the U.S. Department of Health & Human Services responsible for administration of several key federal health care programs.

25 Complaint: An expression of dissatisfaction received orally or in writing that is of a less serious or formal nature that is resolved within one (1) business day of receipt.

26 Covered Person: An individual who meets all of the eligibility requirements for Mississippi Medicaid and is currently enrolled with Health Plan for the provision of services under a MississippiCAN Program. A Covered Person may also be referred to as an Enrollee, Member or Customer under the Agreement.

27 Covered Services: Health care services or products for which a Covered Person is enrolled with Health Plan to receive coverage under the State Contract.

28 DOM: Division of Medicaid, Office of the Governor, State of Mississippi.

29 Early, Periodic, Screening, Diagnosis, and Treatment (EPSDT) Services: Defined by DOM to include:

a. Age appropriate, comprehensive health and development history that includes physician and mental health assessments along with counseling and anticipatory guidance and risk factor reduction interventions;
b. Calculation of Body Mass Index;
c. Growth measurements and head circumference;
d. Nutritional counseling;
e. Developmental surveillance and Developmental and autism Spectrum Disorders Screenings as appropriate;
f. Comprehensive unclothed exam;
g. Appropriate laboratory tests (including blood level assessment appropriate to age and risk);
h. Appropriate immunizations in accordance with Recommended Childhood and Adolescent Immunization Schedule adopted by DOM;
i. A vision assessment;
j. A hearing assessment;
k. A dental screening and/or referral to dental care;
l. Health education; and
m. Referrals for identified abnormalities.

2.10 Fraud and Abuse: Fraud is any type of intentional deception or misrepresentation made by an entity or person with the knowledge that the deception could result in some unauthorized benefit to the entity, him or herself, or some other person. The Fraud can be committed by many entities, including a vendor, a subcontractor, a provider, a State employee, or a Covered Person, among others. Abuse is any practice that is inconsistent with sound fiscal, business, or medical practices, and results in an unnecessary cost to the Medicaid program, a vendor, a subcontractor or Provider or in reimbursement for services that are not Medically Necessary or that fail to meet professionally recognized standards for health care.

2.11 Grievance: An expression of dissatisfaction about any matter or aspect of Health Plan or its operation, other than an Action as defined herein.

2.12 Health Plan: An appropriately licensed entity that has entered into a contract with Subcontractor, either directly or indirectly, under which Subcontractor provides certain administrative services for Health Plan pursuant to the State Contract. For purposes of this Appendix, Health Plan refers to Health Care Vendor.

2.13 Marketing: The activities that promote visibility and awareness for the MississippiCAN Program and Health Plan's participation in the program. All activities are subject to prior review and approval by DOM.

2.14 Medical Record: A single complete record, which documents the entire treatment plan developed for, and medical services received by, the Covered Person including inpatient, outpatient, referral services and emergency medical services whether provided by contracted Providers or non-contracted providers.

2.15 Mississippi Coordinated Access Network (MississippiCAN) Program: Mississippi Medicaid's coordinated care program for select Medicaid Beneficiaries.

2.16 Primary Care Provider (PCP): Any physician or health care practitioner or group operating within the scope of his or her licensure who is responsible for supervising, prescribing and providing primary care and primary case management services in the MississippiCAN Program, whose practice is limited to the general practice of medicine or who is an Internist, Pediatrician, Obstetrician, Gynecologist, Family Practitioner, General Practitioner, Certified Nurse Practitioners whose specialty is pediatrics, adult, family, certified nurse midwife, obstetrics/gynecology, or a physician assistant.

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

2.18 Provider: A hospital, ancillary provider, physician group, individual physician or other healthcare provider who has entered into an Agreement.

2.19 Provider Network: The Panel of health service Providers with which Subcontractor and/or Health Plan contracts for the provision of covered services to Covered Persons and Non-Contracted Providers administering services to Covered Persons.

2.20 State: The State of Mississippi or its designated regulatory agencies.

2.21 State Contract: Health Plan's contract with the State for the purpose of providing and paying for Covered Services to Covered Persons enrolled in the MississippiCAN Program.

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

SECTION 3
PROVIDER REQUIREMENTS

The MississippiCAN Program, through the State Contract and federal and State statutes and regulations, requires the Agreement to contain certain conditions that Health Plan, Subcontractor and Provider agree to undertake, which include the following:

3.1 Definitions Related to the Provision of Covered Services. Provider shall follow the applicable State Contract's requirements for the provision of Covered Services. Provider's decisions affecting the delivery of acute or chronic care services to Covered Persons shall be made on an individualized basis and in accordance with the following definitions:

(a) Emergency Medical Condition: A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in any of the following: (1) 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; (2) serious impairment to body functions; or (3) serious dysfunction of any body organ or part.

(b) Emergency Services: Covered inpatient and outpatient services furnished by a provider who is qualified to furnish those health services and that are needed to evaluate or stabilize an Emergency Medical Condition.

(c) Medically Necessary Services: As set forth in the Social Security Act, Section 1905 (42 USC 1396d(a)), Medically Necessary Services are defined as services, supplies, or equipment provided by a licensed health care professional that are:

1. Appropriate and consistent with the diagnosis or treatment of the Covered Person's condition, illness, or injury;

2. In accordance with the standards of good medical practice consistent with the individual Covered Person's condition(s);

3. Not primarily for the personal comfort or convenience of the Member, family, or Provider;

4. The most appropriate services, supplies, equipment, or levels of care that can be safely and efficiently provided to the Covered Person;

5. Furnished in a setting appropriate to the Covered Person's medical need and condition and, when applied to the care of an inpatient, further mean that the Covered Person's medical symptoms or conditions require that the services cannot be safely provided to the Covered Person as an outpatient;

6. Not experimental or investigational or for research or education;

7. Provided by an appropriately licensed practitioner; and

8. Documented in the patient's record in a reasonable manner, including the relationship of the diagnosis to the service.

Medically Necessary Services may also be those services for children that are necessary to correct or ameliorate defects and physical and mental illnesses and conditions discovered during an interperiodic or periodic EPSDT screen, whether such services are covered or exceed the benefit limits in the Medicaid State Plan and Title 23 of Mississippi Administrative Code.

3.2 Provider Eligibility. Provider must be enrolled in the Mississippi Medicaid program and must use the same National Provider Identifier (NPI) number. Health Plan and Subcontractor will exclude from its network any provider who has been terminated or suspended from the Medicare or Medicaid program in any state.

3.3 Accessibility Standards. Provider shall provide for timely access for Covered Person appointments in accordance with the appointment availability requirements established under the State Contract, as further described in the applicable provider manual.

Type	Appointment Scheduling Time Frames
PCP (well care visit)	Not to exceed thirty (30) calendar days
PCP (routine sick visit)	Not to exceed seven (7) calendar days
PCP (urgent care visit)	Not to exceed twenty-four (24) hours
Specialists	Not to exceed forty-five (45) calendar days
Dental Providers (routine visits)	Not to exceed forty-five (45) calendar days
Dental Providers (urgent Care)	Not to exceed forty-eight (48) calendar d
Behavioral Health Providers (routine visit)	Not to exceed fourteen (14) calendar
Behavioral Health Providers (urgent visit)	Not to exceed twenty-four (24) hours

Behavioral Health Providers (post-discharge from an acute psychiatric hospital when the Contractor is aware of the Member's discharge)	Not to exceed seven (7) calendar days
Urgent Care Providers	Not to exceed twenty-four (24) hours
Emergency Providers	Immediately (twenty-four (24) hours a day, seven (7) days a week) and without Prior Authorization

3.4 Hours of Operation; Appointments. Provider shall offer hours of operation that are no less than the hours of operation offered to commercial beneficiaries or comparable to Medicaid fee-for-service if Provider serves only Medicaid beneficiaries.

3.5 Hold Harmless. Except for any applicable cost-sharing requirements under the State Contract, Provider shall look solely to Subcontractor and Health Plan for payment of Covered Services provided to Covered Persons pursuant to the Agreement and the State Contract and hold the State, DOM, the U.S. Department of Health and Human Services and Covered Persons harmless in the event that Subcontractor and/or Health Plan cannot or will not pay for such Covered Services. In accordance with 42 CFR 447.15, as may be amended from time to time, the Covered Person is not liable to Provider for any services for which Subcontractor and/or Health Plan is liable and as specified under the State's relevant health insurance or managed care statutes, rules or administrative agency guidance. Provider shall not require any copayment or cost sharing for Covered Services provided under the Agreement unless expressly permitted under the State Contract. Provider shall also be prohibited from charging Covered Persons for missed appointments if such practice is prohibited under the State Contract or applicable law. Neither the State, DOM nor Covered Persons shall be in any manner liable for the debts and obligations of Subcontractor and/or Health Plan and under no circumstances shall Subcontractor, Health Plan, or any providers used to deliver services covered under the terms of the State Contract, charge Covered Persons for Covered Services.

Covered Person may be responsible for non-covered item(s) and/or service(s), only if the Provider ensures that written documentation in compliance with the Advance Beneficiary Notification (ABN) is received from the Covered Person that an item(s) or service(s) rendered is a non-covered item and/or service(s) and that the Covered Person will be financially responsible for the item(s) and/or service(s). If Subcontractor and/or Health Plan determines a Covered Person was charged for Covered Services inappropriately, such payment may be recovered, as applicable.

This provision shall survive any termination of the Agreement, including breach of the Agreement due to insolvency.

3.6 Indemnification. To the extent applicable to Provider in performance of the Agreement, Provider shall indemnify, defend protect, save and hold DOM and its employees and Covered Persons harmless from and against all injuries, deaths, losses, damages, claims, suits, liabilities, judgments, costs and expenses, including, without limitation, court costs, investigative fees and expenses and attorney fees, to the extent proximately caused by any negligent act or other

intentional misconduct or omission of Provider, its agents, officers, employees or contractors arising from the Agreement. DOM may waive this requirement for public entities if Provider is a

state agency or sub-unit as defined by the State or a public health entity with statutory immunity. This clause shall survive the termination of the Agreement for any reason, including breach due to insolvency.

3.7 Provider Selection. To the extent applicable to Provider in performance of the Agreement, Provider shall comply with 42 CFR 438.214, as may be amended from time to time, which includes, but is not limited to the selection and retention of providers, credentialing and recredentialing requirements and nondiscrimination. If Subcontractor and/or Health Plan delegates credentialing to Provider, Subcontractor and Health Plan will provide monitoring and oversight and Provider shall ensure that all licensed medical professionals are credentialed in accordance with Health Plan's and the State Contract's credentialing requirements.

3.8 Restrictions on Referrals. Provider shall not make inappropriate referrals for designated health services to health care entities with which Provider or a member of Provider's family has a financial relationship, pursuant to federal anti-kickback and physician self-referral laws that prohibit such referrals.

3.9 Records Retention. As required under State or federal law or the State Contract, Provider shall maintain an adequate record keeping system for recording services, charges, dates and all other commonly accepted information elements sufficient to disclose the quality, quantity, appropriateness and timeliness of services rendered to Covered Persons. All financial records shall follow generally accepted accounting principles. Medical records and supporting management systems shall include all pertinent information related to the medical management of each Covered Person. Other records shall be maintained as necessary to clearly reflect all actions taken by Provider related to services provided under the State Contract. Such records shall be maintained for a period of not less than five (5) years from the close of the Agreement, or such other period as required by law. If records are under review or audit, they must be retained for a minimum of five (5) years following resolution of such action. Prior approval for the disposal of records must be requested and approved by Health Plan if the Agreement is continuous.

3.10 Records Access. Provider acknowledges and agrees that the State, DOM, the U.S. Department of Health and Human Services and other authorized federal and state personnel shall have complete access to all records pertaining to services provided to Covered Persons. Provider shall provide immediate access to facilities, records and supportive materials pertinent to the State Contract for State or Federal fraud investigators. Copies of requested documents shall be provided to the State, DOM, the U.S. Department of Health and Human Services and other authorized federal and state personnel or their designees free of charge.

3.11 Government Audit; Investigations. Provider acknowledges and agrees that the State and the U.S. Department of Health and Human Services, the Centers for Medicare & Medicaid Services, the Office of Inspector General, the General Accounting Office, or any other auditing agency or their authorized representatives, with prior approval by DOM, shall, at all reasonable time, with or without notice, or their authorized representatives shall have the right to inspect or otherwise evaluate the quality, appropriateness, and timeliness of services provided under the terms of the State Contract and any other applicable rules. There shall be no restrictions on the right of the State or federal government to conduct whatever inspections and audits are necessary

to assure quality, appropriateness or timeliness of services provided pursuant to the State Contract and the reasonableness of their costs.

3.12 Privacy; HIPAA. Provider shall comply with all applicable privacy rule and security rule provisions of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), and associated implementing regulations, as may be amended from time to time, and shall safeguard information about Covered Persons in accordance with applicable federal and State privacy laws and rules including 42 CFR 438.224 and 42 CFR Part 431, Subpart F, as may be amended from time to time. Health Plan agrees and shall require Provider to agree that confidential information, including but not limited to medical and other pertinent information relative to Covered Persons, shall not be disclosed to any person or organization for any purpose without the expressed, written authority of DOM or as otherwise required by law and that all such disclosures shall fully comply with HIPAA privacy and security standards.

3.13 Compliance with Law. Provider shall comply with all applicable federal and State laws and regulations, and all provisions of the State Contract, that pertain to a Covered Person's rights, including but not limited to the following to the extent applicable to Provider in performance of the Agreement:

(a) Title VI of the Civil Rights Act of 1964; Title XIX of the Social Security Act; 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 Genetic Information Non-Discrimination Act of 2008 (GINA); and the Americans with Disabilities Act, and their implementing regulations, as may be amended from time to time.

(b) 42 CFR 434 and 42 CFR 438.6, as may be amended from time to time.

(c) All relevant federal and State statutes, regulations and orders related to equal opportunity in employment, including but not limited to compliance with E.O. 11246, "Equal Employment Opportunity," as amended by E.O. 11375, "Amending Executive Order 11246 Relating to Equal Employment Opportunity," and as supplemented by regulations at 41 CFR part 60, "Office of Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor."

(d) All federal and State professional and facility licensing and accreditation requirements/standards that apply to the services Health Plan and Provider perform pursuant to the Agreement, including but not limited to:

1. All applicable standards, orders or requirements issued under Section 306 of the Clean Air Act (42 USC 1857 (h)). Section 508 of the Clean Water Act (33 USC 1368), Executive Order 11738, and Environmental Protection Agency (EPA) regulations (40) CFR Part 15), which prohibit the use of facilities included on the EPA list of violating facilities. Any violations must be reported to DSHS, DHHS, and the EPA;

2. Any applicable mandatory standards and policies relating to energy

efficiency that are contained in the State Energy Conservation Plan, including the Energy Policy & conservation Act (Pub. L. 94-165), and issued in compliance with the Federal Energy Policy & Conservation Act.

3. Those specified for laboratory services in the Clinical Laboratory Improvement Amendments (CLIA). All laboratory service sites must have a CLIA certificate of registration or waiver, and a CLIA identification number.

4. Section 1128B(d)(1) of the Balanced Budget Act of 1997; and,

5. Any other requirements associated with the receipt of federal funds.

3.14 Physician Incentive Plans. In the event Provider participates in a physician incentive plan ("PIP") under the Agreement, Provider agrees that such PIPs must comply with 42 CFR 417.479, 42 CFR 438.6(h), 42 CFR 422.208, and 42 CFR 422.210, as may be amended from time to time. Subcontractor, Health Plan nor Provider may make a specific payment directly or indirectly under a PIP to a physician or physician group as an inducement to reduce or limit Medically Necessary services furnished to an individual Covered Person. PIPs must not contain provisions that provide incentives, monetary or otherwise, for the withholding of services that meet the definition of Medical Necessity.

3.15 Lobbying. Provider agrees to comply with the following requirements related to lobbying:

(a) Prohibition on Use of Federal Funds for Lobbying: By signing the Agreement, Provider certifies to the best of Provider's knowledge and belief, pursuant to 31 U.S.C. Section 1352 and 45 CFR Part 93, as may be amended from time to time, that no federally appropriated funds have been paid or will be paid to any person by or on Provider's behalf for the purpose of influencing or attempting to influence an officer or employee of any agency, a member of Congress, an officer or employee of Congress, or an employee of a member of Congress in connection with the award of any federal contract, the making of any federal grant, the making of any federal loan, the entering into of any cooperative agreement, or the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan, or cooperative agreement.

(b) Disclosure Form to Report Lobbying: If any funds other than federally appropriated funds have been paid or will be paid to any person for the purpose of influencing or attempting to influence an officer or employee of any agency, a member of Congress, an officer or employee of Congress, or an employee of a member of Congress in connection with the award of any federal contract, the making of any federal grant, the making of any federal loan, the entering into of any cooperative agreement, or the extension, continuation, renewal, amendment or modification of any federal contract, grant, loan, or cooperative agreement and the value of the Agreement exceeds $100,000, Provider shall complete and submit Standard Form-LLL, "Disclosure Form to Report Lobbying," in accordance with its instructions.

3.16 Excluded Individuals and Entities. Provider certifies that neither it nor any of its employees, principals, nor any providers, subcontractors or consultants or persons with an ownership or controlling interest in the Provider (an owner including the Provider himself or herself), or an agent or managing employee of the Provider, with whom Provider contracts and who are providing items or services that are significant and material to Provider's obligations under the Agreement is:

(a) excluded from participation in federal health care programs under either Section 1128 or section 1128A of the Social Security Act; or

(b) debarred, suspended or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in nonprocurement activities under regulations issued under Executive Order no. 12549 or under guidelines implementing Executive Order No. 12549; or an affiliate, as defined in the Federal Acquisition Regulation, of such a person.

Provider acknowledges and agrees that payment will not be made for any items or Covered Services provided by an excluded individual pursuant to 42 CFR 1001.1901(b) and is obligated to screen all employees, contractors, and subcontractors for exclusion as required under applicable State and Federal laws. Additionally, Provider acknowledges that pursuant to 42 CFR 1003.102(a)(2) civil monetary penalties may be imposed against Provider if he or she employs or enters into contracts with excluded individuals or entities to provide items or Covered Services to Covered Persons under this Agreement. Provider agrees not to employ or subcontract with individuals or entities whose owner, those with a controlling interest, or managing employees are on a State or Federal exclusion list to provide items or Covered Services under this Agreement. Provider shall immediately report to Subcontractor and/or Health Plan any exclusion information discovered. Provider can search the HHS-OIG website, at no cost, by the names of any individuals or entities. The database is called LEIE and can be accessed at http://www.oig.hhs.gov/fraud/exclusions.asp. The GSA EPLS/SAM database can be accessed at https://www.sam.gov. Applicable state exclusion databases can be accessed through the State's Medicaid website. Subcontractor and Health Plan will terminate the Agreement immediately and exclude from its network any provider who has been excluded from federal health care programs or terminated from the Medicare or the Medicaid program in any state. Subcontractor and Health Plan may also terminate the Agreement if Provider's owners, agents, or managing employees are found to be excluded on a State or Federal exclusion list.

3.17 Disclosure. Provider shall cooperate with Subcontractor and Health Plan in disclosing information DOM may require related to ownership and control, significant business transactions, and persons convicted of crimes in accordance with 42 CFR Part 455 and shall provide information upon request. Provider shall submit information related to ownership and control of subcontractors or wholly owned suppliers within thirty-five (35) calendar days of a request for such information.

By executing this Agreement, Provider certifies that neither Provider nor any of its principals is presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in any State or federal health care program or from participating in

transactions by any State or federal department or agency. Subcontractor and/or Health Plan will terminate the Agreement upon becoming aware or receiving notice from DOM, whichever is earlier, that Provider is or has been excluded from participation in any State or federal health care program or by any State or federal agency.

3.18 Cultural Competency. Provider shall participate in Subcontractor and Health Plan's and the State's efforts to promote the delivery of services in a culturally competent manner to all Covered Persons, including those with limited English proficiency and diverse cultural and ethnic backgrounds and shall provide interpreter services in a Covered Person's primary language and for the hearing impaired for all appointments and emergency services. Provider shall provide information to Covered Persons regarding treatment options and alternatives, as well as information on complaints and appeals, in a manner appropriate to the Covered Person's condition and ability to understand.

3.19 Marketing. As required under State or federal law or the applicable State Contract, any marketing materials developed and distributed by Provider as related to the performance of the Agreement must be submitted to Health Plan for submission to DOM for prior approval.

3.20 Fraud, Waste and Abuse Prevention. Provider shall cooperate fully with Subcontractor and Health Plan's policies and procedures designed to protect program integrity and prevent and detect potential or suspected fraud, waste, and abuse in the administration and delivery of services under the State Contract and shall cooperate and assist DOM and any other State or federal agency charged with the duty of preventing, identifying, investigating, sanctioning or prosecuting suspected fraud, waste, and abuse in state and/or federal health care programs.

In accordance with Health Plan's policies and the Deficit Reduction Act of 2005 (DRA), Provider shall have written policies for its employees, contractors or agents that: (a) provide detailed information about the federal False Claims Act (established under sections 3729 through 3733 of title 31, United States Code); (b) cite administrative remedies for false claims and statements (established under chapter 38 of title 31, United States Code) and whistleblower protections under federal and state laws; (c) reference state laws pertaining to civil or criminal penalties for false claims and statements; and (d) with respect to the role of such laws in preventing and detecting fraud, waste, and abuse in federal health care programs (as defined in section 1128B(f)), include as part of such written policies, detailed provisions regarding Provider's policies and procedures for detecting and preventing fraud, waste, and abuse. Provider agrees to train its staff on the aforesaid policies and procedures.

3.21 Data; Reports. Provider shall cooperate with and release to Subcontractor and Health Plan any information necessary for Subcontractor and Health Plan to perform its obligations under the State Contract to the extent applicable to Provider in performance of the Agreement, including the timely submission of reports and information required by Subcontractor and Health Plan. Such reports shall include child health check-up reporting, if applicable, as well as complete and accurate encounter data in accordance with the requirements of Subcontractor and Health Plan and the State.

3.22 Encounter Data. Provider agrees to cooperate with Subcontractor and Health Plan to comply with Subcontractor and Health Plan's obligation to prepare encounter data submissions, reports, and clinical information including, without limitation, child and adolescent health check-up reporting, EPSDT encounters, and cancer screening encounters, as applicable, and such other reporting regarding Covered Services as may be required under the State Contract.

3.23 Claims Information. Provider shall promptly submit to Subcontractor or Health Plan the information needed to make payment and shall identify third party liability coverage, including Medicare and other insurance, and if applicable seek such third party liability payment before submitting claims to Subcontractor or Health Plan. Provider understands and agrees that each claim Provider submits to Subcontractor constitutes a certification that the claim is true and accurate to the best of Provider's knowledge and belief and that the Covered Services are 1) Medically Necessary and 2) have been provided to the Covered Person prior to submitting the claim.

Effective July 1, 2014, Provider must submit claims within six (6) months from the date of service. Claims filed within the appropriate time frame but denied may be resubmitted to the Contractor within ninety (90) calendar days from the date of denial

3.24 Reserved.

3.25 Licensure. Provider represents that it is currently licensed and/or certified under applicable State and federal statutes and regulations and by the appropriate State licensing body or standard-setting agency, as applicable. Provider represents that it is in compliance with all applicable State and federal statutory and regulatory requirements of the Medicaid program and that it is eligible to participate in the Medicaid program. Provider represents that it does not have a Medicaid provider agreement with DOM that is terminated, suspended, denied, or not renewed as a result of any action of DOM, CMS, HHS, or the Medicaid Fraud Control Unit of the State's Attorney General. Provider shall maintain at all times throughout the term of the Agreement all necessary licenses, certifications, registrations and permits as are required to provide the health care services and/or other related activities delegated to Provider by Health Plan under the Agreement. If at any time during the term of the Agreement, Provider is not properly licensed as described in this Section, Provider shall discontinue providing services to Covered Persons.

3.26 Quality; Utilization Management. Pursuant to any applicable provider manuals and related protocols, or as elsewhere specified under the Agreement, Provider agrees to cooperate with Subcontractor and Health Plan's quality improvement and utilization review and management activities. This shall include, but not be limited to, participation in any internal and external quality assurance, utilization review, peer review, and grievance procedures established by Subcontractor and Health Plan or as required under the State Contract to ensure that Covered Persons have due process for their complaints, grievances, appeals, fair hearings or requests for external review of adverse decisions made by Health Plan or Provider. Provider shall adhere to the quality assurance and utilization review standards of the MississippiCAN Program and shall monitor quality and initiate corrective action to improve quality consistent with the generally accepted level of care.

3.27 Non-Discrimination. Covered Persons must be provided Covered Services without regard to race, color, creed, sex, religion, age, national origin, ancestry, marital status, sexual orientation, language, health status, disease or pre-existing condition (including genetic information), anticipated need for health care or physical or mental handicap, except where medically indicated. Examples of prohibited practices include, but are not limited to, the following:

(a) Denying or not providing a Covered Person any Medicaid Covered Service. Health care and treatment necessary to preserve life must be provided to all Covered Persons who are not terminally ill or permanently unconscious, except where a competent Covered Person objects to such care on his/her own behalf.

(b) Subjecting a Covered Person to segregated, separate, or different treatment, including a different place or time from that provided to other Covered Persons or public or private patients, in any manner related to the receipt of any Medicaid Covered Service, except where Medically Necessary.

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

3.28 Advance Directives. Provider shall comply with the advance directives requirements set forth in the Uniform Health-Care Decisions Act, Section 41-41-215 of the Mississippi Code.

3.29 National Provider ID (NPI). Provider shall obtain a National Provider Identification Number (NPI) and when filing claims with Health Plan, the NPI used is the same NPI used when filing claims with DOM.

3.30 Termination. In the event of termination of the Agreement, Provider shall promptly supply to Subcontractor and Health Plan all information necessary for the reimbursement of any outstanding Medicaid claims.

3.31 Complaints; Grievances and Appeals. Information on how Provider or Provider's authorized representative can submit complaints and file grievances and appeals, and the resolution process, is contained in the applicable provider manual.

3.32 Health Care Acquired/Preventable Conditions. Provider agrees that no payment shall be made for the provision of medical assistance for health care acquired conditions and other provider preventable conditions as may be identified by the State. As a condition of payment, Provider shall identify and report to Subcontractor any provider preventable conditions in accordance with 42 CFR Part 438, including but not limited to 438.6(f)(2)(i).

3.33 Quality and Utilization Management Program. Provider shall cooperate with Subcontractor and Health Plan in meeting the Quality Management and Utilization Management Program standards outlined in the State Contract.

3.34 Referrals. Provider shall make referrals for social, vocational, education or human services when a need for such service is identified.

3.35 Insolvency. In the event Subcontractor and/or Health Plan becomes insolvent or unable to pay Provider, Provider shall not seek compensation for services rendered from the State, DOM, or their officers, Agents, or employees, or the Covered Persons or their eligible dependents.

3.36 Third Party Resources. Provider will report all third party resources to Subcontractor and Health Plan identified through the provision of medical services.

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

3.38 Capitated Providers. If Provider is capitated and terminates its agreement with Subcontractor, for any reason, Provider will provide services to Covered Persons assigned to Provider up to the end of the month in which the effective date of termination falls.

3.39 Certification on Relationship to State, DOM and CMS. Provider certifies that no officer, director, employee, subcontractor or agent of Provider, or person with an ownership or control interest in Provider, is also employed by, or is a public official of, the State of Mississippi or any of its agencies, DOM or CMS.

3.40 Funding. Provider recognizes that the obligation of DOM to proceed under its Contract with CCO is conditioned upon the appropriation of funds by the Mississippi State Legislature and the receipt of State and/or Federal funds. If the funds anticipated for the continuing fulfillment of the agreement are, at any time, not forthcoming or insufficient, either through the failure of the

Federal government to provide or the State of Mississippi to appropriate funds, or the discontinuance, or material alteration of the program under which the funds were provided or if funds are not otherwise available to DOM, DOM has the right upon ten (10) working days written notice to CCO to terminate the Contract.

3.41 Gratuities. Provider represents that it has not violated, is not violating, and promises that it will not violate the prohibitions against gratuities set forth in Section 6-204 (Gratuities) of the Mississippi Personal Service Contract Procurement Regulations.

3.42 Assignment/Delegation. Provider shall not assign or delegate the Agreement without the express written consent of CCO or DOM. The transfer of five percent (5%) or more of the beneficial ownership in Provider at any time during the term of this Agreement shall be deemed an assignment under this Agreement.

3.43 Notice of Legal Action. Immediately upon obtaining knowledge or receiving notice of any legal action or notice listed below, Provider shall provide to CCO written notice of such legal action or notice and, upon request by CCO, a complete copy of all filings and other documents generated in connection with any such legal action:

(a) Any action, suit or counterclaim filed against Provider;

(b) Any regulatory action, or proposed action, respecting Provider's business or operations;

(c) Any notice received by Provider from the Department of Insurance or the State Health Officer;

(d) The filing of a petition in bankruptcy by or against Provider, or the insolvency of Provider;

(e) The conviction of any person who has an ownership or control interest in Provider, or who is an agent or managing employee of Provider, of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or Title XX of the Social Security Act; or

(f) A malpractice action against any Provider delivering service under an agreement.

3.44 Federal and State Funds Liability. Providers acknowledges and agrees that payments made to Provider for services provided under the Agreement are derived from federal and State funds and that any false claim or statement in documents or any concealment of material fact related to such services may be a cause for sanctions and prosecution under applicable federal and State laws. Provider shall be subject to all laws applicable to individuals and entities receiving State and federal funds and may be held civilly or criminally liable to both CCO and DOM in the event of nonperformance, misrepresentation, fraud, or abuse related to services provided pursuant to the State Contract. Provider recognizes that payments made to the Provider are derived from federal and State funds, and are contingent upon and subject to availability and receipt of funds.

3.45 Insurance Requirements. As applicable, Provider shall secure and maintain during the term of the Agreement insurance appropriate to the services to be performed under the Agreement. Provider shall require that its providers secure and maintain during the term of the Agreement general liability insurance, professional liability insurance, and workers' compensation insurance for all employees connected with the provision of services under the Agreement. Such workers compensation insurance shall comply with Mississippi Workers' Compensation Laws. Such comprehensive general liability insurance and professional liability insurance shall provide coverage in an amount established by CCO pursuant to the Agreement or as required under the State Contract.

SECTION 4
ADDITIONAL PROVIDER REQUIREMENTS FOR SPECIFIC ACTIVITIES

4.1 Behavioral Health Providers. Behavioral health Providers shall ensure that all Covered Persons receiving inpatient psychiatric services are scheduled for outpatient follow-up and/or continuing treatment prior to discharge from the inpatient psychiatric hospital if the Provider is aware of the Covered Person's inpatient hospitalization status. Behavioral health Providers will be provided daily reports identifying Covered Persons known to be admitted to an inpatient facility.

4.2 PCP Responsibilities. Providers acting as PCPs shall meet the following requirements:

(a) PCPs who serve Covered Persons under the age of twenty-one (21) are responsible for conducting all EPSDT screens for individuals on their Panel under the age of twenty-one (21). Should the PCP be unable to conduct the necessary EPSDT screens, the PCP is responsible for arranging to have the necessary EPSDT screens conducted by another network Provider and ensure that all relevant medical information, including the results of the EPSDT screens, are incorporated into the Covered Person's PCP Medical Record.

(b) PCPs who serve Members under the age of twenty-one (21) report encounter data associated with EPSDT screens, using a format approved by DOM, to the Contractor within ninety (90) calendar days from the date of service.

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

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

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

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

4.3 Specialists as PCPs. Covered Persons with disabling conditions, chronic illnesses, or child(ren) with special health care needs may request that their PCP be a specialist. The designation of a specialist as a PCP must be pursuant to a treatment plan approved by Subcontractor and Health Plan, in consultation with the PCP to which the Covered Person is currently assigned, the Covered Person and, as appropriate, the specialist.

The specialist as a PCP shall provide or arrange for all primary care, including routine preventive care, and to provide those specialty medical services consistent with the Covered Person's disabling condition, chronic illness, or special health care need in accordance with Subcontractor and Health Plan's standards and within the scope of the specialty training and clinical expertise.

The specialist as a PCP shall have admitting privileges at a hospital in Health Plan's network.

SECTION 5
HEALTH PLAN AND SUBCONTRACTOR REQUIREMENTS

5.1 Prompt Payment. Subcontractor or Health Plan shall pay Provider pursuant to the State Contract and applicable State and federal law and regulations, including but not limited to Mississippi Code Section 83-9-5, 42 CFR 447.46, 42 CFR 447.45(d)(2), 42 CFR 447.45(d)(3), 42 CFR 447.45(d)(5) and 42 CFR 447.45(d)(6), as applicable and as may be amended from time to time. If a third party liability exists, payment of claims shall be determined in accordance with federal and/or State third party liability law and the terms of the State Contract. Unless Subcontractor or Health Plan otherwise requests assistance from Provider, Subcontractor or Health Plan will be responsible for third party collections in accordance with the terms of the State Contract.

5.2 No Incentives to Limit Medically Necessary Services. Subcontractor and Health Plan shall not structure compensation provided to individuals or entities that conduct utilization management and concurrent review activities so as to provide incentives for the individual or entity to deny, limit, or discontinue Medically Necessary services to any Covered Person.

5.3 Provider Discrimination Prohibition. Subcontractor and Health Plan shall not discriminate with respect to participation, reimbursement, or indemnification of a provider who is acting within the scope of the provider's license or certification under applicable State law, solely on the basis of such license or certification. Subcontractor and Health Plan shall not discriminate against Provider for serving high-risk Covered Persons or if Provider specializes in conditions requiring costly treatments. This provision shall not be construed as prohibiting Subcontractor and/or Health Plan from limiting a provider's participation to the extent necessary to meet the needs of Covered Persons. This provision also is not intended and shall not interfere with measures established by Health Plan that are designed to maintain quality of care practice standards and control costs.

54 Communications with Covered Persons. Covered Persons are entitled to the full range of their Providers' opinions and counsel about the availability of Medically Necessary Services under the provisions of the State Contract. Any contractual provisions, including gag clauses or rules, that restrict a Provider's ability to advise Covered Persons about Medically Necessary treatment options violate federal law and regulations.

Subcontractor and Health Plan shall not prohibit or otherwise restrict Provider, when acting within the lawful scope of practice, from advising or advocating on behalf of a Covered Person for the following:

(a) The Covered Person's health status, medical care, or treatment options, including any alternative treatment that may be self-administered;

(b) Any information the Covered Person needs in order to decide among all relevant treatment options;

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

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

(e) Information regarding the nature of treatment options including those that may not reflect Health Plan's position or may not be covered by Health Plan.

Subcontractor and Health Plan also shall not prohibit a Provider from advocating on behalf of a Covered Person in any grievance system, utilization review process, or individual authorization process to obtain necessary health care services.

55 Termination, Revocation and Sanctions. In addition to its termination rights under the Agreement, Subcontractor and Health Plan shall have the right to revoke any functions or activities Subcontractor and/or Health Plan delegates to Provider under the Agreement or impose other sanctions consistent with the State Contract if in Subcontractor and/or Health Plan's reasonable judgment Provider's performance under the Agreement is inadequate. Subcontractor and Health Plan shall also have the right to suspend, deny, refuse to renew or terminate Provider in accordance with the terms of the State Contract and applicable law and regulation. However, Subcontractor and Health Plan shall not exclude or terminate a Provider from participation in Subcontractor and/or Health Plan's Provider Network due to the fact that the Provider has a practice that includes a substantial number of patients with expensive medical conditions, and shall not terminate a Provider for filing a Complaint, Grievance, or Appeal on a Covered Person's behalf.

56 Rights of DOM. DOM shall have the right to invoke against Provider any remedy set forth in the State Contract, including the right to require the termination of the Agreement, for each and every reason for which it may invoke such a remedy against CCO or require termination of the State Contract. Suspected Fraud and Abuse by Provider will be investigated by DOM.

SECTION 6

OTHER REQUIREMENTS

6.1 Compliance with State Contract. All tasks performed under the Agreement shall be performed in accordance with the requirements of the applicable State Contract, as set forth in this Appendix, applicable provider manuals, and protocols, policies and procedures that Subcontractor and/or Health Plan have provided or delivered to Provider. The applicable provisions of the State Contract are incorporated into the Agreement by reference. Nothing in the Agreement relieves Health Plan of its responsibility under the State Contract. If any provision of the Agreement is in conflict with provisions of the State Contract, the terms of the State Contract shall control and the terms of the Agreement in conflict with those of the State Contract will be considered waived.

6.2 Monitoring. Subcontractor and/or Health Plan shall perform ongoing monitoring (announced or unannounced) of services rendered by Provider under the Agreement and shall perform periodic formal reviews of Provider according to a schedule established by the State, consistent with industry standards or State managed care organization laws and regulations or requirements under the State Contract. As a result of such monitoring activities, Subcontractor and/or Health Plan shall identify to Provider any deficiencies or areas for improvement mandated under the State Contract and Provider and Subcontractor and/or Health Plan shall take appropriate corrective action. Provider shall comply with any corrective action plan initiated by Subcontractor and/or Health Plan and/or required by the MississippiCAN Program. In addition, Provider shall monitor and report the quality of services delivered under the Agreement and initiate a plan of correction where necessary to improve quality of care, in accordance with that level of care which is recognized as acceptable professional practice in the respective community in which Subcontractor, Health Plan and Provider practice and/or the performance standards established under the State Contract.

6.3 Enrollment. The parties acknowledge and agree that DOM is responsible for enrollment, reenrollment and disenrollment of Covered Persons.

6.4 No Exclusivity. Nothing in the Agreement or this Appendix shall be construed as prohibiting or penalizing Provider for contracting with a managed care organization other than Subcontractor and/or Health Plan or as prohibiting or penalizing Subcontractor and Health Plan for contracting with other providers. Health Plan may not require Providers who agree to participate in the MississippiCAN Program to contract with Health Plan's other lines of business.

6.5 Delegation. The parties agree that, prior to execution of the Agreement, Subcontractor and/or Health Plan evaluated Provider's ability to perform any duties delegated to Provider under the Agreement. Any delegated duties and reporting responsibilities shall be set forth in the Agreement or other written delegation agreement or addendum between the parties. Subcontractor and Health Plan shall have the right to revoke any functions or activities Subcontractor and/or Health Plan delegates to Provider under the Agreement if in Subcontractor and/or Health Plan's reasonable judgment Provider's performance under the Agreement is inadequate.

Transportation Vendor
Provider Services Agreement

THIS AGREEMENT ("Agreement") is made and entered into by and between [redacted] (hereinafter referred to as [redacted]) and [redacted], (hereinafter referred to as "Transportation Provider" or "Provider"). [redacted] and Transportation Provider individually shall be referenced herein as a "Party" and collectively as the "Parties").

WHEREAS, [redacted] provides transportation brokerage services under contract ("Client contract") with governmental agencies and health care plans ("Clients") for the provision of non-emergency medical transportation ("NEMT" or "NET") benefits management, transportation provider network administration, and related services; and

WHEREAS, [redacted] wishes to enter into Agreements with qualified transportation companies and other business entities for the provision of high quality NEMT services ("Services"); and

WHEREAS, Transportation Provider wishes to enter into this Agreement for the provision of Services under the terms and conditions set forth herein;

NOW, THEREFORE, in consideration of the foregoing and of the mutual covenants, promises and undertakings herein set forth, the parties, intending to be legally bound, agree as follows:

1. DEFINITIONS

A. **Attendant** means a person that accompanies a Member and may be employed by the Transportation Provider, and/or may be a family member, caregiver or caseworker of the Member. Attendant requirements herein apply only to Attendants employed by the Transportation Provider.

B. **Beneficiary or Member** means any person enrolled in and entitled to NEMT services under a health benefit plan issued by [redacted]'s Client.

C. **Covered Service** means any medical transportation service that [redacted] is obligated to provide to a Member pursuant to a Client agreement.

D. **Criminal Background Check** shall mean a fingerprint-based national criminal record search conducted by a government agency or by a nationally recognized screening organization to include a social security number trace, a National Criminal Database search or the equivalent and a County Criminal Court Search or the equivalent based on the previous addresses as well as the names associated with the individual.

E. **Door-through-Door** level of service means that the driver must enter the residence or pick-up location and help the member to ensure safe assistance to and from the vehicle. Upon arrival at the destination the driver must deliver the Member inside of the facility or residence to an appropriate individual or facility representative.

F. **Door-to- Door** level of service means that the driver must go to the entrance of the Member's residence or pick-up location and announce arrival. Upon arrival at the destination, it is the driver's responsibility to bring the Member to the appropriate entrance of the designated facility or drop-off location.

G. **Drug Screen** means a urine based drug test that meets the requirements of the Federal Department of Health and Human Services, or the Department of Transportation, and screens at minimum for the use of marijuana, cocaine, amphetamines, opiates (codeine, morphine, and heroin) and Phencyclidine (PCP).

H. [redacted] **Transportation Provider Handbook** ("Handbook") is incorporated herein by reference and contains procedures, guidelines and processes established by [redacted], compliance to which is required of Transportation Providers in order to affect the intent of this Agreement. A copy of the Handbook is provided to Transportation Provider in electronic form and/or hard copy, and the receipt is herein acknowledged.

I. **Service Area** means the geographical area within the State of Mississippi where the Transportation Provider's transportation services will take place.

J. **Transportation Provider** means a transportation company or other business entity under agreement with [redacted] to provide transportation services.

K. **Trip** or **Trip Leg** means one-way transportation from point of pick-up to destination drop off.

L. **Turn-back** or **Reassignment** means a trip assignment that is refused by Transportation Provider and that is returned to MTM to be directed to a different Transportation Provider.

2. TRANSPORTATION PROVIDER REQUIREMENTS

A. Transportation Provider understands that selection of the Transportation Provider's transportation services by [redacted] will include but not be limited to factors such as quality, service availability, and competitive pricing of its services relative to other Transportation Providers doing business in the Service Area.

B. Transportation Provider is a legally recognized business entity duly incorporated or organized, validly existing, authorized to transact business, and in good standing under the laws of the State in which services are being rendered to [redacted]. A Certificate of Good Standing from the Secretary of State must be provided to [redacted] upon the signing of this Agreement.

C. Transportation Provider must immediately report to [redacted] any changes in Transportation Provider's contact information, company ownership or Federal Tax ID. A change of ownership or change in the FEIN number or the legal name of a Transportation Provider will require a new Agreement.

D. Transportation Provider agrees and understands that its dispatch/office must be available for immediate response during regular business hours. Moreover, a dispatcher, manager or owner must be available for immediate response on weekdays until 8 p.m. Central Standard Time.

E. The Immigration Reform & Control Act of 1986 prohibits employers from knowingly hiring illegal workers. Transportation Provider agrees that it shall only employ individuals who may legally work in the United States; either U.S. citizens or authorized aliens. Verification of U.S. employment eligibility must be provided to MTM upon request.

F. Transportation Provider warrants that neither it nor any of its owners or officers have ever been terminated or excluded from participation in any State Medicaid or Medicare program or have been determined to have committed Medicaid or Medicare fraud, or, are on any excluded parties list maintained by any Federal or State agency.

G. Transportation Provider warrants that no monies or gifts have been or will be paid or given directly or indirectly to any employee or agent of [redacted] as wages, compensation or gifts in exchange for favors in granting of transportation services to Transportation Providers.

H. Transportation Provider understands and agrees that it is the Transportation Provider's responsibility for itself and its drivers, to obtain and maintain in active status any and all licenses, permits, certificates, and registrations that are required by Federal, State or local laws, rules and regulations, as they currently exist and may hereafter be amended, including but not limited to any and all licenses, registrations, or certificates required to provide transportation for hire, and to operate as a Medicaid Provider in the assigned Service Area.

I. Transportation Provider must meet Federal guidelines for HIPAA compliance by keeping all Member protected health information (PHI) and personally identifiable information (PII) confidential, reporting to [redacted] any breaches of PHI or PII, and complying with the requirements set forth in the Business Associate Agreement, attached hereto as Appendix A and incorporated herein by reference. The Transportation Provider is deemed a Business Associate and must sign a Business Associate Agreement.

J. Transportation Provider agrees to comply with the Medicare Advantage and Medicaid Program Requirements, a copy of which is attached as Appendix C to this Agreement and incorporated herein by reference.

K. Transportation Provider must provide safe and reliable transportation services under this Agreement on an efficient and timely basis. Transportation Provider understands that this Agreement does not guarantee or ensure Transportation Provider any minimum number of trips, and that actual trip volume may vary within the sole discretion of [redacted].

L. Transportation Provider agrees to provide a sufficient staff of appropriately trained, licensed, and fully credentialed drivers meeting all applicable Federal, State, and local laws, rules and regulations to perform the Covered Service. It is in the Transportation Provider's best interest to employ drivers and/or office personnel who are also fluent in the languages prevalent in Transportation Provider's Service Area.

M. Transportation Provider shall provide drivers with visible, easily readable identification including a picture ID badge with driver's name and Transportation Provider's Company name, for security and identification purposes.

N. Transportation Provider shall only use drivers and vehicles to perform services under this Agreement that are approved and fully credentialed by [redacted]. [redacted] may not pay Transportation Provider for trips provided by Transportation Provider's unapproved drivers, and [redacted] may not pay Transportation Provider for trips using unapproved vehicles. The use of unapproved drivers and vehicles may be subject to liquidated damages as set forth in Schedule B attached hereto and incorporated herein by reference, and may result in termination of this Agreement.

O. Transportation Provider represents, by submission of a driver for credentialing approval by [redacted] that the driver has represented that he/she has no known physical or mental impairment that would hinder or prevent driver from performing the Services and safely transporting Members.

P. Transportation Provider for itself and its drivers agrees that [redacted] trip requests will have equal priority with Transportation Provider's day to day services, and that services available to Members have equal priority to services available to the general public. Transportation Provider agrees to have in place, a specific contingency or back-up plan to accommodate a trip which has been assigned to Transportation Provider whether or not the trip occurs.

Q. Transportation Provider understands that all trips, including recurring trips, may be assigned or reassigned by [redacted] in its sole discretion. Transportation Provider has no claim or right to transport any particular person or any claim or right to transport any person attending any particular health care services facility.

R. Transportation Provider shall give immediate notice to [redacted] of: (i) any criminal investigation, charge or proceeding against Transportation Provider or drivers; (ii) any conviction(s) of Transportation Provider or drivers for misdemeanor or felony crimes against a person, alcohol related driving offenses, and crimes involving moral turpitude and (iii) any civil claim asserted against Transportation Provider or drivers arising from services rendered by Transportation Provider under this Agreement.

S. Transportation Provider is required to keep records of all Services provided under this Agreement and shall provide [redacted] with all necessary requested data as may be required in order for [redacted] and Transportation Provider to comply with all Federal, State, local, NCQA, URAC, and Client standards. Transportation Provider agrees to maintain full and complete records reflecting all of its operations related to this Agreement for a period of ten (10) years or such longer period as maybe required by applicable laws, regulations or Client requirements.

T. Transportation Provider agrees to participate in [redacted]'s Quality and Compliance program which may include developing and cooperating with corrective action plans to ensure that the proper level and quality of service is provided. Transportation Provider must allow inspections, audits, monitoring, and duplication of records at no charge, of billing reports, trip/log sheets, vouchers and other records maintained by Transportation Provider for use by [redacted], [redacted]'s Client or City, County, State or Federal government officials during normal business hours. Such evaluations and inspections may be conducted unannounced. The failure of Transportation Provider to timely allow Transportation Provider audits or to respond to document requests by the requested date, could result in disciplinary measures up to and including removal from [redacted]'s Transportation Provider network, at [redacted]'s discretion. Any requested records will not be returned by [redacted]. Transportation Provider must maintain copies.

U. It is the Transportation Provider's responsibility to understand and comply with all applicable State, Federal and local laws and regulations as they currently exist and may hereafter be amended to provide services under this Agreement, including but not limited to: the False Claims Act (32 USC 3729, et. seq.), and the Anti-Kickback Statute (section 1128 (b)) of the Social Security Act; the Americans With Disabilities Act (ADA) of 1990; the Rehabilitation Act of 1973, Section 504; the requirements of 42 Code of Regulations, Part 431, Subpart F; Title VII of the Civil Rights Act of 1964; Medicaid and Medicare laws and regulations; and State and local traffic and distracted driving laws.

V. Transportation Provider must follow and ensure that its drivers follow the procedures and policies set forth in the Handbook.

W. Transportation Provider agrees to provide such trips as are assigned to Transportation Provider by [redacted] for a specified Service Area, and Transportation Provider agrees to and understands that liquidated damages as set forth in the attached Schedule B may be assessed by [redacted] for trips that are unable to be completed, or for Transportation Provider's noncompliance with this Agreement.

X. Transportation Provider understands that Transportation Provider misconduct will not be tolerated and could result in disciplinary measures including but not limited to reduction of trips, suspension, or removal from [redacted]'s Transportation Provider Network.

Y. Transportation Provider acknowledges that the [redacted] Transportation Provider Handbook will be reviewed

periodically by [redacted] and may be modified within its sole discretion with notification by [redacted] to Transportation Provider prior to implementation. Transportation Provider agrees to comply with all terms and provisions of the Handbook, to which the Transportation Provider has access.

Z. Transportation Provider agrees to cooperate with [redacted] and the [redacted] Client in the investigation process for complaints, grievances and suspected fraudulent activity. Transportation Provider understands and agrees that any complaints or grievances received by [redacted] with respect to the provision of Transportation Provider services will be forwarded to Transportation Provider for immediate attention and response. Any problem(s) related to the service shall be promptly resolved. Transportation Provider agrees to comply with [redacted]'s complaint resolution policies and provide [redacted] with the information necessary to help resolve grievances, complaints and inquiries with respect to Transportation Provider's services and other issues.

AA. Transportation Provider understands if there is suspicion of fraudulent driver or Transportation Provider activity, an investigation will be conducted by [redacted], with appropriate action taken, including notification to the Client and/or the appropriate governmental authorities. Investigations by applicable government authorities may result in civil fines and penalties, and the potential for criminal prosecution.

BB. Transportation Provider must not inquire as to the nature of a Member's illness or medical services received, except in the following instances: (i) Transportation Provider needs to know such information due to medical necessity relating to appropriate transportation and (ii) the Member becomes ill during the course of the trip and acquiring such information is considered pertinent to assuring the Member's safety and well-being. Transportation Provider must immediately report to [redacted] any known or suspected fraud or willful abuse of [redacted] services by a Member.

CC. Transportation Provider must report accidents, and injuries that occur during the transport of an [redacted] Member to [redacted]. Transportation Provider agrees to cooperate with [redacted] in the investigation of accidents and injuries.

DD. If a Member is delayed due to late pick-up or drop-off by Transportation Provider, and cannot be seen at appointment, the Transportation Provider may be assessed a vendor 'no-show' and the Transportation Provider will not be compensated for trip.

EE. Transportation Provider agrees to notify [redacted] immediately of any significant delays which cause the Member to be late for his/her medical appointment. In addition to [redacted] notification, Transportation Provider must make alternate plans for completing the trip in a timely manner if the medical appointment can still be attended.

FF. If the Transportation Provider determines a scheduled trip cannot be performed due to unsafe driving conditions during inclement weather, the Transportation Provider must immediately notify both the Member and [redacted] of the cancellation.

GG. Transportation Provider understands that, due to disability, age or mental condition, some Members require assistance and/or the use of an escort/attendant to assist the member during transport and at the place of treatment. Transportation Provider agrees to transport the Member and one (1) escort/attendant as requested. Multiple escorts require prior approval from [redacted].

HH. Transportation Provider must comply at a minimum with its assigned service level. Provider shall provide curb-to curb service as the standard service. Provider shall also provide levels of service including but not limited to door-to-door and door-through-door service with [redacted]'s prior approval, based on the medical necessity of the Member.

II. Transportation Provider must ensure that drivers do not charge for any general assistance into or out of the vehicle for any Member and/or passenger. General assistance includes but is not limited to opening doors, offering an arm to lean on, or holding a bag.

JJ. Transportation Provider agrees that [redacted] may use Provider's name, address, telephone number(s), and a description of Transportation Provider's services in [redacted]'s directory, advertising, and other material.

KK. Transportation Provider understands that no driver or attendant shall leave a Member unattended at any time. If a driver is transporting multiple passengers at the same time, Provider shall provide the assistance of an attendant at Provider's cost so that no Member is left unattended while the driver is assisting a Member exiting the vehicle.

3. DRIVER AND ATTENDANT REQUIREMENTS

A. Any driver or attendant failing to meet [redacted]'s qualifications, or any requirements imposed by State or local law, shall be prohibited from providing service under this Agreement. [redacted] and the Client reserve the right to disallow any driver or attendant from performing services under this Agreement.

B. All drivers for trips taken under this Agreement must possess a current, valid driver's license appropriate for the services rendered and for the type of vehicle the driver is operating and as required by the State and municipality in which driver provides transportation. A current, legible copy of each driver's license must be provided to [redacted] as part of the credentialing process.

C. Drivers and attendants must be at least 21 years of age, must be a U.S. citizen or legal resident alien, and must obey all Federal, State and local traffic laws.

D. Drivers and attendants must be able to read, write and communicate effectively in English.

E. Drivers and attendants must properly identify and announce his/her presence at the entrance of the building or with attending facility staff at the specified pick-up location, if a suitable curbside pick-up is not apparent.

F. Drivers must be physically able to assist Members entering and exiting vehicles, and must be capable of safely providing transportation services. Driver and Attendant represent, by submission of a credential to Transportation Provider for credentialing approval by [redacted], that driver &/or attendant, as applicable, have no known physical or mental impairment which would hinder or prevent him or her from performing services under this Agreement and safely transporting [redacted] Members.

G. Drivers and Attendants understand that in the event a driver or Member feels there is a need for emergency medical assistance, the driver or Attendant must immediately call 911.

H. Drivers must drive in a professional and safe manner, and must conduct themselves in an appropriate, courteous, helpful, and patient manner.

I. Drivers and Attendants must maintain acceptable standards of dress and personal grooming in order to present a neat, clean and professional appearance.

J. Drivers and Attendants must not enter the Member's home except under prior authorization from [redacted].

K. Drivers and Attendants must not smoke in the vehicle, or smoke in the presence of or while assisting any Member. The use of e-cigarettes, vapor smoking products, and the equivalent is also prohibited.

L. Drivers must not allow passengers to smoke or use e-cigarettes or vapor smoking products, or the equivalent in the vehicle. It is required that Transportation Provider post a "NO SMOKING" sign in all vehicles.

M. Drivers and attendants must not eat in the vehicle or while assisting or transporting [redacted] Members.

N. Drivers and attendants must not use alcohol or drugs or be under the influence of alcohol or drugs at any time while providing [redacted] transportation services. Any driver taking prescribed medication which may hinder his/her performance must report such use to his/her supervisor, and not transport [redacted] Members. A driver or attendant may use properly prescribed medication as long as his/her duties can still be performed in a safe manner and Transportation Provider has written medical documentation from his or her medical provider that the medication will not impact the ability of the driver.

O. Drivers and attendants must not allow personal friends or family members to ride in the vehicle while transporting [redacted] Members unless specifically authorized by [redacted].

P. Drivers must allow service animals in their vehicles as per the Americans with Disabilities Act.

Q. Drivers must not make personal stops, other than for restroom and Member/ Transportation Provider agreed-upon restaurant breaks, while transporting [redacted] Members unless specifically authorized by [redacted].

R. Drivers must require Members to use seatbelts properly and must refuse to continue travel if Members are non-compliant. Drivers must have seat belt extenders and be knowledgeable in their use for securing Members that require the extenders.

S. Drivers must ensure that all wheelchairs and mobility devices are properly secured to the vehicle and ensure that Members utilizing wheelchairs and scooters are properly secured before putting the vehicle in motion.

T. Drivers understand infants/children are to be in proper infant/child restraint seats as required by State and/or Federal law. In the event a proper seat is not available, or the use of the proper child restraint seat is refused, the driver must deny transportation.

U. Drivers must not place children in child restraint seats in the front seat of a vehicle.

V. Drivers and attendants must assure Members enter and exit the vehicle in an unobstructed and safe location. Where needed, drivers must provide assistance to Members entering and exiting a vehicle and ensure all doors are securely closed before vehicle is put in motion.

W. Drivers are required to safely secure folding wheelchairs and walking aids. Transportation Provider is responsible for all damages caused by drivers to Member's transported equipment and personal property.

X. Drivers and attendants must not touch any Member except as appropriate and necessary to assist the Member into or out of the vehicle or a seat; and to secure the seatbelt, or as necessary to render first aid or assistance for which the driver has been trained. Drivers and attendants must request permission from the Member prior to touching the Member.

Y. Drivers and attendants must not sexually harass, solicit sexual favors, or make sexually explicit comments to Members.

Z. Drivers and attendants must not solicit or accept favors, including but not limited to medications, goods, money, controlled substances, or alcohol from Members.

AA. Drivers and attendants shall not wear any type of headphones or earpieces, unless it is part of the Transportation Provider's two-way communication system.

BB. Drivers shall maintain the radio volume at a level acceptable to Members.

CC. Hand-held cellular devices may only be used in performance of services under this Agreement, and driver shall at all times comply with applicable laws regarding the use of cellular telephones by the driver of a moving vehicle.

DD. Drivers must not accept responsibility for any of Member's personal items.

EE. Drivers must not allow firearms or other weapons, unauthorized controlled substances, or highly combustible materials to be transported in the vehicle.

FF. Drivers must check their vehicle to ensure that at the end of each trip or trip route, all Members have vacated the vehicle.

4. VEHICLE REQUIREMENTS

A. Use of any vehicle prior to approval by [redacted] is prohibited and may result in nonpayment for the trip and subject the Transportation Provider to further disciplinary action including assessment of liquidated damages.

B. All vehicles in use for Services under this Agreement must meet all local, State and Federal requirements and comply with all vehicle requirements of MTM and its Client. Vehicles must display any applicable State or local motor vehicle registration and/or inspection sticker. Transportation Provider agrees that all vehicles that transport Members utilizing mobility devices will comply with current Federal ADA vehicle regulations, as defined by the U.S. Department of Transportation.

C. Vehicles may be taken out of service for use with [redacted] Members at the discretion of [redacted]. Transportation Provider agrees to remove from [redacted] service any vehicle to be found unsatisfactory in reference to conditions listed in this section, or which is questionable with regards to safety or roadworthiness, until repairs are completed.

D. No vehicle in use for services under this Agreement shall have:

i) Damaged or broken seats or seatbelts

ii) Protruding or sharp edges

iii) Dirt, oil, grease or litter in the vehicle

iv) Broken mirrors or windows (other than small chips/cracks)

v) Excessive grime, rust, chipped paint or major dents

E. Vehicles used for the transportation of members must have operational AVL/GPS capability which at minimum is capable of recalling the location of the vehicle for specific periods of time, and an internet connected device (ICD) which can be used to access [redacted]'s mobile applications for drivers.

F. The Transportation Provider shall provide and ensure each driver uses a two-way voice communication system linking all vehicles used in delivering the services under this Agreement with the Transportation Provider's place of business. Pagers are not an acceptable substitute.

5. CREDENTIALING, AND RE-CREDENTIALING

A. Transportation Provider agrees to develop and maintain a Driver Orientation and Training Program. All training and orientation documentation must be maintained by the Transportation Provider in the individual driver's file.

B. Driver training programs must include Fraud, Waste and Abuse ("FWA") and HIPAA. The Driver training program could include, but not be limited to:

i) Assisting Passengers with Disabilities

ii) Emergency Situation Training

iii) Wheelchair Securement

iv) CPR

v) First Aid

vi) Defensive Driving

C. Transportation Provider agrees to maintain records on each driver and attendant, including owner-drivers. The file contents shall be provided to [redacted] upon request and shall include but not be limited to the following current credentials:

i) Driver's License

ii) Criminal Background Check

iv) Motor Vehicle Driving Record Report

v) Drug & Alcohol Screening Results

vi) Health Record Attestation

vii) Driver Evaluations

viii) Training Certificates

ix) MS Sex Offender Registry Check

D. No driver or attendant may perform transportation services under this Agreement until fully credentialed and approved by [redacted]. [redacted] has entered into agreements with independent credentialing companies for nationwide access to credentials and screening services for drivers. [redacted] may make available these services to Transportation Providers. Transportation Provider agrees to sign or have signed all further documents as may reasonably be necessary to give effect to the credentialing and screening services for drivers.

E. Transportation Provider must not use any person as a driver or attendant whose name appears on the Office of the Inspector General (OIG) exclusion list; the Federal Excluded Party List System (EPLS), or similar government exclusion lists.

F. Transportation Provider must maintain a driver's health record, signed by the driver, that no physical or health limitation exists that prevents safe, competent operation of the motor vehicle or ability to assist any passenger in and out of the vehicle, or the performance of any other passenger assistance services, when a passenger requests such assistance.

G. If [redacted] or the Transportation Provider has reasonable suspicion that a driver or attendant is under the influence of alcohol or drugs, the Transportation Provider must immediately remove the driver or attendant from [redacted] service and submit him or her to an alcohol and/or drug screening at the Transportation Provider's expense.

H. Transportation Providers must maintain a Substance Free Workplace Policy to include but not be limited to pre-employment, random, and post-accident drug and alcohol screening for drivers and attendants pursuant to drug and alcohol testing regulations for safety sensitive positions. A copy of the policy must be provided to [redacted] upon request. Refusal to submit to testing within the designated time frame is considered a positive test result and will have disciplinary consequences. Drivers or attendants testing positive for drugs and/or alcohol will no longer be permitted to transport [redacted] Members.

I. Transportation Provider must not use any driver or attendant in the conduct of [redacted] services with any of the following convictions (misdemeanor or felony) or substantiated incidents including but not limited to:

i) Child abuse or neglect

ii) Domestic violence

iii) Crimes against children

iv) Crimes against the elderly, incapacitated or infirm

v) Crimes involving rape, sexual assault, or other sexual offenses

vi) Homicide

J. Transportation Provider must not use any person as a driver or attendant in the conduct of [redacted] services who has a felony criminal conviction of a felony offense within the preceding five (5) years or length of time designated by [redacted]'s Client.

K. [redacted] reserves the right to disapprove or suspend any driver or attendant for safety reasons; or where disqualification of a driver or attendant is requested by an [redacted] Client; or for other reasons of good cause within [redacted]'s sole discretion. Transportation Provider acknowledges that the offenses listed herein are not an exclusive listing, but that there are other offenses and pertinent circumstances which can result in the disapproval of a driver or attendant.

L. Transportation Provider must not allow drivers or attendants to perform [redacted] services who are currently on work release, probation, parole, or pending any felony or misdemeanor charge, or arrest, or drug or alcohol related traffic offense charge, which, if the charge were to result in a conviction, would disqualify the driver, Transportation Provider, or attendant under this Agreement. This same requirement applies equally to the Transportation Provider. Further, upon arrest of the Transportation Provider, [redacted] retains the option of suspending the Transportation Provider's services hereunder pending investigation of the arrest related charges.

M. Transportation Provider must not use any driver in the conduct of [redacted] services with the following:

i) Convicted of three (3) or more motor vehicle moving violations within the previous twenty-four (24) months.

ii) Involvement in two (2) or more at-fault accidents resulting in personal injury or property damage within the previous thirty-six (36) months. An "at fault" accident means any accident where the driver is cited with a violation, or negligently contributes to the accident or any single vehicle accident where the cause is not equipment related. A driver's involvement in an accident will be presumed at fault unless driver provides evidence or documentation to the contrary.

iii) A combination of one (1) unrelated motor vehicle moving violation and one (1) at-fault incident (accident) resulting in personal injury or property damage within the previous twenty-four (24) months.

iv) Revocation or suspension of the driver's vehicle operator's license within the previous three (3) years for accumulation of points or drug or alcohol related incident or moving traffic violations.

Copies of police reports are required to verify "no fault" accidents.

N. Further, any conviction, plea of guilty, finding of guilty or plea of "nolo contendere" (misdemeanor or felony), for any of the following driving offenses within the previous five (5) years shall disqualify a driver from performing [redacted] services:

i) DUI or DWI, or other alcohol related offense or under the influence of a controlled substance

ii) Other alcohol related or controlled substance related offense

O. The term "conviction" used herein shall also include any plea of guilty, finding of guilty, plea of "nolo contendere", or similar disposition, whether or not such disposition results in a sentence or conviction under applicable State or local laws.

P. A list of credentials can be found on Appendix B attached hereto. Changes to credentialing and re-credentialing requirements can be viewed online at the Transportation Provider's website.

6. COMPENSATION

A. [redacted] shall pay Transportation Provider for its services at the rates set forth in Schedule A. [redacted] pays properly submitted uncontested invoices within thirty (30) days after online electronic submission. Any claim submitted by Transportation Provider more than ninety (90) days (or such other length of time as required by [redacted]'s Client) after the date of service shall not be eligible for payment, and Transportation Provider thereby waives any right to payment thereafter.

B. No payment will be made for services performed by unapproved drivers or for services performed using unapproved vehicles.

C. Transportation Provider agrees that it will look solely to [redacted] for payment for services rendered. In no event, including but not limited to, non-payment by [redacted] or [redacted]'s Client, may Transportation Provider bill, charge, or otherwise seek compensation from a Member of [redacted]'s Client to whom Transportation Provider rendered services. This provision does not prohibit Transportation Provider from collecting a copayment or other fee where authorized by [redacted] or [redacted]'s Client.

D. The [redacted] appeals process gives Transportation Providers an opportunity to appeal any denied claims. Transportation Provider agrees that recovery of any overpayment or recoupment by [redacted] may be accomplished by offsets against future payments.

7. LIQUIDATED DAMAGES

A. Transportation Provider understands and agrees that liquidated damages may be assessed for noncompliance events, and that any liquidated damages specified are in lieu of actual damages for such occurrences. Transportation Provider agrees to cooperate fully with [redacted] to discuss and agree to appropriate corrective action plans, as necessary.

B. Transportation Provider agrees to pay [redacted] the sums set forth herein as liquidated damages and not as a penalty. Transportation Provider agrees and authorizes [redacted] to withhold, offset, recoup and deduct liquidated damages from any sums owing by [redacted] to Transportation Provider for services rendered. The assessment of liquidated damages shall not prohibit [redacted] from exercising any other right or remedy available to [redacted] at law or in equity. The failure at any time by [redacted] to assess liquidated damages shall not constitute a waiver of [redacted]'s right to assess liquidated damages in the future.

8. NON-DISCRIMINATION

Transportation Provider agrees not to differentiate or discriminate in the treatment of Members because of sex, marital status, family status, age, race, color, national origin, ancestry, religion, mental or physical disability, medical condition, height, weight, veteran status, sexual orientation, political affiliation, economic status, or any other basis prohibited by law, and Transportation Provider will render services to Members in the same manner and in accord with the same standards as offered to other persons.

9. INSURANCE

A. Transportation Provider, at its sole cost and expense, shall procure and maintain throughout the term of this Agreement, such policies of comprehensive general and automobile liability insurance, which policies shall include property damage, contractual liability, and completed operations/ products liability coverage, and other insurance, as may be required by [redacted]. Certificates of insurance evidencing existence of all insurance coverage specified herein shall be provided to [redacted] upon the signing of this Agreement and upon renewal of insurance.

B. The limits of all such insurance shall be in such form and coverage amounts as may be determined by [redacted], and which may be amended by [redacted] upon notice to Transportation Provider, and shall, at a minimum, be in compliance with [redacted]'s contractual requirements with its Client, and in compliance with all Federal, State and local insurance requirements for the jurisdiction in which transportation services are rendered. [redacted] reserves the right to require higher insurance coverage amounts than may be required by minimum Federal, State, or local laws and regulations.

C. Transportation Provider is required to maintain insurance at all times throughout the term of this Agreement. Failure to do so will result in immediate termination of the Agreement. The Transportation Provider's insurance coverage shall be primary insurance and non-contributory with respect to all other available sources. Minimum insurance limits are as follows:

i) Commercial General Liability

Policy shall include bodily injury, property damage, and broad form contractual liability coverage.

$1,000,000 per occurrence
$1,000,000 general aggregate

ii) Commercial Automobile Liability

Bodily Injury and Property Damage for any and all vehicles used in the performance of this Agreement.

$1,000,000 Combined Single Limit

a) Commercial General Liability and Commercial Automobile Liability policies shall be endorsed to include [redacted] as Additional Insured up to the greater of $1,000,000 or the Transportation Provider's policy full liability policy and umbrella limits.

b) Additional Insured endorsements shall be provided to [redacted] upon request. The Additional Insureds shall list:

[redacted]

c) Commercial General Liability and Commercial Automobile Liability policies shall be endorsed to provide specific notice of cancellation to [redacted].

d) The specific Notice of Cancellation endorsements shall be provided to [redacted] upon the signing of this Agreement and upon renewal of insurance.

iii) Workers Compensation

Statutory amounts for the State in which services are rendered

D. Commercial Automobile Liability policies that are scheduled auto policies must list each vehicle insured. Transportation provider must immediately notify [redacted] of all additions and deletions of insured vehicles.

E. "Broad Form" coverage shall include loading and unloading, and contractual liabilities. Waiver of subrogation shall apply and shall be in favor of [redacted]

F. If Transportation Provider does not maintain workers compensation insurance on its drivers, the Transportation Provider must (i) submit documentation from the appropriate governmental regulating authority supporting the Transportation Provider's exclusion or exemption from maintaining such insurance under State law, and (ii) ensure that the driver is contracted with the Provider in the name of the driver's company, and (iii) submit to [redacted] the first page and the signature page of the contract between the Transportation Provider's company and the driver's company. [redacted] reserves the right to require all Transportation Providers, including those otherwise exempt, to maintain workers compensation insurance.

G. Commercial auto liability policies that are scheduled auto policies must list each vehicle insured. Transportation provider must immediately notify [redacted] of all additions and deletions of insured vehicles.

H. In the event that policies shall be endorsed to include [redacted]'s Client as Additional Insured with notice of cancellation, and in the event waiver of subrogation shall apply and be in favor of [redacted]'s Client, [redacted] shall so inform Transportation Provider.

10. INDEMNIFICATION

A. TRANSPORTATION PROVIDER

Transportation Provider agrees to defend, indemnify, and hold harmless [redacted] and [redacted]'s Client from and against any claims, liabilities and expenses of any kind or nature whatsoever, arising or alleged to arise from performance or nonperformance of any service by Transportation Provider in connection with this Agreement, including but not limited to claims by personnel engaged by Transportation Provider; reasonable attorney's fees; and any noncompliance assessments, penalties, or liquidated damages and expenses incurred by or assessed against [redacted] and/or the Client relating to the actions or inactions of Transportation Provider.

B. [redacted] agrees to indemnify and hold harmless Transportation Provider against any claims, liabilities and expenses, including reasonable attorney's fees, arising from performance of any service by [redacted] in connection with this Agreement with respect to which Transportation Provider is not at fault.

11. DISCLOSURE OF OWNERSHIP AND CONTROL INTEREST

A. Transportation Provider understands that the following disclosures of ownership specifically apply to this Agreement, but do not exclude any other applicable Federal or State laws or requirements.

i) Transportation Provider warrants and represents that it, and its officers, directors, employees, agents and representatives, have not been convicted of crimes as specified in Section 1128 of the Social Security Act (42 U.S.C. 1320a-7); excluded from participation in the Medicare or Medicaid program, or any other Federal or State program; assessed a civil penalty under the provisions of Section 1128; entered into a contractual relationship with an entity convicted of a crime specified in Section 1128, or taken any other action that would prohibit it from participation in Medicare or Medicaid, or are otherwise excluded from participation in Federal or State programs.

ii) Transportation Provider warrants and represents that with respect to Transportation Provider or any of its employees, contractors, subcontractors, governing body members, or any major shareholders (5% or more) (i) there are no past or pending investigations, legal actions, or matters subject to arbitration , both Federal and State, for health care and/or prescription drug services; and (ii) that none have been criminally convicted nor has a civil judgment been entered against any of them for fraudulent activities nor are any of them sanctioned under any Federal or State program involving the provision of health care and/or prescription drug services.

B. Transportation Provider must immediately report to [redacted] any change in Transportation Provider's ownership, corporate officers, directors or controlling interest. Transportation Provider must notify [redacted] immediately if it or any of its owners, officers, directors, or managing personnel are barred from participation in any State or Federal program as a result of being sanctioned and placed on an excluded party list.

C. Transportation Provider shall complete and provide a disclosure of ownership, controlling interest and management upon request. Transportation Providers failing to meet the requirements of this section will be excluded from participation in [redacted]'s Transportation Provider network.

12. ASSIGNMENT

A. No portion of this Agreement shall be assigned, sublet, delegated, transferred or otherwise disposed of by Transportation Provider, except with the written consent of [redacted]. Transportation Provider may not subcontract any services herein to any person or business entity without the express written consent of [redacted].

B. This Agreement may be assigned by [redacted] to the participating [redacted] Client under contract to [redacted], or to any [redacted] affiliate or successor entity, after notice of any proposed assignment is made to Transportation Provider. Notwithstanding any such assignment, the rights, obligations and liabilities of Transportation Provider shall remain the same as set forth herein.

13. COMPLETE AGREEMENT

This Agreement including the attachments, addenda and amendments hereto, and the documents incorporated herein, constitute the entire understanding of the parties hereto with respect to the subject matter hereof, and supersedes any prior or contemporaneous agreements, oral or written, between [redacted] and the Transportation Provider.

14. TERM AND TERMINATION

A. This Agreement shall be for a term of three (3) years, and shall only be renewed or extended upon mutual written agreement of the parties. Termination shall have no effect upon the rights and obligations of the parties arising out of any services performed prior to the effective date of such termination. Further, in the event that a Member is provided services by Transportation Provider as of the date of termination of this Agreement, [redacted] will honor its contractual obligations to Members to pay for services rendered. This Agreement may also be terminated without cause for any reason upon a Party giving thirty (30) days written notice to the other party.

B. In the event Transportation Provider has been assigned trips and provides notice to [redacted] of termination, the Transportation Provider must accommodate and run those assigned trips within the thirty (30) day notice period. If Transportation Provider fails to complete said trips, the Transportation Provider may be subject to liquidated damages. Moreover, [redacted] is entitled to recoup or offset and deduct from any payment due Transportation Provider, the cost associated with re-scheduling those trips with another Transportation Provider.

C. Transportation Provider agrees that this Agreement does not guarantee or ensure Transportation Provider any minimum number of trips, and that actual trip volume may vary. Transportation Provider agrees to accept such trips as are assigned to Transportation Provider by [redacted]. If Transportation Provider is not assigned an adequate number of trips and wishes to terminate this Agreement, Transportation Provider must give [redacted] the aforesaid notice.

D. Notwithstanding any provision herein to the contrary, [redacted] shall have the right to immediately terminate this Agreement and the services of Transportation Provider in the event: (1) Transportation Provider fails to perform or otherwise breaches the terms of this Agreement; or (2) [redacted]'s Client suffers a loss of funding for the Contract between Client and MTM; or (3) [redacted]'s contract with its Client is terminated for any reason; or (4) Transportation Provider's conduct in any way affects the potential safety of any Member, in the sole discretion and determination of [redacted]; or (5) the filing of any Petition of Bankruptcy or insolvency, by or against the Transportation Provider; or (6) [redacted]'s Client has requested the termination of Transportation Provider; or (7) for other good cause. Transportation Provider shall have the right to immediately terminate this Agreement in the event [redacted] breaches the terms of this Agreement.

E. Transportation Provider agrees that [redacted] payment for all unpaid claims at time of termination will be withheld until [redacted] has received and audited service records and claims for correctness and accuracy. [redacted] reserves the right to offset any liquidated damages or other noncompliance assessments against sums due for unpaid claims, or to seek recoupment of sums previously paid in error to Transportation Provider.

15. NOTICE

A. Any notice provided for in this Agreement shall be in writing, addressed to the parties at the addresses set forth herein, and shall be delivered as follows with notice deemed given as indicated: (a) by personal delivery when delivered personally; (b) by registered or certified U.S. mail, return receipt requested and postage prepaid, in which case it shall be deemed served on the third mail delivery date after the date of mailing; or (c) nationally recognized courier service with all fees prepaid and shall be deemed delivered on the date of delivery, or the date of refusal.

B. Unless subsequently changed by written notice, notices shall be delivered or sent to the following addresses:

To:

[redacted]

To Transportation Provider at:

Attention:
Email:

16. INDEPENDENT CONTRACTOR RELATIONSHIP

It is mutually understood and agreed that in the performance of the duties and obligations of the parties to this Agreement, each party hereto is a separate and independent contractor. Neither party is the principal, agent, nor representative of the other; and neither shall have any direct control over the manner in which the other performs its services and functions. Each, [redacted] and Transportation Provider, is free to enter into Agreements with other entities or persons to provide the same or similar services.

17. EDUCATION AND TRAINING

It is the sole responsibility of Transportation Provider, as an independent contractor, to provide all necessary education and training of its drivers and other personnel to comply with all applicable laws and regulations, and the terms and conditions of this Agreement, and to provide safe and secure transportation of all transported passengers.

18. INTERPRETATION

This Agreement shall be interpreted and governed in accordance with the laws of the jurisdiction in which transportation services are rendered pursuant to this Agreement.

19. AFFIRMATIVE ACTION

[redacted] is an Equal Opportunity Employer, which maintains an Affirmative Action Program. The parties agree that they will comply with the nondiscrimination and affirmative action clauses contained in: Executive Order 11246, as amended, relative to equal opportunity for all persons without regard to race, color, religion, sex or national origin; the Vietnam Era Veterans Readjustment Act of 1974, as amended, relative to the employment of disabled veterans and veterans of the Vietnam Era; the Vocational Rehabilitation Act of 1973, as amended, relative to the employment of qualified handicapped individuals without discrimination based upon their physical or mental handicaps; the 1964 Civil Rights Act, as amended; the Age Discrimination Act of 1975 as amended; the Omnibus Reconciliation Act of 1981; the Americans with Disabilities

Act of 1990 and all other applicable Federal and State Laws which prohibit discrimination in the delivery of services on the basis of race, color, familial status, national origin, age, sex, sexual orientation, handicap/disability , religious beliefs or any other basis prohibited by law. Transportation Provider shall not discriminate or otherwise violate any Federal, State, or local anti-discrimination law or regulation in the performance of Transportation Provider's services to [redacted] under this Agreement.

20. AMENDMENT AND WAIVER

Transportation Provider acknowledges and agrees that this Agreement may be amended or modified in writing by mutual written agreement of the parties. In addition, [redacted] shall have the right to amend this Agreement without Transportation Provider's consent, to maintain consistency and/or compliance with any State or Federal law, policy, directive or government sponsored program requirement. [redacted] shall otherwise have the right to amend this Agreement upon written notice to Transportation Provider. If Transportation Provider does not deliver to [redacted] written notice of rejection of the amendment within thirty (30) days of the date of the notice of the amendment, the amendment shall be deemed accepted by and incorporated into this Agreement, and said amendment shall be binding upon the Transportation Provider.

21. CONFIDENTIALITY; NON-SOLICITATION; NON-COMPETE

A. Transportation Provider and [redacted] mutually acknowledge that in the course of performing this Agreement, Transportation Provider will become aware of information concerning [redacted]'s operations, business practices, customer practices, software systems, programs, pricing policies, customers, Members, and Clients. To the extent such information is generally unknown in the transportation industry or was unknown to Transportation Provider before Transportation Provider became aware of the information through [redacted], such information shall be deemed trade secrets and confidential, proprietary information of [redacted].

B. With respect to [redacted]'s trade secrets and confidential, proprietary information, including but not limited to all information obtained regarding Members, Transportation Provider agrees that Transportation Provider and its employees, agents, successors and assigns shall not disclose such information to any person or business entity without the written consent of [redacted] except for Transportation Provider's internal use as reasonably necessary to perform this Agreement. Transportation Provider also agrees that only those agents and employees of Transportation Provider who have a need to know any such information to perform their duties in connection with this Agreement will be provided with such information, and then only with those portions of such information as are reasonably necessary to the performance of their jobs. Further, Transportation Provider agrees to instruct such agents and employees not to disclose such information to any unauthorized persons or business entities.

C. Transportation Provider agrees that [redacted]'s non-emergency medical transportation services business and its network of contracted transportation providers, of which Transportation Provider is a member upon execution of this Agreement, are unique and valuable assets of [redacted] for which [redacted] rightfully seeks the protection of this Agreement. Therefore, Transportation Provider agrees not to discuss its compensation rates set forth herein with anyone outside of its organization, except for its accountants, attorneys and organization's representatives. Transportation Provider also agrees that becoming a Member of [redacted]'s transportation provider network through execution of this Agreement, is a valuable business asset of Transportation Provider.

D. Transportation Provider, for itself and its employees, agents, successors and assigns, further agrees that it will not: (a) use [redacted]'s trade secrets and confidential, proprietary information to develop, initiate or establish a business, or further the business of another person or business entity, which competes directly or indirectly with [redacted]; and (b) solicit or hire any employee of [redacted] during the period of employee's employment with [redacted], or for one (1) year following termination of employee's employment.

E. Transportation Provider agrees that a breach or threatened breach of the confidentiality provisions of this paragraph would cause immediate and irreparable harm to [redacted], and that actual damages would be difficult or impossible to ascertain, such that [redacted] shall be entitled to injunctive relief in addition to pursuing such other relief as [redacted] may be entitled to at law or in equity.

F. Transportation Provider will ensure that all information obtained regarding Members in connection with this Agreement, will be held in the strictest confidence and used only as required for the performance of Transportation Provider's obligations under this Agreement. The provisions of this Section shall survive termination of this Agreement.

22. ATTORNEY FEES AND COSTS

In the event that Transportation Provider fails to comply with each and every term of this Agreement or otherwise is in breach of any term of this Agreement; or in the event that Transportation Provider is required to defend, indemnify and hold harmless [redacted] with respect to any claim or liability arising out of the performance of any service by Transportation Provider in connection with this Agreement, Transportation Provider shall pay all of [redacted]'s costs and litigation expenses, including reasonable attorney's fees that may be incurred by MTM.

23. WAIVER OF JURY TRIAL

The parties hereto waive jury trial and consent to a Court trial as to all litigation arising out of the terms and conditions of this Agreement.

24. NO THIRD PARTY BENEFICIARY

Nothing in this Agreement is intended to, or shall be deemed or construed to create any rights or remedies in favor of any third party.

25. FORCE MAJEURE

Neither party shall be deemed to have breached this Agreement if its failure to perform all or any part thereof results from war, terrorism, flood, earthquake, strike, picketing, riot, fire, explosions, accidents, delays of carriers, governmental actions, or other acts of God, or circumstances beyond its control, or by reason of the judgment, ruling or order of any court or agency of competent jurisdiction occurring subsequent to the signing of this Agreement.

26. INCORPORATION OF ATTACHMENTS

This Agreement, the Transportation Provider Handbook, and the following attachments incorporated herein, constitute the entire agreement between the parties.

Appendix A – Business Associate Agreement
Appendix B – Credentials
Appendix C – Medicare Advantage and Medicaid Program Requirement Addendum
Schedule A – Transportation Provider Compensation (Rate Sheet)
Schedule B – Liquidated Damages

27. CONSTRUCTION; ACKNOWLEDGEMENT

All Parties have participated in the negotiation of this Agreement, and accordingly, the Parties agree that this Agreement shall be construed and interpreted without regard to any presumption or other rule requiring construction against the party causing this Agreement to be drafted. Transportation Provider warrants by signing this Agreement that he/she has read the document in its entirety, fully understands its content, and agrees to same. Transportation Provider further pledges to abide by all terms and conditions set forth herein, and acknowledges such by signature hereupon. Transportation Provider is responsible for seeking the advice of an attorney for clarification prior to signing.

28. COUNTERPARTS

This Agreement may be executed in multiple counterparts, including both counterparts that are executed on paper and counterparts that are electronic records and executed electronically, and each such executed counterpart (and any copy of an executed counterpart that is an electronic record) shall be deemed an original of this Agreement.

29. CONSENT TO ELECTRONIC RECORDS AND SIGNATURES

Electronic records and signatures may be used in connection with the execution of this Agreement. If executed on paper by original signature or executed electronically by one or more Parties to this Agreement, this Agreement or one or more of its signed counterparts is an electronic record and is just as legally valid and enforceable as if such parties had signed it on paper using a handwritten signature.

30. FURTHER ASSURANCES

Each party shall cooperate with the other and execute such instruments or documents and take such other actions as may reasonably be requested from time to time in order to carry out, evidence or confirm their rights or obligations or as may be reasonably necessary or helpful to give effect to this Agreement.

31. REPRESENTATIONS

The signers of this document represent that they are acting officially and properly on behalf of their respective business entities, and have been duly authorized, directed, and empowered to execute this

IN WITNESS WHEREOF, this Agreement is entered into and is effective as of this day of , 20 .

[redacted]	
By:	By:
(Printed Name)	(Printed Name)
By:	By:
(Signature)	(Signature)
Title:	Title:
Date:	Date:
[redacted]	Federal Tax ID:
[redacted]	Address to be used for giving Notice under this Agreement: Attn:

Medical Group Participation Agreement

Medical Group Participation Agreement

This Agreement is entered into by and between CCO, contracting on behalf of itself, HMO and the other entities that are CCO Affiliates (collectively referred to as "CCO") and _____ ("Medical Group").

This Agreement is effective on the later of _____, ___ or the first day of the first calendar month that begins at least 30 days after the date this Agreement has been executed by all parties (the "Effective Date").

Through contracts with physicians and other providers of health care services, CCO maintains one or more networks of providers that are available to Customers. Medical Group is a provider of health care services.

CCO wishes to make Medical Group's services available to Customers. Medical Group wishes to provide those services, under the terms and conditions set forth in this Agreement.

The parties therefore enter into this Agreement.

Article I
Definitions

The following capitalized terms in this Agreement have the meanings set forth below:

1.1 **Benefit Plan** means a certificate of coverage, summary plan description, or other document or agreement, whether delivered in paper or electronic format, under which a Payer is obligated to provide coverage of Covered Services for a Customer.

1.2 **Covered Service** is a health care service or product for which a Customer is entitled to receive coverage from a Payer, pursuant to the terms of the Customer's Benefit Plan with that Payer.

1.3 **Customary Charge** is the fee for health care services charged by Medical Group that does not exceed the fee Medical Group would ordinarily charge another person regardless of whether the person is a Customer.

1.4 **Customer** is a person eligible and enrolled to receive coverage from a Payer for Covered Services.

1.5 **Medical Group Physician** is a physician, as defined by the laws of the jurisdiction in which Covered Services are provided and duly licensed and qualified under those laws, who practices as a shareholder, partner, employee or Subcontractor of Medical Group.

1.6 **Medical Group Non-Physician Provider** is a healthcare professional other than a Medical Group Physician, who is duly authorized under the laws of the jurisdiction in which

Covered Services are provided, and who renders Covered Services as an employee or Subcontractor of Medical Group.

1.7 **Medical Group Professional** is a Medical Group Physician or a Medical Group Non-Physician Provider.

1.8 **Medical Group Records** are Medical Group's medical, financial and administrative records related to Covered Services rendered by Medical Group under this Agreement, including claims records.

1.9 **Payment Policies** are the guidelines adopted by CCO for calculating payment of claims to providers of health care services. The Payment Policies operate in conjunction with the specific reimbursement rates and terms set forth in this Agreement. The Payment Policies may change from time to time as described in section 6.1 of this Agreement.

1.10 **Payer** is an entity obligated to a Customer to provide reimbursement for Covered Services under the Customer's Benefit Plan and authorized by CCO to access Medical Group's services under this Agreement.

1.11 **Protocols** are the programs and administrative procedures adopted by CCO or a Payer to be followed by Medical Group in providing services and doing business with CCO and Payers under this Agreement. Protocols may include, among other things, credentialing and recredentialing processes, utilization management and care management processes, quality improvement, peer review, Customer grievance, or concurrent review. Protocols may change from time to time as described in section 5.4 of this Agreement.

1.12 **Subcontractor** is an individual or entity contracted or otherwise engaged by a party to this Agreement. For purposes of Medical Group Professionals, a Subcontractor is a Medical Group Professional only with respect to services rendered to patients of Medical Group and billed under Medical Group's Taxpayer Identification Number(s). Additionally, a Subcontractor is not a Medical Group Professional with regard to any services rendered in a physician's office or other non-facility location other than those locations listed in Appendix 1.

1.13 **CCO Affiliates** are those entities controlling, controlled by, or under common control with CCO.

Article II
Representations and Warranties

2.1 **Representations and warranties of Medical Group**. Medical Group, by virtue of its execution and delivery of this Agreement, represents and warrants as follows:

i) Medical Group is a duly organized and validly existing legal entity in good standing under the laws of its jurisdiction of organization.

ii) Medical Group has all requisite corporate power and authority to conduct its business as presently conducted, and to execute, deliver and perform its obligations under this Agreement. The execution, delivery and performance of this Agreement by Medical Group have been duly and validly authorized by all action necessary under its organizational documents and applicable corporate law. This Agreement has been duly and validly executed and delivered by Medical Group and (assuming the due authorization, execution and delivery of this Agreement by CCO) constitutes a valid and binding obligation of Medical Group, enforceable against Medical Group in accordance with its terms, except as enforceability may be limited by the availability of equitable remedies or defenses and by applicable bankruptcy, insolvency, reorganization, moratorium or similar laws affecting the enforcement of creditors' rights generally.

iii) The execution, delivery and performance of this Agreement by Medical Group do not and will not violate or conflict with (a) the organizational documents of Medical Group, (b) any material agreement or instrument to which Medical Group is a party or by which Medical Group or any material part of its property is bound, or (c) applicable law. Medical Group has the unqualified authority to bind, and does bind, itself and Medical Group Professionals to all of the terms and conditions of this Agreement, including any Appendices, Attachments and Exhibits, as applicable.

iv) Medical Group has obtained and holds all registrations, permits, licenses, and other approvals and consents, and has made all filings, that it is required to obtain from or make with all governmental entities under applicable law in order to conduct its business as presently conducted and to enter into and perform its obligations under this Agreement.

v) Medical Group has been given an opportunity to review the Protocols and Payment Policies. See the Additional Manuals Appendix for additional information regarding the Protocols and Payment Policies applicable to Customers enrolled in certain Benefit Plans.

vi) Each submission of a claim by Medical Group pursuant to this Agreement will be deemed to constitute the representation and warranty by Medical Group to CCO that (a) the representations and warranties of Medical Group set forth in this section 2.1 and elsewhere in this Agreement are true and correct as of the date the claim is submitted, (b) Medical Group has complied with the requirements of this Agreement with respect to the Covered Services involved and the submission of the claim, (c) the charge amount set forth on the claim is the Customary Charge and (d) the claim is a valid claim.

2.2 Representations and warranties of CCO. CCO, by virtue of its execution and delivery of this Agreement, represents and warrants as follows:

i) CCO is a duly organized and validly existing legal entity in good standing under the laws of its jurisdiction of organization.

ii) CCO has all requisite corporate power and authority to conduct its business as presently conducted, and to execute, deliver and perform its obligations under this Agreement. The execution, delivery and performance of this Agreement by CCO have been duly and validly authorized by all action necessary under its organizational documents and applicable corporate law. This Agreement has been duly and validly executed and delivered by CCO and (assuming the due authorization, execution and delivery of this Agreement by Medical Group) constitutes a valid and binding obligation of CCO, enforceable against CCO in accordance with its terms, except as enforceability may be limited by the availability of equitable remedies or defenses and by applicable bankruptcy, insolvency, reorganization, moratorium or similar laws affecting the enforcement of creditors' rights generally.

iii) The execution, delivery and performance of this Agreement by CCO do not and will not violate or conflict with (a) the organizational documents of CCO, (b) any material agreement or instrument to which CCO is a party or by which CCO or any material part of its property is bound, or (c) applicable law.

iv) CCO has obtained and holds all registrations, permits, licenses, and other approvals and consents, and has made all filings, that it is required to obtain from or make with all governmental entities under applicable law in order to conduct its business as presently conducted and to enter into and perform its obligations under this Agreement.

Article III
Applicability of this Agreement

3.1 Medical Group's services.

i) This Agreement applies to Covered Services provided at Medical Group's service locations set forth in Appendix 1. If a service location is not listed in Appendix 1, this section 3.1 and this Agreement should nevertheless be understood as applying to Medical Group's actual service locations that existed when this Agreement was executed, rather than to a billing address, post office box, or any other address set forth in Appendix 1.

In the event Medical Group intends to begin providing services at other service locations, or under other Tax Identification Number(s), Medical Group will provide 60[45] days' advance notice to CCO. Those additional service locations or Taxpayer Identification Numbers will become subject to this Agreement only upon written agreement of the parties. This subsection 3.1(i) applies to cases when Medical Group adds the location itself (such as through new construction) and when Medical Group acquires, merges with, or otherwise becomes affiliated with an existing provider that

was not already under contract with CCO or a CCO Affiliate to participate in a network of health care providers.

ii) Medical Group will provide 60[45] days' advance notice to CCO in the event Medical Group intends to acquire or be acquired by, merge with, or otherwise become affiliated with another provider of health care services that is already under contract with CCO or a CCO Affiliate to participate in a network of health care providers. If one of these events occurs, this Agreement and the other agreement will each remain in effect and will continue to apply as they did prior to the acquisition, merger or affiliation, unless otherwise agreed to in writing by all parties to such agreements.

Similarly, Medical Group will provide 60[45] days' advance notice to CCO if Medical Group intends to buy assets of, or lease space from, a medical group under contract directly with CCO or a CCO Affiliate to participate in a network of health care providers. If that occurs, and Medical Group provides services at that location, but does not assume the CCO contract held by the prior operator, Covered Services rendered at that location will be subject to the same rates and other key terms (including term and termination) as applied under the prior operator's contract.

iii) Medical Group will provide 60[45] days' advance notice to CCO in the event Medical Group intends to transfer all or some of its assets to another entity, with the result that all or some of the Covered Services subject to this Agreement will be rendered by the other entity rather than by Medical Group. In addition, Medical Group will request that CCO approve the assignment of this Agreement as it relates to those Covered Services, and if approved by CCO, Medical Group will ensure the other entity agrees to assume this Agreement. This subsection 3.1(iii) does not limit CCO's right under section 10.4 of this Agreement to elect whether to approve the assignment of this Agreement. This subsection 3.1(iii) applies to arrangements under which another provider intends to lease space from Medical Group, or intends to enter into a subcontract with Medical Group to perform services, after the Effective Date of this Agreement, so that Covered Services that were subject to this Agreement as of the Effective Date of this Agreement are rendered and billed instead by the other provider rather than by Medical Group after the lease or subcontract takes place.

3.2 Payers and Benefit Plans. CCO may allow Payers to access Medical Group's services under this Agreement for certain Benefit Plans, as described in Appendix 2. CCO may modify Appendix 2 without amendment to include or exclude Benefit Plans in Appendix 2 by providing 30 days prior written or electronic notice to Medical Group.

In addition to changes allowed above, CCO may make additional changes to Appendix 2 as described in section 3 of that appendix.

Section 9.3 of this Agreement will apply to Covered Services provided to Customers covered by Benefit Plans that are added to the list in Appendix 2 of Benefit Plans excluded from this Agreement as described above.

3.3 Patients who are not Customers. This Agreement does not apply to services rendered to patients who are not Customers at the time the services were rendered. Section 7.6 of this Agreement addresses circumstances in which claims for services rendered to those patients are inadvertently paid.

3.4 Health care. This Agreement and Benefit Plans do not dictate the health care provided by Medical Group Professionals, or govern Medical Group Professionals' determination of what care to provide patients, even if those patients are Customers. The decision regarding what care is to be provided remains with Medical Group Professionals and with Customers, and not with CCO or any Payer.

3.5 Communication with Customers. Nothing in this Agreement is intended to limit Medical Group's or Medical Group Professional's right or ability to communicate fully with a Customer regarding the Customer's health condition and treatment options. Medical Group and Medical Group Professionals are free to discuss all treatment options without regard to whether or not a given option is a Covered Service. Medical Group and Medical Group Professionals are free to discuss with a Customer any financial incentives Medical Group may have under this Agreement, including describing at a general level the payment methodologies contained in this Agreement.

Additional Language: use if Medical Group is a hospital-based group or is a multi-specialty group that includes hospital- based professionals.

[3.6 Services rendered by Facility-Based Medical Group Professionals.

i) **Definition and applicability.** For purposes of this section 3.6, "Facility-Based Medical Group Professional" means a Medical Group Professional who provides substantially all of his or her professional services in a facility setting (such as, hospital inpatient, hospital outpatient, or ambulatory surgical center). Facility-Based Medical Group Professionals include, but are not limited to, emergency room physicians, pathologists, radiologists, anesthesiologists (other than for pain management services), certified registered nurse anesthetists ("CRNAs"), hospitalists, and intensivists. All of the provisions of this Agreement, including those listed in this section 3.6, apply to services rendered by Medical Group Professionals who are not acting as Facility-Based Medical Group Professionals at the time the services are rendered.

ii) **Services provided by hospital.** The following provisions of this Agreement do not apply to services rendered by Medical Group Professionals, when acting as Facility-Based Medical Group Professionals, so long as the facility performs the requirement instead:

a) Section 5.6 with regard to the requirement that Medical Group purchase commercial general and/or umbrella liability insurance.

b) Section 5.8 with regard to the requirement that Medical Group obtains the Customer's consent to provide access to data.

c) Section 5.9 with regard to the requirement to maintain Medical Group Records.

d) Section 5.10 with regard to the requirement to collect and review certain quality data.

e) Section 7.5(ii) with regard to the requirement to obtain the Customer's written consent prior to providing services that are not Covered Services.

f) Section 7.6 with regard to the requirement to request the patient to present his or her Customer identification card.

iii) **Other provisions not applicable.** The following provisions of this Agreement do not apply to services rendered by Medical Group Professionals, when acting as Facility-Based Medical Group Professionals:

a) Section 5.4(i)(a) with regard to the requirement to direct Customers only to other participating providers.

b) Sections 5.4(i)(b)(1) and (2) with regard to the requirement to notify Customers' primary care physicians of referrals to other providers and the requirement to provide Covered Services pursuant to the terms and limitations of the referral notification issued by or on behalf of the Customer's primary care physician, but only if Facility-Based Medical Group Professionals do not have hospital admitting privileges.

c) Section 5.4(i)(b)(3) with regard to the requirement to notify Customers' primary care physicians of admissions.

d) Section 5.7(ii) with regard to the requirement to provide notice to CCO of any suspension, revocation, condition, limitation, qualification or other material restriction of a Medical Group Physician's staff privileges at any licensed hospital, nursing home or other facility at which a Medical Group Physician has staff privileges during the term of this Agreement, but only if Facility-Based Medical Group Professionals do not have hospital admitting privileges.]

Article IV
Participation of Medical Group Professionals in CCO's Network

4.1 Medical Group Professionals as participating providers. Except as described in section 4.2, all Medical Group Professionals must participate in CCO's network. Medical Group has the authority to bind, and will bind, all new Medical Group Professionals to the obligations of this Agreement**.** Medical Group will provide to CCO the information described in the Medical Group Professional Roster to this Agreement.

4.2 Medical Group Professionals who are not participating providers. The following Medical Group Professionals are not participating providers in CCO's network:

i) A Medical Group Professional who has been denied participation in CCO's credentialing program, whose credentialing application has not been submitted (to the extent CCO's credentialing program applies to the Medical Group Professional), or whose credentialing application remains pending; or

ii) A Medical Group Professional who has been terminated from participation in CCO's network under this Agreement or any other agreement with CCO through which the Medical Group Professional participated in CCO's network.

4.3 Credentialing. Medical Group and Medical Group Professionals will participate in and cooperate with CCO's credentialing program to the extent that program applies to Medical Group and Medical Group Professionals. To the extent Medical Group and Medical Group Professionals are subject to credentialing, Medical Group and Medical Group Professionals must be credentialed by CCO or its delegate prior to furnishing any Covered Services under this Agreement.

4.4 New Medical Group Professionals. Medical Group will notify CCO at least 30 days before a physician or other healthcare professional becomes a Medical Group Professional. In the event that the Medical Group's agreement with the new Medical Group Professional provides for a starting date that would make it impossible for Medical Group to provide 30 days advance notice to CCO, then Medical Group will give notice to CCO as soon as reasonably possible but no later than five business days after reaching agreement with the new Medical Group Professional. In either case, the new Medical Group Professional will submit a credentialing application to CCO or its delegate within 30 days of the new Medical Group Professional's agreement to join Medical Group, unless CCO's credentialing program does not apply to the new Medical Group Professional. In addition, Medical Group will provide to CCO the information described in the Medical Group Professional Roster to this Agreement with respect to the new Medical Group Professional.

4.5 Termination of a Medical Group Professional from CCO's network. CCO may terminate a Medical Group Professional's participation in CCO's network, without terminating this Agreement, immediately, upon becoming aware of any of the following:

i) the material breach of this Agreement by the Medical Group Professional that is not cured by Medical Group and/or the Medical Group Professional within 30 days after CCO provided notice to Medical Group of the breach;

ii) the suspension, revocation, condition, limitation, qualification or other material restriction on a Medical Group Professional's license, certification and/or permit by any government agency under which the Medical Group Professional is authorized to provide health care services;

iii) the suspension, revocation, condition, limitation, qualification or other material restriction of a Medical Group Physician's staff privileges at any licensed hospital,

nursing home or other facility at which the Medical Group Physician has staff privileges during the term of this Agreement;

iv) for any criminal charge related to the practice of Medical Group Professional's profession or for an indictment, arrest, or conviction for a felony;

v) a sanction imposed by any governmental agency or authority, including Medicare or Medicaid; or

vi) the failure to meet the requirements of CCO's credentialing program to the extent that those requirements apply to the Medical Group Professional.

CCO will notify Medical Group of the Medical Group Professional's termination according to the notice provision set forth in section 10.8 of this Agreement.

4.6 Covered Services by Medical Group Professionals who are not participating providers. Medical Group will staff its service locations so that Covered Services can appropriately be rendered to Customers by Medical Group Professionals who participate in CCO's network. A Medical Group Professional who does not participate in CCO's network, pursuant to section 4.2 of this Agreement, will not render Covered Services to a Customer.

In the event Covered Services are rendered by a Medical Group Professional who does not participate in CCO's network, neither Medical Group nor the Medical Group Professional will submit a claim or other request for payment to CCO or Payer, and will not seek or accept payment from the Customer.

Article V
Duties of Medical Group

5.1 Provide Covered Services. Medical Group will provide Covered Services to Customers.

5.2 Nondiscrimination. Medical Group will not discriminate against any patient, with regard to quality or accessibility of services, on the basis that the patient is a Customer. Medical Group will not require a Customer to pay a "membership fee" or other fee in order to access Medical Group for Covered Services (except for co-payments, coinsurance and/or deductibles provided for under Customer's Benefit Plan) and will not discriminate against any Customer based on the failure to pay such a fee.

5.3 Accessibility. Medical Group will be open during normal business hours and will provide or arrange for the provision of advice and assistance to Customers in emergency situations 24 hours a day, seven days a week.

5.4 Protocols.

i) **Cooperation with Protocols.** Medical Group will cooperate with and be bound by CCO's and Payers' Protocols. The Protocols include, but are not limited to, all of the following:

a) For non-emergency Covered Services, Medical Group will assist Customers to maximize their benefits by referring or directing Customers only to other providers that participate in CCO's network, except as otherwise authorized by CCO through CCO's process for approving out-of-network services at in-network benefit levels.

b) If the Customer's Benefit Plan requires the Customer to receive certain Covered Services from or upon referral by a primary care physician, Medical Group Professionals must adhere to the following additional protocols:

1) Notify Customer's primary care physician of referrals to other participating or non-participating providers.

2) Render Covered Services pursuant to the terms and limitations of the referral notification issued by or on behalf of the Customer's primary care physician.

3) Notify the Customer's primary care physician of all admissions.

c) Medical Group will provide notification for certain Covered Services, accept and return telephone calls from CCO staff, and respond to CCO requests for clinical information, as required by CCO or Payer as described in the Protocols.

ii) **Availability of Protocols.** The Protocols will be made available to Medical Group online or upon request. Some or all Protocols also may be disseminated in the form of an administrative manual or guide or in other communications. Currently, the Protocols may be found at Portal.com or as indicated in the Additional Manual Appendix, if applicable. CCO will notify Medical Group of any changes in the location of the Protocols.

iii) **Changes to Protocols.** CCO may change the Protocols from time to time. CCO will use reasonable commercial efforts to inform Medical Group at least 30 days in advance of any material changes to the Protocols. CCO may implement changes in the Protocols without Medical Group's consent if the change is applicable to all or substantially all medical groups of the same type and specialty offering similar services in CCO's network, and are located in the same state as Medical Group. Otherwise, changes to the Protocols proposed by CCO to be applicable to Medical Group are subject to the requirements regarding amendments in section 10.2 of this Agreement.

5.5 Licensure. Medical Group and Medical Group Professionals will maintain, without material restriction, such licensure, registration, and permits as are necessary to enable Medical Group and Medical Group Professionals to lawfully perform under this Agreement.

5.6 Liability insurance. Medical Group will ensure that Medical Group and all Medical Group Professionals are covered by liability insurance. Except to the extent coverage is a state mandated placement, the liability coverage must be placed with insurance carriers

that have an A.M. Best Rating of A-VII or better, and that are authorized or approved to write coverage in the state in which the Covered Services are provided. The liability insurance will be, at a minimum, of the types and in the amounts set forth below. Medical malpractice insurance will be either occurrence or claims made with an extended reporting period option for at least three years. Upon request, Medical Group will submit to CCO in writing evidence of insurance coverage.

Type of Insurance	Minimum Limits
Medical malpractice and/or professional liability insurance	If Medical Group insures each Medical Group Professional separately, $1,000,000 per occurrence/claim and $3,000,000 aggregate for each Medical Group Professional. OR If Medical Group insures all Medical Group Professionals in a single policy with shared limits: $3,000,000 per occurrence/claim and $5,000,000 aggregate.
Commercial general and/or umbrella liability insurance	$1,000,000 per occurrence/claim and $2,000,000 aggregate.

[Substitute Language: Use this table for groups that ARE at high risk.

Type of Insurance	Minimum Limits
Medical malpractice and/or professional liability insurance	If Medical Group insures each Medical Group Professional separately, $5,000,000 per occurrence/claim and aggregate for each Medical Group Professional. OR If Medical Group insures all Medical Group Professionals in a single policy with shared limits: $10,000,000 per occurrence/claim and aggregate.
Commercial general and/or umbrella liability insurance	$5,000,000 per occurrence/claim and aggregate.

]

In lieu of purchasing the insurance coverage required in this section, Medical Group may self-insure any of the required insurance. Medical Group will maintain a separate reserve for its self-insurance. If Medical Group uses the self-insurance option described in this paragraph, Medical Group will provide to CCO, prior to the Effective Date, a statement verified by an independent auditor or actuary that its reserve funding levels and process of funding appears adequate to meet the requirements of this section and fairly represents the financial condition of the fund. Medical Group will provide a similar statement during the term of this Agreement upon CCO's request, which will be made no more frequently than

annually. Medical Group will assure that its self-insurance fund will comply with applicable laws and regulations.

5.7 Notices by Medical Group. Medical Group will give notice to CCO within 10 days after any event that causes Medical Group to be out of compliance with section 5.5 or 5.6 of this Agreement. Medical Group will give notice to CCO at least 30 days prior to any change in Medical Group's name, ownership, control, National Provider ID (NPI) or Taxpayer Identification Number.

In addition, Medical Group will give written notice to CCO within 10 days after it learns of any of the following:

i) any suspension, revocation, condition, limitation, qualification or other material restriction on a Medical Group Professional's licenses, certifications and permits by any government agency under which a Medical Group Professional is authorized to provide health care services;

ii) any suspension, revocation, condition, limitation, qualification or other material restriction of a Medical Group Physician's staff privileges at any hospital, nursing home or other facility at which a Medical Group Physician has staff privileges during the term of this Agreement;

iii) an indictment, arrest or conviction of a Medical Group Professional for a felony, or for any criminal charge related to the practice of the Medical Group Professional's profession;

iv) the departure of any Medical Group Professional from Medical Group; or

v) any changes to the information contained in Appendix 1**.**

5.8 Customer consent to release of Medical Group Records. Medical Group will obtain any Customer consent required in order to authorize Medical Group to provide access to requested Medical Group Records as contemplated in section 5.9 of this Agreement, including copies of the Medical Group's medical records relating to the care provided to Customer.

5.9 Maintenance of and access to records.

i) **Maintenance.** Medical Group will maintain Medical Group Records for at least 10 years following the end of the calendar year during which the Covered Services are provided, unless a longer retention period is required by applicable law.

ii) **Access to Agencies**. Medical Group will provide access to Medical Group Records to agencies of the government, in accordance with applicable law, to the extent access is necessary to comply with the requirements of such agencies as applicable to Medical Group, CCO or Payers.

iii) **Access to CCO.** Medical Group will provide CCO or its designees access to Medical Group Records for purposes of CCO's health care operations and other administrative obligations, including without limitation, utilization management, quality assurance and improvement, claims payment, and review or audit of Medical Group's compliance with the provisions of this Agreement and appropriate billing practices.

Medical Group will provide access to Medical Group Records by providing CCO electronic medical records ("EMR") access and electronic file transfer. When the requested Medical Group Records are not available through EMR access and electronic file transfer, Medical Group will submit those Medical Group Records through other means reasonably acceptable to CCO, such as facsimile, compact disc, or mail, that is suitable to the purpose for which CCO requested the Medical Group Records.

Medical Group Records provided by EMR access will be available to CCO on a 24 hour/7 day a week basis. Medical Group Records provided by electronic file transfer will be available to CCO within 24 hours of CCO's request for those Medical Group Records or a shorter time as may be required for urgent requests for Medical Group Records. Medical Group Records provided by other means will be available in the time frame specified in the request for the Medical Group Records; provided, however, Medical Group will have up to 14 days to provide the Medical Group Records for requests not related to urgent requests. Urgent requests are those requests for Medical Group Records to address allegations of fraud or abuse, matters related to the health and safety of a Customer, or related to an expedited appeal or grievance.

Medical Group may meet the requirements of this section 5.9 directly or through a subcontractor.

iv) **Audits.** Pursuant to paragraph (iii) above, CCO may request Medical Group Records from Medical Group for purposes of performing an audit of Medical Group's compliance with this Agreement, Medical Group's billing practices, or CCO's health care operations, including without limitation claims payments. In addition, CCO may perform audits at Medical Group's locations upon 14 days' prior notice. Medical Group will cooperate with CCO on a timely basis in connection with any such audit including, among other things, in the scheduling of and participation in an interview to review audit findings, within 30 days after CCO's request.

v) When Medical Group has provided records through EMR access or file transfer, CCO will not request duplicative paper records from Medical Group.

vi) Medical Group will provide Medical Group Records free of charge**.**

5.10 Access to data. Medical Group represents that in conducting its operations, it collects and reviews certain quality data relating to care rendered by Medical Group that is reported in a manner which has been validated by a third party as having a clear, evidence-based link to quality or safety (e.g., AHRQ standards) or which has been created by employer coalitions as proxies for quality (e.g., Leapfrog standards)**.**

CCO recognizes that Medical Group has the sole discretion to select the metrics which it will track from time to time and that Medical Group's primary goal in tracking quality data is to advance the quality of patient care. If the information that Medical Group chooses to report on is available in the public domain in a format that includes all data elements required by CCO, CCO will obtain quality information directly from that source. If the Medical Group does not report metrics in the public domain, on a quarterly basis, Medical Group will share these metrics with CCO as tracked against a database of all patients (including patients who are not Customers). CCO may publish this data to entities to which CCO renders services or seeks to render services, and to Customers.

5.11 Compliance with law. Medical Group will comply with applicable regulatory requirements, including but not limited to those relating to confidentiality of Customer medical information.

5.12 Electronic connectivity. When made available by CCO, Medical Group will do business with CCO electronically, including using EMR access and connectivity. Medical Group will use the CCO service tool, found at portal.com and/or other electronic connectivity as available, to check eligibility status, claims status, and submit requests for claims adjustment for products supported by CCO's online resources and other electronic connectivity. Medical Group will use or other tools for additional functionalities (for example, notification of admission, prior authorization and any other available transaction or viewing) after CCO informs Medical Group that these functionalities have become available for the applicable Customer.

5.13 Employees and Subcontractors. Medical Group will ensure that its employees, affiliates and any individuals or entities subcontracted by Medical Group to render services in connection with this Agreement adhere to the requirements of this Agreement. The use of employees, affiliates or Subcontractors to render services in connection with this Agreement will not limit Medical Group's obligations and accountability under this Agreement with regard to those services.

5.14 Laboratory Services. Medical Group will be reimbursed for Covered Services that are laboratory services only if, (i) Medical Group is certified through the Clinical Laboratory Improvement Amendments (CLIA) to perform those services, or (ii) those services have "waived" status under CLIA and Medical Group is performing those services pursuant to a CLIA Certificate of Waiver. Medical Group must not bill Customers for any other laboratory services.

Article VI
Duties of CCO and Payers

6.1 Payment of claims. As described in further detail in Article VII of this Agreement, Payers will pay Medical Group for rendering Covered Services to Customers. CCO will make its Payment Policies available to Medical Group online and upon request. CCO may change

its Payment Policies from time to time, and will make information available describing the change.

6.2 Liability insurance. CCO will procure and maintain professional and general liability insurance and other insurance, as CCO reasonably determines may be necessary, to protect CCO and CCO's employees against claims, liabilities, damages or judgments that arise out of services provided by CCO or CCO's employees under this Agreement.

6.3 Licensure. CCO will maintain, without material restriction, such licensure, registration, and permits as are necessary to enable CCO to lawfully perform this Agreement.

6.4 Notice by CCO. CCO will give written notice to Medical Group within 10 days after any event that causes CCO to be out of compliance with section 6.2 or 6.3 of this Agreement, or of any change in CCO's name, ownership, control, or Taxpayer Identification Number. This section does not apply to changes of ownership or control that result in CCO being owned or controlled by an entity with which it was already affiliated prior to the change.

6.5 Compliance with law. CCO will comply with applicable regulatory requirements, including but not limited to those relating to confidentiality of Customer medical information and those relating to prompt payment of claims, to the extent those requirements are applicable.

6.6 Electronic connectivity. As described in section 5.12 of this Agreement, CCO will do business with Medical Group electronically. CCO will communicate enhancements in its electronic connectivity functionality as they become available.

6.7 Employees and Subcontractors. CCO will assure that its employees, affiliates and any individuals or entities subcontracted by CCO to render services in connection with this Agreement adhere to the requirements of this Agreement. The use of employees, affiliates or Subcontractors to render services in connection with this Agreement will not limit CCO's obligations and accountability under this Agreement with regard to those services.

Article VII
Submission, Processing, and Payment of Claims

7.1 Form and content of claims. Medical Group must submit claims for Covered Services as described in the Protocols, using current, correct, and applicable coding.

Medical Group will submit claims only for services performed by Medical Group or Medical Group staff. Pass-through billing is not payable under this Agreement.

7.2 Electronic filing of claims. Within six months after the Effective Date of this Agreement, Medical Group will use electronic submission for all of its claims under this Agreement that CCO is able to accept electronically.

7.3 **Time to file claims.** Unless a longer timeframe is required under applicable law, all information necessary to process a claim must be received by CCO no more than 90 days from the date Covered Services are rendered. If Payer is not the primary payer on a claim, and Medical Group is pursuing payment from the primary payer, the period in which Medical Group must submit the claim will begin on the date Medical Group receives the claim response from the primary payer.

7.4 **Payment of claims for Covered Services.** Payer will pay claims for Covered Services according to the least of the contract rates in the applicable Payment Appendix, the Medical Group's Customary Charge or as otherwise described in the Payment Appendix, and in accordance with Payment Policies.

Claims for Covered Services subject to coordination of benefits will be paid in accordance with the Customer's Benefit Plan and applicable law.

The obligation for payment under this Agreement is solely that of Payer and not that of CCO unless CCO is the Payer.

Ordinarily, fee amounts listed in the Payment Appendix(ices) are based upon primary fee sources. CCO reserves the right to use gap-fill fee sources where primary fee sources are not available.

CCO routinely updates its payment appendices: (1) to remain current with applicable coding practices; (2) in response to price changes for immunizations and injectable medications; and (3) to remain in compliance with HIPAA requirements. CCO will not attempt to communicate routine updates of this nature. Ordinarily, CCO's fee schedule is updated using similar methodologies for similar services.

CCO will give Medical Group at least 90 days written or electronic notice of non-routine fee schedule changes which will substantially alter the overall methodology or reimbursement level of the fee schedule. In the event such changes will reduce Medical Group's overall reimbursement under this Agreement, Medical Group may terminate this Agreement by giving 60 days written notice to CCO, provided that the notice is given by Medical Group within 30 days after the notice of the fee schedule change.

7.5 **Denial of claims for not following Protocols, for not filing timely, for services not covered under the Customer's Benefit Plan, or for lack of medical necessity.**

i) **Non-compliance with Protocol.** Compliance with Protocols and timely claim filing are conditions precedent to payment under this Agreement. Payment will be denied, in whole or in part if Medical Group does not comply with a Protocol or does not file a timely claim as required under section 7.3 of this Agreement. Medical Group may request reconsideration of the denial and the denial will be reversed if Medical Group can show one or more of the following:

a) the denial was incorrect because Medical Group complied with the Protocol.

b) at the time the Protocol required notification or prior authorization, Medical Group (i) did not know and was unable to reasonably determine that the patient was a Customer, (ii) Medical Group took reasonable steps to learn that the patient was a Customer, and (iii) Medical Group promptly submitted a claim after learning the patient was a Customer.

A claim is also subject to denial for other reasons permitted under the Agreement. Reversal of a claim denial under this subsection (i) does not preclude CCO from upholding a denial for one of these other reasons.

ii) **Non-Covered Services.** Services not covered under the applicable Benefit Plan are not subject to the rates or discounts of this Agreement. Medical Group may seek and collect payment from a Customer for such services (provided that Medical Group obtained the Customer's prior written consent).

iii) **Denials for lack of medical necessity through the prior authorization process.** If a service would otherwise be a Covered Service, but is not a Covered Service under the applicable Benefit Plan because it is determined through the prior authorization process to not meet the requirement of medical necessity, as defined in the Benefit Plan or applicable law (or not meet a similar concept in the Benefit Plan, such as not being consistent with nationally recognized scientific evidence as available, or not being consistent with prevailing medical standards and clinical guidelines), Medical Group may seek or collect payment from the Customer, if, prior to receiving the service, the Customer had knowledge of the determination of non-coverage and specifically agreed in writing to be responsible for payment of those charges.

7.6 Retroactive correction of information regarding whether patient is a Customer. Prior to rendering services, Medical Group will ask the patient to present his or her Customer identification card. In addition, Medical Group may contact CCO to obtain the most current information available to CCO on the patient's status as a Customer.

However, such information provided by CCO is subject to change retroactively, under any of the following circumstances:

i) if CCO has not yet received information that an individual is no longer a Customer;
ii) if the individual's Benefit Plan is terminated retroactively for any reason including, but not limited to, non-payment of premium;
iii) as a result of the Customer's final decision regarding continuation of coverage pursuant to state and federal laws; or
iv) if eligibility information CCO receives is later proven to be false.

If Medical Group provides health care services to an individual, and it is determined that the individual was not a Customer at the time the health care services were provided, those services are not payable under this Agreement, and any payments made with regard to those services may be recovered as overpayments under the process described in section

7.10 of this Agreement. Medical Group may then directly bill the individual, or other responsible party, for those services.

7.7 Payment under this Agreement is payment in full. Payment as provided under section 7.4 of this Agreement, together with any co-payment, deductible or coinsurance for which the Customer is responsible under the Benefit Plan, is payment in full for a Covered Service. Medical Group will not seek to recover, and will not accept any payment from Customer, CCO, Payer or anyone acting on their behalf, in excess of payment in full as provided in this section 7.7, regardless of whether that amount is less than Medical Group's billed charge or Customary Charge.

7.8 Customer hold harmless. Medical Group will not bill or collect payment from the Customer, or seek to impose a lien, for the difference between the amount paid under this Agreement and Medical Group's billed charge or Customary Charge, or for any amounts denied or not paid under this Agreement due to:

i) Medical Group's failure to comply with the Protocols,

ii) Medical Group's failure to file a timely claim,

iii) Payer's Payment Policies,

iv) inaccurate or incorrect claim processing,

v) insolvency or other failure by Payer to maintain its obligation to fund claims payments, if Payer is CCO, or is an entity required by applicable law to assure that its Customers not be billed in these circumstances, or

vi) a denial based on lack of medical necessity or consistency with nationally recognized scientific evidence as available, and prevailing medical standards and clinical guidelines, except as provided in section 7.5 of this Agreement.

This obligation to refrain from billing Customers applies even in those cases in which Medical Group believes that CCO or Payer has made an incorrect determination. In such cases, Medical Group may pursue remedies under this Agreement against CCO or Payer, as applicable, but must still hold the Customer harmless.

Medical Group may seek payment directly from the Payer or from Customers upon 15 days prior notice to CCO, after Medical Group seeks and receives confirmation from CCO that the Payer is in default (other than a default covered by the above clause (v) of this section 7.8). For purposes of this paragraph, a default is a systematic failure by a Payer to fund claims payments related to Customers covered through that Payer. A default does not occur in the case of a dispute as to whether certain claims should be paid or the amounts that should be paid for certain claims.

This section 7.8 and section 7.7 will survive the termination of this Agreement, with regard to Covered Services rendered prior to when the termination takes effect.

7.9 Consequences for failure to adhere to Customer protection requirements. If Medical Group collects payment from, brings a collection action against, or asserts a lien against a Customer for Covered Services rendered (other than for the applicable co-payment, deductible or coinsurance), contrary to section 7.7 or 7.8 of this Agreement, Medical Group will be in breach of this Agreement. This section 7.9 will apply regardless of whether the Customer or anyone purporting to act on the Customer's behalf has executed a waiver or other document of any kind purporting to allow Medical Group to collect such payment from the Customer.

In the event of such a breach, Payer may deduct, from any amounts otherwise due Medical Group, the amount wrongfully collected from Customers, and may also deduct an amount equal to any costs or expenses incurred by the Customer, CCO or Payer in defending the Customer and otherwise enforcing sections 7.7 through 7.9 of this Agreement. Any amounts deducted by Payer in accordance with this provision will be used to reimburse the Customer and to satisfy any costs incurred. The remedy contained in this paragraph does not preclude CCO from invoking any other remedy for breach that may be available under this Agreement.

7.10 Correction of claims payments. If Medical Group does not seek correction of a given claim payment or denial by giving notice to CCO within 12 months after the claim was initially processed, it will have waived any right to subsequently seek such correction under this section 7.10, or through dispute resolution under Article VIII of this Agreement or in any other forum.

Medical Group will repay overpayments within 30 days of written or electronic notice of the overpayment. Medical Group will promptly report any credit balance that it maintains with regard to any claim overpayment under this Agreement, and will return the overpayment to CCO within 30 days after posting it as a credit balance.

Recovery of overpayments may be accomplished by offsets against future payments.

7.11 Claims payment issues arising from departure of Medical Group Professionals from Medical Group. In the event a Medical Group Professional departs from Medical Group, and uncertainty arises as to whether Medical Group or some other entity is entitled to receive payment for certain services rendered by such former Medical Group Professional, the parties will cooperate with each other in good faith in an attempt to resolve the situation appropriately.

In the event that Medical Group's failure to give timely notice under section 5.7 (iv) of this Agreement resulted in claims payments being made incorrectly to Medical Group, Medical Group will promptly notify CCO and return such payments to CCO. In the event Medical Group fails to do so, CCO may hold Medical Group liable for any attorneys' fees, costs, or administrative expenses incurred by CCO as a result.

In the event that both Medical Group and some other entity assert a right to payment for the same service rendered by the former Medical Group Professional, CCO may refrain from paying either entity until the entity to which payment is owed is determined. Provided that CCO acts in good faith, Medical Group will waive any right to receive interest or penalties under any applicable law relating to the prompt payment of claims.

Article VIII
Dispute Resolution

The parties will work together in good faith to resolve any and all disputes between them ("Disputes") including, but not limited to the existence, validity, scope or termination of this Agreement or any term thereof, with the exception of any question regarding the arbitrability of the Dispute, and the availability of class arbitration or consolidated arbitration, which is expressly waived below. Disputes also include any dispute in which Medical Group is acting as the assignee of one or more Customer. In such cases, Medical Group agrees that the provisions of this Article VIII will apply, including without limitation the requirement for arbitration.

If the Dispute pertains to a matter which is generally administered by certain CCO procedures, such as a credentialing or quality improvement plan, the policies and procedures set forth in that plan must be fully exhausted by Medical Group before Medical Group may invoke any right to arbitration under this Article VIII.

For Disputes regarding payment of claims, a party must have timely initiated and completed the claim reconsideration and appeal process as set forth in the Administrative Guide in order to initiate the Dispute process.

If the parties are unable to resolve any such Dispute within 60 days following the date one party sent written notice of the Dispute to the other party, and if either party wishes to pursue the Dispute, it may do so only by submitting the Dispute to binding arbitration conducted by the American Arbitration Association ("AAA") in accordance with the AAA Healthcare Payor Provider Arbitration Rules, as they may be amended from time to time (see http://www.adr.org), except that, in any case involving a Dispute in which a party seeks an award of $1,000,000 or greater or seeks termination of this Agreement, a panel of three arbitrators will be used; a single arbitrator cannot award $1,000,000 or more or order that this Agreement is terminated. The arbitrator(s) will be selected from the AAA National Healthcare Roster (as described in the AAA Healthcare Payor Provider Arbitration Rules) or the AAA's National Roster of Arbitrators. Unless otherwise agreed to in writing by the parties, if the party wishing to pursue the Dispute does not initiate the arbitration within one year after the date on which written notice of the Dispute was given, or, for Disputes subject to the procedures or processes described in the previous paragraph, within one year after the completion of the applicable procedure or process, it will have waived its right to pursue the Dispute in any forum.

Any arbitration proceeding under this Agreement will be conducted in [name of county], [state]. The arbitrator(s) may construe or interpret but must not vary or ignore the terms of this Agreement and will be bound by controlling law. The arbitrator(s) have no authority to award punitive, exemplary, indirect or special damages, except in connection with a statutory claim that explicitly provides for that relief.

Except as may be required by law, neither a party (including without limitation, the parties' representatives, consultants and counsel of record in the arbitration), nor an arbitrator may disclose the existence, content, or results of any arbitration hereunder, or any Confidential Arbitration Information, without the prior written consent of all parties. "Confidential Arbitration Information" means any written submissions in an arbitration by either party, discovery exchanged, evidence submitted, transcriptions or other records of hearings in the matter and any orders and awards issued, and any reference to whether either party won, lost, prevailed, or did not prevail against the other party in any arbitration proceeding, as well as any settlement agreement related to an arbitration. However, judgment on the award may be entered under seal in any court having jurisdiction thereof, by either party.

The parties expressly intend that any arbitration be conducted on an individual basis, so that no third parties may be consolidated or joined or allowed to proceed with class arbitration. The parties agree that any arbitration ruling allowing class arbitration, or requiring consolidated arbitration involving any third party(ies), would be contrary to the terms of this Agreement and require immediate judicial review. Notwithstanding anything in this Agreement to the contrary, this paragraph may not be severed from Article VIII of the Agreement under any circumstances, including but not limited to unlawfulness, invalidity or unenforceability.

The decision of the arbitrator(s) on the points in dispute will be binding. The parties acknowledge that because this Agreement affects interstate commerce, the Federal Arbitration Act applies.

In the event any court determines that this arbitration procedure is not binding or otherwise allows litigation involving a Dispute to proceed, the parties hereby waive any and all right to trial by jury in, or with respect to, the litigation. The litigation would instead proceed with the judge as the finder of fact.

In the event a party wishes to terminate this Agreement based on an assertion of uncured material breach, and the other party disputes whether grounds for the termination exist, the matter will be resolved through arbitration under this Article VIII. While the arbitration remains pending, the termination for breach will not take effect.

This Article VIII will survive any termination of this Agreement.

Article IX
Term and Termination

9.1 Term. This Agreement will take effect on the Effective Date. This Agreement has an initial term of [three years] and renews automatically for renewal terms of one year, until terminated pursuant to section 9.2 of this Agreement.

9.2 Termination. This Agreement may be terminated under any of the following circumstances:

i) by mutual written agreement of the parties;

ii) by either party, upon at least 180 days' prior written notice, effective at the end of the initial term or effective at the end of any renewal term;

iii) by either party, upon 60 days' prior written notice, in the event of a material breach of this Agreement by the other party, which notice will include a specific description of the alleged breach; however, the termination will not take effect if the breach is cured within 60 days after notice of the termination or if the termination is deferred under Article VIII of this Agreement;

iv) by either party upon 10 days' prior written notice in the event the other party loses licensure or other governmental authorization necessary to perform this Agreement or fails to have insurance as required under section 5.6 or section 6.2 of this Agreement; or

v) by Medical Group, as described in section 7.4 of this Agreement, in the event of a non-routine fee schedule change.

9.3 Ongoing services to certain Customers after termination takes effect.

i) In the event a Customer is receiving any of the Covered Services listed below, as of the effective date of the termination of this Agreement, or the effective date that a Benefit Plan is added to the list in Appendix 2 of Benefit Plans excluded from this Agreement, Medical Group will continue to render those Covered Services to that Customer, and this Agreement will continue to apply to those Covered Services, after the termination/exclusion takes effect, for the length of time indicated below:

Covered Service	Continuity of Care Period
Inpatient Covered Services	30 days or until discharge, whichever comes first
Pregnancy, Third Trimester – Low Risk	Through postpartum follow up visit
Pregnancy, First, Second or Third Trimester – Moderate Risk and High Risk	Through postpartum follow up visit

Non-Surgical Cancer Treatment	30 days or a complete cycle of radiation or chemotherapy, whichever is greater
End Stage Kidney Disease and Dialysis	30 days
Symptomatic AIDS undergoing active treatment	30 days
Ongoing services to Medicare Advantage Customers	As described below
Any circumstance where Payer is required by applicable law to provide transition coverage of services rendered by Medical Group after Medical Group leaves the provider network accessed by Payer.	As required by applicable law

ii) **Medicare Advantage Customers.** This subsection only applies if Medical Group participates in networks for Medicare Advantage Benefit Plans under this Agreement.

a) Ninety days prior to the effective date of the termination or expiration of this Agreement, CCO may close Medical Group's practice to new Medicare Advantage Customers and CCO may remove Medical Group from any provider directory, online or in print, unless the parties agree otherwise.

b) To protect existing Medicare Advantage Customers who are patients of Medical Group from the disruption caused by the termination or expiration of this Agreement during the course of the Customer's Benefit Plan year, Medical Group will continue to provide Covered Services, and the terms of this Agreement will continue to apply, to Medicare Advantage Customers who have an existing relationship with Medical Group on the date the termination or expiration would be effective under the notice through the end of the calendar year. If the effective date of the termination or expiration would otherwise occur during the month of December, Medical Group will continue to provide Covered Services, and the terms of this Agreement will continue to apply, to such Medicare Advantage Customers through the end of the following calendar year. However, payment to Medical Group for such continued care, as described in this paragraph, will be the greater of the contract rate in place at the time the termination or expiration of the Agreement would have been effective, or 100% of CMS.

Section 9.3(ii)(b) does not apply if CCO has terminated this Agreement due to:
1) an uncured material breach,
2) Medical Group losing licensure or other governmental authorization necessary to perform this Agreement, or
3) Medical Group failing to have insurance as required under section 5.6 of this Agreement.

Article X
Miscellaneous Provisions

10.1 Entire Agreement. In order for this Agreement to be binding, it must be executed by all parties through written or electronic signature. This Agreement is the entire agreement between the parties with regard to its subject matter, and supersedes any prior written or unwritten agreements between the parties or their affiliates with regard to the same subject matter.

10.2 Amendment. CCO may amend this Agreement or any of the appendices on 90 days' written or electronic notice by sending Medical Group a copy of the amendment.

Additionally, CCO may amend this Agreement upon written notice to Medical Group in order to comply with applicable regulatory requirements, but only if that amendment is imposed on a similar basis to all or substantially all of the medical groups in CCO's network that would be similarly impacted by the regulation in question. CCO will provide at least 30 days' notice of any such regulatory amendment, unless a shorter notice period is necessary in order to comply with regulatory requirements.

Medical Group's signature is not required to make the amendment effective. However, if the amendment is not required by law or regulation and would impose a material adverse impact on Medical Group, then Medical Group may terminate this Agreement on 60 days' written notice to CCO by sending a termination notice within 30 days after receipt of the amendment.

10.3 Non-waiver. The waiver by either party of any breach of any provision of this Agreement will not operate as a waiver of any subsequent breach of the same or any other provision.

10.4 Assignment. This Agreement may not be assigned by either party without the written consent of the other party, except that this Agreement may be assigned by CCO to any CCO Affiliate.

Additionally, if CCO transfers to a third party all of its business described in a given line item in Appendix 2, section 1, or other line of business, CCO may assign this Agreement, only as it relates to that transferred business, to that third party. Such an assignment will not impact the relationship of the parties under this Agreement with regard to the remainder of CCO's business.

10.5 Relationship of the parties. The sole relationship between the parties to this Agreement is that of independent contractors. This Agreement does not create a joint venture, partnership, agency, employment or other relationship between the parties.

10.6 No third-party beneficiaries. CCO and Medical Group are the only entities with rights and remedies under this Agreement. Any claims, collection actions or disputes may not be assigned, transferred or sold by either party without the written consent of the other party.

10.7 Calendar days. Unless this Agreement specifically provides otherwise, all references in this Agreement to a period of days refers to calendar days.

10.8 Notice procedures. Any notice required to be given under this Agreement must be in writing, except in cases in which this Agreement specifically permits electronic notice, or as otherwise permitted or required in the Protocols. Acceptable forms of written notice include facsimile, first class mail, certified mail, or overnight delivery by a national, recognized delivery service. All notices of termination of this Agreement by either party must be sent by certified mail, return receipt requested, addressed to the appropriate party at the address set forth on the signature portion of this Agreement. Each party will provide the other with proper addresses, facsimile numbers and electronic mail addresses. All notices will be deemed received upon receipt by the party to which notice is given or on the 5th business day following mailing, whichever occurs first.

10.9 Confidentiality. Neither party may disclose to a Customer, other health care provider, or other third party any of the following information (except as required by an agency of the government):

i) any proprietary business information, not available to the general public, obtained by the party from the other party;

ii) the specific reimbursement amounts provided for under this Agreement, except for purposes of administration of benefits, including informing Customers, Benefit Plan sponsors and/or referring providers about the cost of a particular Covered Service or set of Covered Services; or

iii) any customer list of the other party regardless of how such customer list was generated.

This section 10.9 does not preclude the disclosure of information by CCO to a third party as part of the process by which the third party is evaluating administration of benefits or considering whether to purchase services from CCO.

At least 48 hours before either party issues a press release, advertisement, or other media statement about the business relationship between the parties, that party will give the other party a copy of the material the party intends to issue.

10.10 Governing law. This Agreement will be governed by and construed in accordance with the laws of the state in which Medical Group renders Covered Services, and any other applicable law.

10.11 Regulatory appendices. One or more regulatory appendices may be attached to this Agreement, setting forth additional provisions included in this Agreement in order to satisfy regulatory requirements under applicable law. These regulatory appendices, and any attachments to them, are expressly incorporated into this Agreement and are binding on the parties to this Agreement. In the event of any inconsistent or contrary language between a regulatory appendix and any other part of this Agreement, including but not

limited to appendices, amendments and exhibits, the regulatory appendix will control, to the extent it is applicable.

10.12 Severability. Except as otherwise set forth in this Agreement, any provision of this Agreement that is unlawful, invalid or unenforceable in any situation in any jurisdiction will not affect the validity or enforceability of the remaining provisions of this Agreement or the lawfulness, validity or enforceability of the offending provision in any other situation or jurisdiction.

10.13 Survival. Notwithstanding the termination of this Agreement, this Agreement will continue to apply to Covered Services rendered while this Agreement was in effect. Additionally, section 10.9 of this Agreement, (except for the last paragraph) will survive the termination of this Agreement.

10.14 Fines; Penalties. Medical Group will be responsible for any and all fines or penalties that may be assessed against CCO by any government agency that arise from Medical Group's failure to execute, deliver or perform its obligations under this Agreement.

THIS AGREEMENT CONTAINS A BINDING ARBITRATION PROVISION THAT MAY BE ENFORCED BY THE PARTIES.

[Medical Group], as signed by its authorized representative:		*Address to be used to give notice to Medical Group under this Agreement.*	
Signature:	_____	Street:	_____
Print Name and Title:	_____	City:	_____
		State:	_____ Zip Code: _____
D/B/A:	_____	Phone:	_____ Fax: _____
Date: _____		E-mail:	_____

CCO, on behalf of itself, HMO and its other affiliates, as signed by its authorized representative:

Signature:	_____
Print Name:	_____
Title:	_____
Date:	_____

Address to be used for giving notice to CCO under this Agreement:

Street:_____
City:_____
State: _____ Zip Code:_____
Fax:_____
Email:_____

For office use only: [_____]
[_____]
Month, day and year in which Agreement is first effective: [_____]

Appendix 1
Medical Group Service Locations

Medical Group attests that this Appendix identifies all services and locations covered under this Agreement.

IMPORTANT NOTE: Medical Group acknowledges its obligation under Section 5.7 to promptly report any change in Medical Group's name or Taxpayer Identification Number. Failure to do so may result in denial of claims or incorrect payment.

Practice Name_____
Street Address_____
City_____ State_____ Zip_____
Taxpayer Identification Number(s) (TIN) _____
National Provider ID (NPI) _____

MEDICAL GROUP LOCATION - List BOTH the Service Location and the Billing Address for the Service Location	
Service Location	**Billing Address for the Service Location**
Medical Group Name	**Medical Group Name**
Street Address	**Street Address**
City	**City**
State and Zip Code	**State and Zip Code**
Phone Number	**Phone Number**
TIN (*If different from above*)	
National Provider ID (NPI)	
ADDITIONAL MEDICAL GROUP LOCATIONS - List BOTH the Service Location and the Billing Address for the Service Location	
Service Location	**Billing Address for the Service Location**
Medical Group Name	**Medical Group Name**
Street Address	**Street Address**
City	**City**
State and Zip Code	**State and Zip Code**
Phone Number	**Phone Number**
TIN (*If different from above*)	
National Provider ID (NPI)	

Medical Group Name	**Medical Group Name**
Street Address	**Street Address**
City	**City**
State and Zip Code	**State and Zip Code**
Phone Number	**Phone Number**
TIN (*If different from above*)	
National Provider ID (NPI)	
Medical Group Name	**Medical Group Name**
Street Address	**Street Address**
City	**City**
State and Zip Code	**State and Zip Code**
Phone Number	**Phone Number**
TIN (*If different from above*)	
National Provider ID (NPI)	

Appendix 2
Benefit Plan Descriptions

Section 1. CCO may allow Payers to access Medical Group's services under this Agreement for the Benefit Plan types described in each line item below, unless otherwise specified in section 2 of this Appendix 2:

- [Mississippi Medicaid Benefit Plans.]
- [Mississippi CHIP Benefit Plans.]

Section 2. Notwithstanding the above section 1 of this Appendix 2, this Agreement will not apply to the Benefit Plan types described in the following line items:

- [Mississippi Medicaid Benefit Plans.]
- [Mississippi CHIP Benefit Plans.]
- Medicaid and CHIP Benefit Plans other than those separately addressed in this Appendix 2.

Note: Excluding certain Benefit Plans or programs from this Agreement does not preclude the parties or their affiliates from having or entering into a separate agreement providing for Medical Group's participation in a network for such Benefit Plans or programs.

Section 3. Definitions:

Note: CCO may adopt a different name for a particular Benefit Plan, and/or may modify information referenced in the definitions in this Appendix 2 regarding Customer identification cards. If that happens, section 1 or section 2 of this Appendix 2 will continue to apply to those Benefit Plans as it did previously, and CCO will provide Medical Group with the updated information. Additionally, CCO may revise the definitions in this Appendix 2 to reflect changes in the names or roles of CCO's business units, provided that doing so does not change Medical Group's participation status in Benefit Plans impacted by that change, and further provided that CCO provides Medical Group with the updated information.

MEDICAID, CHIP AND OTHER STATE PROGRAMS:

- **Medicaid Benefit Plans** means Benefit Plans that offer coverage to beneficiaries of a program that is authorized by Title XIX of the federal Social Security Act, and jointly financed by the federal and state governments and administered by the state.

- **Mississippi Medicaid Benefit Plans** means Medicaid Benefit Plans issued in Mississippi that have a reference to "CCO" on the valid identification card of any Customer eligible for and enrolled in that Benefit Plan.

- **Children's Health Insurance Program ("CHIP") Benefit Plans** means Benefit Plans under the program authorized by Title XXI of the federal Social Security Act that is jointly financed by the federal and state governments and administered by the state.

- **Mississippi CHIP Benefit Plans** means CHIP Benefit Plans issued in Mississippi that include a reference to "CCO" and "MSCHIP" on the face of the valid identification card of any Customer eligible for and enrolled in that Benefit Plan.

- **Other Governmental Benefit Plans** means Benefit Plans that are funded wholly or substantially by a state or district government or a subdivision of a state (such as a city or county), but do not include Benefit Plans for:

  i) employees of a state government or a subdivision of a state and their dependents;
  ii) students at a public university, college or school;
  iii) employer-based coverage of private sector employees, even if the employer receives a government subsidy to help fund the coverage;
  iv) Medicaid beneficiaries;
  v) Children's Health Insurance Program (CHIP) beneficiaries; and
  vi) Medicare and Medicaid Enrollees (MME).

Page Intentionally left blank.

Additional Manuals Appendix

For some of the Benefit Plans for which Medical Group may provide Covered Services under this Agreement, Medical Group is subject to additional requirements of one or more additional provider manuals ("Additional Manuals"). When this Agreement refers to Protocols or Payment Policies, it is also referring to the Additional Manuals. An Additional Manual may be a separate document or it may be a supplement to the CCO Care Provider Administrative Guide ("CCO Administrative Guide").

For Benefit Plans subject to an Additional Manual, the Additional Manual controls if it conflicts with any of the following: (1) a provision of this Agreement or of the CCO Administrative Guide; or (2) a CCO Protocol or Payment Policy. However, the Additional Manual does not control where it conflicts with applicable statutes or regulations.

The Additional Manuals will be made available to Medical Group on a designated website and upon request. The names of the Additional Manuals, the websites to view and download them, and the Benefit Plans to which they apply, are listed in Table 1 below. CCO may change the location of a website or the Customer identification card identifier used to identify Customers subject to a given Additional Manual; if CCO does so, CCO will inform Medical Group.

CCO may make changes to the Additional Manuals subject to this Appendix in accordance with the provisions of this Agreement relating to Protocol and Payment Policy changes.

Table 1

Benefit Plan(s)	**Description of Applicable Additional Manual**	**Website**
[No Additional Manuals Apply]		
[Mississippi CHIP Benefit Plans	Administrative Guide for Mississippi Children's Health Insurance Program (CHIP)	portal.com]
[Mississippi Medicaid Benefit Plans	Administrative Guide for Mississippi Medicaid	portal.com]

Medical Group Professional Roster

IMPORTANT NOTE: Medical Group acknowledges its obligation to notify CCO of any change in Medical Group Professionals in accordance with Article IV and Section 5.7. Failure to do so may result in denial of claims or incorrect payment.

Medical Group represents that it has provided CCO with a Medical Group Professional Roster that includes all of the following data elements for each Medical Group Professional:

- Name of Professional (first name, middle initial, last name)
- Degree (MD, DO, NP, PA, other)
- Gender (M/F)
- Provider Specialty(ies) (primary, secondary, additional specialties)
- Operates as and willing to be listed/assigned as a Primary Care Professional “PCP” (Y/N)
- State License Number
- Medicaid ID Number
- NPI Number
- Foreign Language(s)
- Admitting Hospital(s)

If any data element is not applicable to a specific Medical Group Professional, Medical Group will indicate "not applicable" in the appropriate field. Acceptable formats include in writing, electronically in Excel, ANSI, or text (comma delineated) formats.

[Payment Appendix – Mississippi Medicaid

Applicability

This Payment Appendix applies to Covered Services rendered by Medical Group to Customers covered under the following types of Benefit Plans, as described in the Agreement:

- Mississippi Medicaid Benefit Plans.

Section 1
Payment for Covered Services

1.1 Payment. Medical Group's contract rates for Covered Services are the lesser of (i) Medical Group's Customary Charges or (ii) the following, in order of applicability:

a) [X]% of the Mississippi Medicaid conversion factor published by the applicable state agency for anesthesia services;

b) [Y]% of the Mississippi Medicaid fee schedule published by the applicable state agency;

c) In the event a fee source listed above in clause (a) or (b) does not publish a specific fee amount, then CCO will pay [Z]% of Medical Group's Customary Charges for Covered Services.

d) For certain CPT/HCPCS codes, CCO may pay an amount higher than the amount listed in this section 1.1, and in the future, CCO may reduce that higher amount paid for those CPT/HCPCS codes, but not less than the amount payable in clauses (a), (b) and (c) above.

The actual payment amount is also subject to matters described in this Agreement, such as Payment Policies.

Medical Group will submit claims using a CMS 1500, its successor form or its electronic equivalent. All claims submitted under this Payment Appendix must use CPT Codes, HCPCS Codes, ICD-10 Codes or its successor and other codes in compliance with HIPAA standard data set requirements. Claims submitted without HIPAA standard data set requirements may be denied.

If an applicable state or federal program is available to provide items or payment directly to Medical Group for specific Covered Services for Customers subject to this Payment Appendix that would otherwise be payable under this Payment Appendix, the applicable program will apply and not this Payment Appendix. (For example, the Vaccines For Children program currently provides vaccines free of charge, and therefore no amount will be payable under this Payment Appendix for vaccines within the Vaccines For Children program. However, the administration of such vaccine may be payable under this Payment Appendix, if payment is not provided to physicians under the Vaccines For Children program for vaccine administration.)

The contract rates established by this Payment Appendix are all-inclusive, including without limitation any applicable taxes, for all Covered Services provided to the Customer. Unless specifically indicated otherwise, amounts listed in this fee schedule represent global fees and may be subject to reductions based on appropriate modifiers (for example, professional and technical modifiers).

1.2 Routine Maintenance. CCO routinely updates the fee schedule in response to changes published by the state agency, such as fee amount changes. Provided that the state does not change its methodology, CCO will implement fee schedule changes in its systems within 45 days from the date the change is published in the Medicaid agency's official correspondence to CCO or is otherwise formally communicated by the Medicaid agency to CCO.

CCO will make the changes effective in its system on the effective date of the change by the primary fee source. However, claims already processed prior to the change being implemented by CCO will not be reprocessed unless otherwise required by law.

CCO also routinely updates the fee schedule in response to coding changes as described in this Agreement. When implementing coding updates, CCO will apply the same percentage(s) as set forth above in Section 1.1 and the then-current value of the published code to determine the contract rate. CCO will use reasonable commercial efforts to implement such changes within 90 days from the date of publication. However, claims already processed prior to the change being implemented by CCO will not be reprocessed unless otherwise required by law.

1.3 Medicaid Agency Payment Changes. If the Medicaid agency changes the manner in which it reimburses or changes the Medicaid primary fee source such that CCO is required to make significant programming or platform changes in order to implement the Medicaid agency changes, CCO will implement the new state methodologies effective on the date that is published in the Medicaid agency's official correspondence to CCO or as otherwise formally communicated by the Medicaid agency to CCO. Medical Group agrees that, in such case, it will accept the current payment as set forth in this Payment Appendix until such a time as CCO can implement the Medicaid agency change. At such time as CCO is able to implement the change, CCO will communicate the change via a copy of a new payment appendix. The changes will be incorporated into this Payment Appendix for all dates of service on or after those changes are effective in the Medicaid program. If CCO is unable, through commercially reasonable efforts, to incorporate the Medicaid agency payment changes in their entirety, CCO will so notify Medical Group within 90 days from the date the change is published in the Medicaid agency's official correspondence to CCO, or otherwise formally communicated by the Medicaid agency. The parties will then negotiate in good faith for a period of up to 60 days to amend the Agreement to replace this Payment Appendix with a new payment appendix and stated effective date for the new contract rates. If the parties have not reached an agreement upon such an amendment within the aforementioned 60 day period, either party may initiate Dispute Resolution according to this Agreement.

[Payment Appendix – Mississippi State Department of Health

This Payment Appendix applies to Covered Services rendered by Medical Group to Customers covered under the following type(s) of Benefit Plans as described in this Agreement.

- Mississippi Medicaid Benefit Plans.

Section 1
Definitions

Any capitalized terms used herein, but not otherwise defined, will have the meanings ascribed to them in the Agreement.

Medical Group: The Mississippi State Department of Health.

Medicaid Rate Letter: To the extent applicable, written notice from the Mississippi Medicaid Program to Medical Group regarding the Medicaid rate payable to Medical Group for Covered Services.

Per Visit: The flat rate payment made to Medical Group for all Covered Services rendered to a Customer, during a one calendar day period, for all service categories listed in the Fixed Fees Table. Unless otherwise specified in this Payment Appendix, the Per Visit, together with any co-payment, deductible or coinsurance for which the Customer is responsible under the Benefit Plan, will be considered payment in full for all Covered Services rendered to the Customer including, but not limited to, physician and other professional fees billed by Medical Group on a

claim, (including services rendered by non-physician personnel, regardless of whether those personnel are employed by Medical Group and regardless of whether those services are characterized as professional services), nursing care, diagnostic and therapeutic services, durable medical equipment, supplies (including, but not limited to anesthesia supplies), medications, Facility and ancillary services.

Fee Schedule: The Mississippi Medicaid fee schedule published by Mississippi Division of Medicaid (the "Mississippi Medicaid Program").

Section 2
Contracted Rate for Covered Services

2.1 Contract Rate. For Covered Services rendered by Medical Group to a Customer, CCO will pay Medical Group the lesser of (i) Medical Group's Customary Charges for Covered Services or (ii) the applicable contract rate determined in accordance with Section 2.2 of this Payment Appendix. Payment under this Payment Appendix will be less any applicable co-payments, deductibles and coinsurance and is subject to the requirements set forth in the Agreement, such as the Payment Policies.

2.2 Covered Services. For Covered Services rendered by Medical Group to a Customer, the contract rates will be the rates set forth in the Covered Service Table.

Covered Services Table

Service Category	Payment Method	Contract Rate
Department of Health Covered Services	Per Visit Rate	100% of the Medical Group specific Mississippi Per Visit rate for Department of Health Covered Services

For Department of Health Covered Services rendered by Medical Group to a Mississippi Medicaid Benefit Plan Customer that are not payable under Department of Health Covered Services Table, the contract rates will be 100% of the Mississippi Medicaid Fee Schedule rate.

If an applicable Mississippi or federal program is available to provide items or payment directly to Medical Group for specific Covered Services for Customers subject to this Payment Appendix that would otherwise be payable under this Payment Appendix, the applicable program will apply and not this Payment Appendix. (For example, the Vaccines For Children program currently provides vaccines free of charge, and therefore no amount will be payable under this Payment Appendix for vaccines within the Vaccines For Children program. However, the administration of such vaccine may be payable under this Payment Appendix if payment is not provided under the Vaccines For Children program for vaccine administration.)

2.3 Billing and Filing of Claims. Medical Group will submit a single claim for all Covered Services performed during one calendar day for a Customer. Medical Group will immediately notify CCO if Medical Group files more than one claim for services provided to a Customer on one calendar day. Medical Group will bill using a CMS 1500 or successor form or its electronic equivalent. All claims submitted under this Payment Appendix must use CPT Codes, HCPCS Codes, ICD-10 Codes or its successor and other codes in compliance with HIPAA standard data set requirements. Claims submitted without HIPAA standard data set requirements may be denied.

Section 3
Miscellaneous Provisions

3.1 Inclusive Rates. The contract rates established by this Payment Appendix for the service categories listed in this Payment Appendix are all-inclusive and represent the entire payment, including but not limited to any

applicable tax, for the provision to the Customer of all Covered Services that are in the given service category, including but not limited to those Covered Services that are generally provided as a part of the service in the given service category. No additional payments will be made for any Covered Services billed for separately by Medical Group.

Covered Services billed for separately by Medical Group that are not generally provided as a part of the service categories listed in this Payment Appendix are not subject to reimbursement under this Payment Appendix, but may be payable under another payment appendix to this Agreement or under another agreement.

3.2 Payment Code Updates. CCO will have the right to update any codes, such as Revenue Codes, ICD-10-CM Codes or successor version, HCPCS Codes and/or CPT Codes, from time to time according to changes in the industry, including among other things (a) the latest edition of the Current Procedural Terminology (CPT) manual which is revised by the American Medical Association, (b) the latest edition of the HCPCS manual which is revised by the Centers for Medicare and Medicaid Services (CMS), (c) the latest edition of the ICD-10-CM or successor version which is issued by the U.S. Department of Health and Human Services, and (d) the latest guidelines from the National Uniform Billing Committee. CCO will not generally notify Medical Group of these code updates.

3.3 Changes to Medicaid State Agency Services Rate and Reimbursement Methodology. With regard to all Covered Services that are reimbursed under this Payment Appendix and based on the Mississippi Medicaid Program (Medicaid State agency) rate (including a contract rate that is a fixed percentage of the Mississippi Medicaid Program rate) and reimbursement methodology, the contract rate and reimbursement methodology under this Payment Appendix will be adjusted consistent with changes made by the Mississippi Medicaid Program, as finalized and published, and as further described in this Sections 3.3, 3.3(i) and 3.3(ii). In the case of a contract rate that is a fixed percentage of the Mississippi Medicaid Program Rate, the new contract rate, after a change to the Mississippi Medicaid Program Rate, will be the same fixed percentage of the new Mississippi Medicaid Program Rate; the timetable for implementing the change is described in Section 3.3(i).

i) **Rate Changes**. With regard to Covered Services reimbursed under this Payment Appendix using a Per Visit Payment, the contract rate will be adjusted in accordance with this Section 3.3(i). If applicable, Medical Group agrees to provide CCO with a copy of the annual or any interim Medicaid Rate Letter applicable to Medical Group within 30 days of Medical Group's receipt of such Medicaid Rate Letter. The contract rate under this Payment Appendix using a Per Visit Payment Method will be updated within 90 days after Medical Group provides CCO with the Medicaid Rate Letter or within 90 days after the final publication date by the Mississippi Medicaid State agency, whichever date is earliest. CCO will make the contract rate effective on the effective date of the change stated by the Mississippi state agency. Changes include without limitation the addition or deletion of CPT/HCPCS codes that the Mississippi Medicaid Program covers at Medical Group. Claims for dates of service on or after the effective date of the Mississippi Medicaid Program Rate change that were adjudicated before CCO implemented the change will not be adjusted to the new contract rate unless required by law.

ii) **Mississippi Medicaid Program Payment Changes.** If the Medicaid agency changes the manner in which it reimburses or changes the Medicaid primary fee source such that CCO is required to make significant programming or platform changes in order to implement the Medicaid agency changes, CCO will implement the Medicaid agency changes, within 45 days, from the date the change is published in the Medicaid agency's official correspondence to CCO or is otherwise formally communicated by the Medicaid agency to CCO. Medical Group agrees that, in such case, it will accept the current payment as set forth in this Payment Appendix until such a time as CCO can implement the Medicaid agency change. At such time as CCO is able to implement the change, CCO will communicate the change and the effective date of the change via a copy of a new payment

appendix. The changes will be incorporated into this Appendix for all dates of service on or after those changes are effective in the Medicaid program.

If CCO is unable, through commercially reasonable efforts, to incorporate the Medicaid agency payment changes in their entirety, CCO will so notify Medical Group within 90 days from the date the change is published in the Medicaid agency's official correspondence to CCO, or otherwise formally communicated by the Medicaid agency. The parties will then negotiate in good faith for a period of up to 60 days to amend the Agreement to replace this Payment Appendix with a new payment appendix and Mississippi effective date for the new contract rates. If the parties have not reached an agreement upon such an amendment within the aforementioned 60 day period, either party may initiate Dispute Resolution according to this Agreement.

[Payment Appendix – Mississippi CHIP]

Mississippi CHIP Fee Information Document: [Fee Schedule ID]

This Payment Appendix applies to Covered Services rendered by Medical Group to Customers covered under the following types of Benefit Plans, as described in this Agreement:

- Mississippi CHIP Benefit Plans.

Mississippi Medicaid Program
Regulatory Requirements Appendix

MISSISSIPPI MEDICAID PROGRAM

REGULATORY REQUIREMENTS APPENDIX

PROVIDER

THIS MISSISSIPPI MEDICAID PROGRAM REGULATORY REQUIREMENTS APPENDIX (this "Appendix") supplements and is made part of the provider agreement (the "Agreement") between HMO ("HMO") or one of its Affiliates and the party named in the Agreement ("Provider").

SECTION 1
APPLICABILITY

The requirements of this Appendix apply to Medicaid benefit plans sponsored, issued or administered by HMO under the Mississippi Coordinated Access Network Program (the "MississippiCAN Program") governed by the State's designated regulatory agencies. In the event of a conflict between this Appendix and other appendices or any provision of the Agreement, the provisions of this Appendix shall control except with regard to benefit plans outside the scope of this Appendix or unless otherwise required by law. In the event HMO is required to amend or supplement this Appendix as required or requested by the State to comply with federal or State regulations, HMO will unilaterally initiate such additions, deletions or modifications. All provider agreements must be in writing and must include all specific activities and report responsibilities delegated to the Provider by HMO.

SECTION 2
DEFINITIONS

Unless otherwise defined in this Appendix, all capitalized terms shall be as defined in the Agreement. For purposes of this Appendix, the following terms shall have the meanings set forth below; provided, however, in the event any definition set forth in this Appendix or the Agreement is inconsistent with any definitions under the MississippiCAN Program, the definitions shall have the meaning set forth under the MississippiCAN Program.

2.1 Adverse Benefit Determination: The denial or limited authorization of a requested service, including determinations on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit; the reduction, suspension, or termination of previously authorized services; the denial, in whole or in part, of payment for a service; HMO's failure to provide services in a timely manner; HMO's failure to resolve Complaints, Grievances, or Appeals within the specified time frames; for residents in a rural area with only one MCO, the denial of a Covered Person's request to exercise his or her right, under 42 C.F.R. §438.52(b)(2)(ii); the denial of a Covered Person's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other enrollee financial liabilities; and determinations by skilled nursing facilities and nursing facilities to transfer or discharge residents and adverse determinations made by a State with regard to the preadmission screening and annual resident review requirements of Section 1919(e)(7) of the Act, if applicable.

2.2 **Affiliate:** Those entities controlling, controlled by, or under common control with HMO.

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

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

2.5 **CMS:** Center for Medicare and Medicaid Services is an agency within the U.S. Department of Health & Human Services responsible for administration of several key federal health care programs.

2.6 **Complaint:** An expression of dissatisfaction received orally or in writing that is of a less serious or formal nature that is resolved within one (1) business day of receipt.

2.7 **Covered Person:** An individual who meets all of the eligibility requirements for Mississippi Medicaid and is currently enrolled with HMO for the provision of services under a MississippiCAN Program. A Covered Person may also be referred to as an Enrollee, Member or Customer under the Agreement.

2.8 **Covered Services:** Health care services or products for which a Covered Person is enrolled with HMO to receive coverage under the State Contract, including all services required by the State Contract and State and federal law.

2.9 **DOM:** Division of Medicaid, Office of the Governor, State of Mississippi.

2.10 **Early, Periodic, Screening, Diagnosis, and Treatment (EPSDT) Services:** Defined by DOM to include:

i) Age appropriate, comprehensive health and development history that includes physician and mental health assessments along with counseling and anticipatory guidance and risk factor reduction interventions;
ii) Calculation of Body Mass Index;
iii) Growth measurements and head circumference;
iv) Nutritional counseling;
v) Developmental surveillance and Developmental and autism Spectrum Disorders Screenings as appropriate;
vi) Comprehensive unclothed exam;
vii) Appropriate laboratory tests (including blood level assessment appropriate to age and risk);

viii) Appropriate immunizations in accordance with Recommended Childhood and Adolescent Immunization Schedule adopted by DOM;
ix) A vision assessment;
x) A hearing assessment;
xi) A dental screening and/or referral to dental care;
xii) Health education; and
xiii) Referrals for identified abnormalities.

2.11 Fraud and Abuse: Fraud is any type of intentional deception or misrepresentation made by an entity or person with the knowledge that the deception could result in some unauthorized benefit to the entity, him or herself, or some other person. The Fraud can be committed by many entities, including a vendor, a subcontractor, a provider, a State employee, or a Covered Person, among others. Abuse is any practice that is inconsistent with sound fiscal, business, or medical practices, and results in an unnecessary cost to the Medicaid program, a vendor, a subcontractor or Provider or in reimbursement for services that are not Medically Necessary or that fail to meet professionally recognized standards for health care.

2.12 Grievance: An expression of dissatisfaction about any matter or aspect of HMO or its operation, other than an Adverse Benefit Determination as defined herein. Grievances may include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the Covered Person's rights regardless of whether remedial action is requested. Grievance includes a Covered Person's right to dispute an extension of time proposed by HMO to make an authorization decision.

2.13 Marketing: The activities that promote visibility and awareness for the MississippiCAN Program and HMO's participation in the program. All marketing activities are subject to prior review and approval by DOM and may not contain misleading information.

2.14 Medical Record: A single complete record, which documents the entire treatment plan developed for, and medical services received by, the Covered Person including inpatient, outpatient, referral services and emergency medical services whether provided by contracted Providers or non-contracted providers.

2.15 Mississippi Coordinated Access Network (MississippiCAN) Program: Mississippi Medicaid's coordinated care program for select Medicaid Beneficiaries.

2.16 Primary Care Provider (PCP): Any physician or health care practitioner or group operating within the scope of his or her licensure who is responsible for supervising, prescribing and providing primary care and primary case management services in the MississippiCAN Program, whose practice is limited to the general practice of medicine or who is an Internist, Pediatrician, Obstetrician, Gynecologist, Family Practitioner, General Practitioner, Certified Nurse Practitioners whose specialty is pediatrics, adult, family, certified nurse midwife, obstetrics/gynecology, or a physician assistant.

2.17 Prior Authorization: A determination to approve a Provider's request, pursuant to services covered in the MississippiCAN Program, to provide a service or course of

treatment of a specific duration and scope to a Member prior to the initiation or continuation of the service.

2.18 Provider Network: The Panel of health service Providers with which HMO contracts for the provision of covered services to Covered Persons and Non-Contracted Providers administering services to Covered Persons.

2.19 State: The State of Mississippi or its designated regulatory agencies.

2.20 State Contract: HMO's contract with the State for the purpose of providing and paying for Covered Services to Covered Persons enrolled in the MississippiCAN Program.

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

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

SECTION 3
PROVIDER REQUIREMENTS

The MississippiCAN Program, through the State Contract and federal and State statutes and regulations, requires the Agreement to contain certain conditions that HMO and Provider agree to undertake, which include the following:

3.1 Definitions Related to the Provision of Covered Services. Provider shall follow the applicable State Contract's requirements for the provision of Covered Services. Provider's decisions affecting the delivery of acute or chronic care services to Covered Persons shall be made on an individualized basis and in accordance with the following definitions:

i) Emergency Medical Condition: A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in any of the following: (a) 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; (b) serious impairment to body functions; or (c) serious dysfunction of any body organ or part.

ii) Emergency Services: Covered inpatient and outpatient services, inclusive of dialysis services, furnished by a provider who is qualified to furnish those health

services and that are needed to evaluate or stabilize an Emergency Medical Condition in accordance with 42 CFR 438.114.

iii) Medically Necessary Services: As set forth in the Social Security Act, Section 1905 (42 USC 1396d(a)), Medically Necessary Services are defined as services, supplies, or equipment provided by a licensed health care professional that are:

a) Appropriate and consistent with the diagnosis or treatment of the Covered Person's condition, illness, or injury;

b) In accordance with the standards of good medical practice consistent with the individual Covered Person's condition(s);

c) Not primarily for the personal comfort or convenience of the Member, family, or Provider;

d) The most appropriate services, supplies, equipment, or levels of care that can be safely and efficiently provided to the Covered Person;

e) Furnished in a setting appropriate to the Covered Person's medical need and condition and, when applied to the care of an inpatient, further mean that the Covered Person's medical symptoms or conditions require that the services cannot be safely provided to the Covered Person as an outpatient;

f) Not experimental or investigational or for research or education;

g) Provided by an appropriately licensed practitioner; and

h) Documented in the patient's record in a reasonable manner, including the relationship of the diagnosis to the service.

Medically Necessary Services may also be those services for children that are necessary to correct or ameliorate defects and physical and mental illnesses and conditions discovered during an interperiodic or periodic EPSDT screen, whether such services are covered or exceed the benefit limits in the Medicaid State Plan and Title 23 of Mississippi Administrative Code.

iv) Urgent Care: Urgent care services are utilized because the Covered Person's primary care physician is not available. An urgent condition is not life threatening but may need prompt attention. Urgent care services are for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe it requires emergency room care.

3.2 Provider Eligibility. Provider must be enrolled in the Mississippi Medicaid program and must use the same National Provider Identifier (NPI) number to participate in HMO's Network. Upon notification from the State that Provider's enrollment has been denied or terminated, HMO must terminate Provider immediately and will notify affected Covered Persons that Provider is no longer participating in the network. HMO will exclude from its

network any provider who has been terminated or suspended from the Medicare or Medicaid program in any state.

3.3 Accessibility Standards. Provider shall provide for timely access for Covered Person appointments in accordance with the appointment availability requirements established under the State Contract, as further described in the applicable provider manual.

Type	Appointment Scheduling Time Frames
PCP (well care visit)	Not to exceed thirty (30) calendar days
PCP (routine sick visit)	Not to exceed seven (7) calendar days
PCP (urgent care visit)	Not to exceed twenty-four (24) hours
Specialists	Not to exceed forty-five (45) calendar days
Dental Providers (routine visits)	Not to exceed forty-five (45) calendar days
Dental Providers (urgent Care)	Not to exceed forty-eight (48) hours
Behavioral Health Providers (routine visit)	Not to exceed fourteen (14) calendar days
Behavioral Health Providers (urgent visit)	Not to exceed twenty-four (24) hours
Behavioral Health Providers (post-discharge from an acute psychiatric hospital when the Contractor is aware of the Member's discharge)	Not to exceed seven (7) calendar days
Urgent Care Providers	Not to exceed twenty-four (24) hours
Emergency Providers	Immediately (twenty-four (24) hours a day, seven (7) days a week) and without Prior Authorization

3.4 Hours of Operation; Appointments. Provider shall offer hours of operation that are no less than the hours of operation offered to commercial beneficiaries or comparable to Medicaid fee-for-service if Provider serves only Medicaid beneficiaries. As applicable, Provider will make Covered Services available 24 hours a day, 7 days a week when medically necessary.

3.5 Hold Harmless. Except for any applicable cost-sharing requirements under the State Contract, Provider shall look solely to HMO for payment of Covered Services provided to Covered Persons pursuant to the Agreement and the State Contract and hold the State, DOM, the U.S. Department of Health and Human Services and Covered Persons harmless in the event that HMO cannot or will not pay for such Covered Services. In accordance with 42 CFR 447.15, as may be amended from time to time, the Covered Person is not liable to Provider for any services for which HMO is liable and as specified under the State's relevant health insurance or managed care statutes, rules or administrative agency guidance. Provider shall not require any copayment or cost sharing for Covered Services provided under the Agreement unless expressly permitted under the State Contract.

Provider shall also be prohibited from charging Covered Persons for missed appointments if such practice is prohibited under the State Contract or applicable law. Neither the State, DOM nor Covered Persons shall be in any manner liable for the debts and obligations of HMO and under no circumstances shall HMO, or any providers used to deliver services covered under the terms of the State Contract, charge Covered Persons for Covered Services.

Covered Person may be responsible for non-covered item(s) and/or service(s), only if the Provider ensures that written documentation in compliance with the Advance Beneficiary Notification (ABN) is received from the Covered Person that an item(s) or service(s) rendered is a non-covered item and/or service(s) and that the Covered Person will be financially responsible for the item(s) and/or service(s). If HMO determines a Covered Person was charged for Covered Services inappropriately, such payment may be recovered, as applicable.

This provision shall survive any termination of the Agreement, including breach of the Agreement due to insolvency.

3.6 **Indemnification.** To the extent applicable to Provider in performance of the Agreement, Provider shall indemnify, defend, protect, save and hold DOM and its employees and Covered Persons harmless from and against all injuries, deaths, losses, damages, claims, suits, liabilities, judgments, costs and expenses, including, without limitation, court costs, investigative fees and expenses and attorney fees, to the extent proximately caused by any negligent act or other intentional misconduct or omission of Provider, its agents, officers, employees or contractors arising from the Agreement. DOM may waive this requirement for public entities if Provider is a state agency or sub-unit as defined by the State or a public health entity with statutory immunity. This clause shall survive the termination of the Agreement for any reason, including breach due to insolvency.

3.7 **Provider Selection.** To the extent applicable to Provider in performance of the Agreement, Provider shall comply with 42 CFR 438.214, as may be amended from time to time, which includes, but is not limited to the selection and retention of providers, credentialing and recredentialing requirements and nondiscrimination. If HMO delegates credentialing to Provider, HMO will provide monitoring and oversight and Provider shall ensure that all licensed medical professionals are credentialed in accordance with HMO's and the State Contract's credentialing requirements.

3.8 **Restrictions on Referrals.** Provider shall not make inappropriate referrals for designated health services to health care entities with which Provider or a member of Provider's family has a financial relationship, pursuant to federal anti-kickback and physician self-referral laws that prohibit such referrals.

3.9 **Records Retention.** As required under State or federal law or the State Contract, Provider shall maintain an adequate record keeping system for recording services, charges, dates and all other commonly accepted information elements sufficient to disclose the quality, quantity, appropriateness and timeliness of services rendered to Covered Persons. All financial records shall follow generally accepted accounting principles. Medical records and supporting management systems shall include all pertinent information related to the

medical management of each Covered Person. Other records shall be maintained as necessary to clearly reflect all actions taken by Provider related to services provided under the State Contract. Such records, including, as applicable, grievance and appeal records shall be maintained for a period of not less than ten (10) years from the close of the Agreement, or such other period as required by law. If records are under review or audit, they must be retained for a minimum of ten (10) years following resolution of such action. Prior approval for the disposal of records must be requested and approved by HMO if the Agreement is continuous.

3.10 Records Access. Provider agrees to cooperate with HMO to maintain and share a health record of all services provided to a Covered Person, as appropriate and in accordance with applicable laws, regulations and professional standards. Provider acknowledges and agrees that the State, DOM, the U.S. Department of Health and Human Services and other authorized federal and state personnel shall have complete access to all records pertaining to services provided to Covered Persons. Provider shall provide immediate access to facilities, records and supportive materials pertinent to the State Contract for State or Federal fraud investigators. Copies of requested documents shall be provided to the State, DOM, the U.S. Department of Health and Human Services and other authorized federal and state personnel or their designees free of charge.

3.11 Government Audit; Investigations. Provider acknowledges and agrees that the State and the U.S. Department of Health and Human Services, the Centers for Medicare & Medicaid Services, the Office of Inspector General, the General Accounting Office, or any other auditing agency and their designees or their authorized representatives, with prior approval by DOM, shall, at all reasonable time, with or without notice, have the right to inspect, audit or otherwise evaluate the quality, appropriateness, and timeliness of services provided under the terms of the State Contract and any other applicable rules, including the right to inspect and audit any records or documents of Provider and its subcontractors, and the right to inspect the premises, physical facilities, and equipment where Medicaid-related activities or work is conducted. The right to audit under this section exists for 10 years from the end date of the State Contract or from the date of completion of any audit, whichever is later. There shall be no restrictions on the right of the State or federal government to conduct whatever inspections and audits are necessary to assure quality, appropriateness or timeliness of services provided pursuant to the State Contract and the reasonableness of their costs.

3.12 Privacy; HIPAA. Provider shall comply with all applicable privacy rule and security rule provisions of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), and associated implementing regulations, as may be amended from time to time, and shall safeguard information about Covered Persons in accordance with applicable federal and State privacy laws and rules including 42 CFR 438.224 and 42 CFR Part 431, Subpart F, as may be amended from time to time. HMO agrees and shall require Provider to agree that confidential information, including but not limited to medical and other pertinent information relative to Covered Persons, shall not be disclosed to any person or organization for any purpose without the expressed, written authority of DOM or as otherwise required by law and that all such disclosures shall fully comply with HIPAA privacy and security standards.

3.13 Compliance with Law. Provider shall comply with all applicable federal and State laws and regulations, and all provisions of the State Contract, that pertain to a Covered Person's rights, including but not limited to the following to the extent applicable to Provider in performance of the Agreement:

i) Title VI of the Civil Rights Act of 1964; Title XIX of the Social Security Act; 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 Genetic Information Non-Discrimination Act of 2008 (GINA); the Americans with Disabilities Act; section 1557 of the Patient Protection and Affordable Care Act, and their implementing regulations, as may be amended from time to time.

ii) All relevant federal and State statutes, regulations and orders related to equal opportunity in employment, including but not limited to compliance with E.O. 11246, "Equal Employment Opportunity," as amended by E.O. 11375, "Amending Executive Order 11246 Relating to Equal Employment Opportunity," and as supplemented by regulations at 41 CFR part 60, "Office of Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor."

iii) All federal and State professional and facility licensing and accreditation requirements/standards that apply to the services HMO and Provider perform pursuant to the Agreement, including but not limited to:

a) All applicable standards, orders or requirements issued under Section 306 of the Clean Air Act (42 USC 1857 (h)). Section 508 of the Clean Water Act (33 USC 1368), Executive Order 11738, and Environmental Protection Agency (EPA) regulations (40) CFR Part 15), which prohibit the use of facilities included on the EPA list of violating facilities. Any violations must be reported to DSHS, DHHS, and the EPA;

b) Any applicable mandatory standards and policies relating to energy efficiency that are contained in the State Energy Conservation Plan, including the Energy Policy & conservation Act (Pub. L. 94-165), and issued in compliance with the Federal Energy Policy & Conservation Act.

c) Those specified for laboratory services in the Clinical Laboratory Improvement Amendments (CLIA). All laboratory service sites must have a CLIA certificate of registration or waiver, and a CLIA identification number.

d) Section 1128B(d)(1) of the Balanced Budget Act of 1997; and,

e) Any other requirements associated with the receipt of federal funds.

iv) All Medicaid laws, regulations and program instructions to the extent applicable to Provider in Provider's performance of the Agreement. Provider understands that payment of a claim by HMO or the State is conditioned upon the claim and the underlying transaction complying with such laws, regulations, and program

instructions (including, but not limited to, federal requirements on fraud, waste and abuse, disclosure, debarment, termination and exclusion screening), and is conditioned on the Provider's compliance with all applicable conditions of participation in Medicaid. Provider understands and agrees that each claim the Provider submits to HMO constitutes a certification that the Provider has complied with all applicable Medicaid laws, regulations and program instructions in connection with such claims and the services provided therein. Provider's payment of a claim will be denied if Provider is terminated or excluded from participation in federal healthcare programs. Provider's payment of a claim may be temporarily suspended if the State or HMO provides notice that a credible allegation of fraud exists and there is a pending investigation. Provider's payment of a claim may also be temporarily suspended or adjusted if the Provider bills a claim with a code that does not match the service provided. HMO performs coding edit procedures based primarily on National Correct Coding Initiative (NCCI) policies and other nationally recognized and validated policies. Provider agrees that it will provide medical records to HMO upon its request in order to determine appropriateness of coding. Provider may dispute any temporarily suspended or adjusted payment consistent with the terms of the Agreement.

3.14 Physician Incentive Plans. In the event Provider participates in a physician incentive plan ("PIP") under the Agreement, Provider agrees that such PIPs must comply with 42 CFR 417.479, 42 CFR 438.3(i), 42 CFR 422.208, and 42 CFR 422.210, as may be amended from time to time. Neither HMO nor Provider may make a specific payment directly or indirectly under a PIP to a physician or physician group as an inducement to reduce or limit Medically Necessary services furnished to an individual Covered Person. PIPs must not contain provisions that provide incentives, monetary or otherwise, for the withholding of services that meet the definition of Medical Necessity.

3.15 Lobbying. Provider agrees to comply with the following requirements related to lobbying:

i) Prohibition on Use of Federal Funds for Lobbying: By signing the Agreement, Provider certifies to the best of Provider's knowledge and belief, pursuant to 31 U.S.C. Section 1352 and 45 CFR Part 93, as may be amended from time to time, that no federally appropriated funds have been paid or will be paid to any person by or on Provider's behalf for the purpose of influencing or attempting to influence an officer or employee of any agency, a member of Congress, an officer or employee of Congress, or an employee of a member of Congress in connection with the award of any federal contract, the making of any federal grant, the making of any federal loan, the entering into of any cooperative agreement, or the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan, or cooperative agreement.

ii) Disclosure Form to Report Lobbying: If any funds other than federally appropriated funds have been paid or will be paid to any person for the purpose of influencing or attempting to influence an officer or employee of any agency, a member of Congress, an officer or employee of Congress, or an employee of a member of Congress in connection with the award of any federal contract, the making of any federal grant, the

making of any federal loan, the entering into of any cooperative agreement, or the extension, continuation, renewal, amendment or modification of any federal contract, grant, loan, or cooperative agreement and the value of the Agreement exceeds $100,000, Provider shall complete and submit Standard Form-LLL, "Disclosure Form to Report Lobbying," in accordance with its instructions.

3.16 Excluded Individuals and Entities. Provider certifies that neither it nor any of its employees, principals, nor any providers, subcontractors or consultants or persons with an ownership or controlling interest in the Provider (an owner including the Provider himself or herself), or an agent or managing employee of the Provider, with whom Provider contracts and who are providing items or services that are significant and material to Provider's obligations under the Agreement is:

i) excluded from participation in federal health care programs under either Section 1128 or section 1128A of the Social Security Act; or

ii) debarred, suspended or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in nonprocurement activities under regulations issued under Executive Order no. 12549 or under guidelines implementing Executive Order No. 12549; or an affiliate, as defined in the Federal Acquisition Regulation, of such a person.

Provider acknowledges and agrees that payment will not be made for any items or Covered Services provided by an excluded individual pursuant to 42 CFR 1001.1901(b) and is obligated to screen all employees, contractors, and subcontractors for exclusion as required under applicable State and Federal laws. Additionally, Provider acknowledges that pursuant to 42 CFR 1003.102(a)(2) civil monetary penalties may be imposed against Provider if he or she employs or enters into contracts with excluded individuals or entities to provide items or Covered Services to Covered Persons under this Agreement. Provider agrees not to employ or subcontract with individuals or entities whose owner, those with a controlling interest, or managing employees are on a State or Federal exclusion list to provide items or Covered Services under this Agreement. Provider shall immediately report to HMO any exclusion information discovered. Provider can search the HHS-OIG website, at no cost, by the names of any individuals or entities. The database is called LEIE and can be accessed at http://www.oig.hhs.gov/fraud/exclusions.asp. The GSA EPLS/SAM database can be accessed at https://www.sam.gov. Federal and State exclusion databases must be reviewed monthly to ensure that no employee or contractor has been excluded. Applicable state exclusion databases can be accessed through the State's Medicaid website. HMO will terminate the Agreement immediately and exclude from its network any provider who has been excluded from federal health care programs or terminated from the Medicare or the Medicaid program in any state. HMO may also terminate the Agreement if Provider or Provider's owners, agents, or managing employees are found to be excluded on a State or Federal exclusion list.

3.17 Disclosure. Provider must be screened and enrolled in the State's Medicaid program and submit disclosures to the DOM related to ownership and control, significant business transactions, and persons convicted of crimes in accordance with 42 CFR Part 455 .Provider must submit information related to ownership and control of subcontractors or

wholly owned suppliers within thirty-five (35) calendar days of a request for such information in accordance with 42 CFR 455.105. Additionally, Provider must cooperate with DOM for submission of fingerprints upon a request from DOM or CMS in accordance with 42 CFR 455.434.

By executing this Agreement, Provider certifies that neither Provider nor any of its principals is presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in any State or federal health care program or from participating in transactions by any State or federal department or agency. HMO will terminate the Agreement upon becoming aware or receiving notice from DOM, whichever is earlier, that Provider is or has been excluded from participation in any State or federal health care program or by any State or federal agency.

3.18 Cultural Competency and Access. Provider shall participate in HMO's and the State's efforts to promote the delivery of services in a culturally competent manner to all Covered Persons, including those with limited English proficiency, physical or mental disabilities, diverse cultural and ethnic backgrounds and regardless of gender, sexual orientation or gender identity, and shall provide interpreter services in a Covered Person's primary language and for the hearing impaired for all appointments and emergency services. Provider shall provide information to Covered Persons regarding treatment options and alternatives, as well as information on complaints and appeals, in a manner appropriate to the Covered Person's condition and ability to understand. Provider shall provide physical access, reasonable accommodations, and accessible equipment for Covered Persons with physical or mental disabilities.

3.19 Marketing. As required under State or federal law or the applicable State Contract, any marketing materials developed and distributed by Provider as related to the performance of the Agreement must be submitted to HMO at least sixty (60) days prior to planned distribution for timely submission to DOM for prior approval. Provider agrees it will not proceed with the statement or communication until the required approval is obtained.

3.20 Fraud, Waste and Abuse Prevention. Provider shall cooperate fully with HMO's policies and procedures designed to protect program integrity and prevent and detect potential or suspected fraud, waste, and abuse in the administration and delivery of services under the State Contract and shall cooperate and assist DOM and any other State or federal agency charged with the duty of preventing, identifying, investigating, sanctioning or prosecuting suspected fraud, waste, and abuse in state and/or federal health care programs.

In accordance with HMO's policies and the Deficit Reduction Act of 2005 (DRA), Provider shall have written policies for its employees, contractors or agents that: (a) provide detailed information about the federal False Claims Act (established under sections 3729 through 3733 of title 31, United States Code), including if any entity makes or receives annual payments under the State Program of at least $5,000,000, such entity must establish certain minimum written policies and information communicated through an employee handbook relating to the Federal False Claims Act in accordance with 42 CFR 438.600; (b) cite administrative remedies for false claims and statements (established under chapter 38 of title 31, United States Code) and whistleblower protections under federal and state laws; (c) reference state laws pertaining to civil or criminal penalties for false claims

and statements; and (d) with respect to the role of such laws in preventing and detecting fraud, waste, and abuse in federal health care programs (as defined in section 1128B(f)), include as part of such written policies, detailed provisions regarding Provider's policies and procedures for detecting and preventing fraud, waste, and abuse. Provider agrees to train its staff on the aforesaid policies and procedures.

3.21 Data; Reports. Provider shall cooperate with and release to HMO any information necessary for HMO to perform its obligations under the State Contract to the extent applicable to Provider in performance of the Agreement, including the timely submission of reports and information required by HMO, in the format specified by HMO and the State. Such reports shall include child health check-up reporting, if applicable, as well as complete and accurate encounter data in accordance with the requirements of HMO and the State. Data must be provided at the frequency and level of detail specified by HMO or the State. By submitting data to HMO, Provider represents and attests to HMO and the State that the data is accurate, complete and truthful, and upon HMO's request Provider shall certify in writing, that the data is accurate, complete, and truthful, based on Provider's best knowledge, information and belief.

Provider shall be able to receive, maintain and utilize applicable data extracts from HMO or DOM and systematically update its database within five (5) calendar days of receipt of the files. Data extract files include but are not limited to the following, as applicable: 1. Daily Active Provider Extract; 2. Weekly Provider Affiliation Details Extract; 3. 834 Enrollment Files; 4. 835 Claims Payment Remittance Advice Transaction; 5. 277 Claims Acknowledgement; 6. NCPDP Formulary; 7. NCPDP Response File; 8. TPL Resource/Policy Information File, etc.; 9. Claims History Extracts; and 10. Prior Authorization Extracts.

3.22 Encounter Data. Provider agrees to cooperate with HMO to comply with HMO's obligation to prepare encounter data submissions, reports, and clinical information including, without limitation, child and adolescent health check-up reporting, EPSDT encounters, and cancer screening encounters, as applicable, and such other reporting regarding Covered Services as may be required under the State Contract. Encounter data must be accurate and include all services furnished to a Covered Person, including capitated provider's data and rendering provider information. Encounter data must be provided within the timeframes specified and in a form that meets HMO and State requirements. By submitting encounter data to HMO, Provider represents to HMO that the data is accurate, complete and truthful, and upon HMO's request Provider shall certify in writing, that the data is accurate, complete, and truthful, based on Provider's best knowledge, information and belief.

3.23 Claims Information. Provider shall promptly submit to HMO the information needed to make payment and shall identify third party liability coverage, including Medicare and other insurance, and if applicable seek such third party liability payment before submitting claims to HMO. Provider understands and agrees that each claim Provider submits to HMO constitutes a certification that the claim is true and accurate to the best of Provider's knowledge and belief and that the Covered Services are 1) Medically Necessary and 2) have been provided to the Covered Person prior to submitting the claim.

Effective July 1, 2014, Provider must submit claims within six (6) months from the date of service. Claims filed within the appropriate time frame but denied may be resubmitted to the Contractor within ninety (90) calendar days from the date of denial

3.24. Electronic Visit Verification. Provider shall cooperate with State requirements for electronic visit verification for personal care services and home health services, as applicable.

3.25 Licensure. Provider represents that it is currently licensed and/or certified under applicable State and federal statutes and regulations and by the appropriate State licensing body or standard-setting agency, as applicable. Provider represents that it is in compliance with all applicable State and federal statutory and regulatory requirements of the Medicaid program and that it is eligible to participate in the Medicaid program. Provider represents that it does not have a Medicaid provider agreement with DOM that is terminated, suspended, denied, or not renewed as a result of any action of DOM, CMS, HHS, or the Medicaid Fraud Control Unit of the State's Attorney General. Provider shall maintain at all times throughout the term of the Agreement all necessary licenses, certifications, registrations and permits as are required to provide the health care services and/or other related activities delegated to Provider by HMO under the Agreement. If at any time during the term of the Agreement, Provider is not properly licensed as described in this Section, Provider shall discontinue providing services to Covered Persons. As applicable, if Provider performs any laboratory tests on human specimens for the purpose of diagnosis and/or treatment, Provider agrees to acquire and maintain the appropriate CLIA certification or waiver for the type of laboratory testing performed. Provider further agrees to provide a copy of the certification if requested by HMO. A State authorized license or permit that meets the CLIA requirements may be substituted for the CLIA certificate pursuant to State law. Medicare and Medicaid programs require the applicable CLIA certification or waiver for the type of services performed as a condition of payment. Provider must include the appropriate CLIA certificate or waiver number on claims submitted for payment for laboratory services.

3.26 Quality; Utilization Management. Pursuant to any applicable provider manuals and related protocols, or as elsewhere specified under the Agreement, Provider agrees to cooperate with HMO's quality improvement and utilization review and management activities. This shall include, but not be limited to, participation in any internal and external quality assurance, utilization review, peer review, and grievance procedures established by HMO or as required under the State Contract to ensure that Covered Persons have due process for their complaints, grievances, appeals, fair hearings or requests for external review of adverse decisions made by HMO or Provider. Provider shall adhere to the quality assurance and utilization review standards of the MississippiCAN Program and shall monitor quality and initiate corrective action to improve quality consistent with the generally accepted level of care.

3.27 Non-Discrimination. Provider will not discriminate against, nor use any policy or practice that has the effect of discriminating against, Covered Persons on the basis of race, color, creed, sex, religion, age, national origin, ancestry, marital status, sexual orientation, gender identity, language, health status, disease or pre-existing condition (including genetic

information), anticipated need for health care or physical or mental handicap, except where medically indicated. Examples of prohibited practices include, but are not limited to, the following:

i) Denying or not providing a Covered Person any Medicaid Covered Service. Health care and treatment necessary to preserve life must be provided to all Covered Persons who are not terminally ill or permanently unconscious, except where a competent Covered Person objects to such care on his/her own behalf.

ii) Subjecting a Covered Person to segregated, separate, or different treatment, including a different place or time from that provided to other Covered Persons or public or private patients, in any manner related to the receipt of any Medicaid Covered Service, except where Medically Necessary.

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

3.28 Advance Directives. Provider shall comply with the advance directives requirements set forth in the Uniform Health-Care Decisions Act, Section 41-41-215 of the Mississippi Code. When applicable, Provider shall comply with the advance directives requirements for hospitals, nursing facilities, providers of home and health care and personal care services, hospices, and HMOs as specified in 42 CFR Part 49, subpart I, 42 CFR § 417.436(d), 42 CFR § 422.128, and 42 CFR 438.3(i).

3.29 National Provider ID (NPI). Provider shall obtain a National Provider Identification Number (NPI) and when filing claims with HMO, the NPI used is the same NPI used when filing claims with DOM.

3.30 Termination. In the event of termination of the Agreement, Provider shall promptly supply to HMO all information necessary for the reimbursement of any outstanding Medicaid claims.

3.31 Complaints; Grievances and Appeals. Information on how Provider or Provider's authorized representative can submit complaints and file grievances and appeals, and the resolution process, is contained in the applicable provider manual.

3.32 Health Care Acquired/Preventable Conditions. Provider agrees that no payment shall be made for the provision of medical assistance for health care acquired conditions and other provider preventable conditions as may be identified by the State. As a condition of payment, Provider shall identify and report to HMO any provider preventable conditions in accordance with 42 CFR §§ 434.6(a)(12), 438 including but not limited to 438.3(g), and 447.26.

3.33 Quality and Utilization Management Program. Provider shall cooperate with HMO in meeting the Quality Management and Utilization Management Program standards outlined

in the State Contract including, without limitation, any external evaluations and assessments of HMO's performance authorized by DOM under the State Contract and conducted by DOM's contracted External Quality Review Organization (EQRO) or other designee.

3.34 Referrals. Provider shall make referrals for social, vocational, education or human services when a need for such service is identified.

3.35 Insolvency. In the event HMO becomes insolvent or unable to pay Provider, Provider shall not seek compensation for services rendered from the State, DOM, their officers, Agents, or employees, or the Covered Persons or their eligible dependents.

3.36 Third Party Resources. Provider will report all third party resources to HMO identified through the provision of medical services.

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

3.38 Capitated Providers. If Provider is capitated and terminates its agreement with HMO, for any reason, Provider will provide services to Covered Persons assigned to Provider up to the end of the month in which the effective date of termination falls.

3.39 Certification on Relationship to State, DOM and CMS. Provider certifies that no officer, director, employee, subcontractor or agent of Provider, or person with an ownership or control interest in Provider, is also employed by, or is a public official of, the State of Mississippi or any of its agencies, DOM or CMS.

3.40 Funding. Provider recognizes that the obligation of DOM to proceed under its Contract with HMO is conditioned upon the appropriation of funds by the Mississippi State

Legislature and the receipt of State and/or Federal funds. If the funds anticipated for the continuing fulfillment of the agreement are, at any time, not forthcoming or insufficient, either through the failure of the Federal government to provide or the State of Mississippi to appropriate funds, or the discontinuance, or material alteration of the program under which the funds were provided or if funds are not otherwise available to DOM, DOM has the right upon ten (10) working days written notice to HMO to terminate the Contract.

3.41 Gratuities. Provider represents that it has not violated, is not violating, and promises that it will not violate the prohibitions against gratuities set forth in Section 6-204 (Gratuities) of the Mississippi Personal Service Contract Procurement Regulations.

3.42 Assignment/Delegation. Provider shall not assign or delegate the Agreement without the express written consent of HMO or DOM. If Provider subcontracts or delegates any functions of the Agreement, in accordance with the terms of the Agreement and with the express written consent of HMO or DOM, the subcontract or delegation must be in writing and include all of the requirements of this Appendix, and applicable requirements of the State Contract, and applicable laws and regulations. The transfer of five percent (5%) or more of the beneficial ownership in Provider at any time during the term of this Agreement shall be deemed an assignment under this Agreement.

3.43 Notice of Legal Action. Immediately upon obtaining knowledge or receiving notice of any legal action or notice listed below, Provider shall provide to HMO written notice of such legal action or notice and, upon request by HMO, a complete copy of all filings and other documents generated in connection with any such legal action:

i. Any action, suit or counterclaim filed against Provider;

ii. Any regulatory action, or proposed action, respecting Provider's business or operations;

iii. Any notice received by Provider from the Department of Insurance or the State Health Officer;

iv. The filing of a petition in bankruptcy by or against Provider, or the insolvency of Provider;

v. The conviction of any person who has an ownership or control interest in Provider, or who is an agent or managing employee of Provider, of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or Title XX of the Social Security Act; or

vi. A malpractice action against any Provider delivering service under an agreement.

3.44 Federal and State Funds Liability. Providers acknowledges and agrees that payments made to Provider for services provided under the Agreement are derived from federal and State funds and that any false claim or statement in documents or any concealment of material fact related to such services may be a cause for sanctions and prosecution under applicable federal and State laws. Provider shall be subject to all laws applicable to

individuals and entities receiving State and federal funds and may be held civilly or criminally liable to both HMO and DOM in the event of nonperformance, misrepresentation, fraud, or abuse related to services provided pursuant to the State Contract. Provider recognizes that payments made to the Provider are derived from federal and State funds, and are contingent upon and subject to availability and receipt of funds.

3.45 Insurance Requirements. As applicable, Provider shall secure and maintain during the term of the Agreement insurance appropriate to the services to be performed under the Agreement. Provider shall require that its providers secure and maintain during the term of the Agreement general liability insurance, professional liability insurance, and workers' compensation insurance for all employees connected with the provision of services under the Agreement. Such workers compensation insurance shall comply with Mississippi Workers' Compensation Laws. Such comprehensive general liability insurance and professional liability insurance shall provide coverage in an amount established by HMO pursuant to the Agreement or as required under the State Contract.

3.46 Overpayment. Provider shall to report to HMO when it has received an overpayment and will return the overpayment to HMO within 60 calendar days after the date on which the overpayment was identified. Provider will notify HMO in writing of the reason for the overpayment.

SECTION 4
ADDITIONAL PROVIDER REQUIREMENTS FOR SPECIFIC ACTIVITIES

4.1 Behavioral Health Providers. Behavioral Health Providers shall ensure that all Covered Persons receiving inpatient psychiatric services are scheduled for outpatient follow-up and/or continuing treatment prior to discharge from the inpatient psychiatric hospital if the Provider is aware of the Covered Person's inpatient hospitalization status. Behavioral Health Providers will be provided daily reports identifying Covered Persons known to be admitted to an inpatient facility. Behavioral Health Services will be delivered in compliance with the requirements of 42 CFR 438 subpart K insofar as those requirements are applicable.

4.2 PCP Responsibilities. Providers acting as PCPs shall meet the following requirements:

i) PCPs who serve Covered Persons under the age of twenty-one (21) are responsible for conducting all EPSDT screens for individuals on their Panel under the age of twenty-one (21). Should the PCP be unable to conduct the necessary EPSDT screens, the PCP is responsible for arranging to have the necessary EPSDT screens conducted by another network Provider and ensure that all relevant medical information, including the results of the EPSDT screens, are incorporated into the Covered Person's PCP Medical Record.

ii) PCPs who serve Members under the age of twenty-one (21) report encounter data associated with EPSDT screens, using a format approved by DOM, to the Contractor within ninety (90) calendar days from the date of service.

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

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

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

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

4.3 Specialists as PCPs. Covered Persons with disabling conditions, chronic illnesses, or child(ren) with special health care needs may request that their PCP be a specialist. The designation of a specialist as a PCP must be pursuant to a treatment plan approved by HMO, in consultation with the PCP to which the Covered Person is currently assigned, the Covered Person and, as appropriate, the specialist.

The specialist as a PCP shall provide or arrange for all primary care, including routine preventive care, and to provide those specialty medical services consistent with the Covered Person's disabling condition, chronic illness, or special health care need in accordance with HMO's standards and within the scope of the specialty training and clinical expertise.

The specialist as a PCP shall have admitting privileges at a hospital in HMO's network.

4.4 Long-Term Services and Supports (LTSS) Providers. Any LTSS Covered Services under the State Contract that could be authorized through a waiver under section 1915(c) of the Social Security Act (the "Act") or a State Program amendment authorized through sections 1915(i) or 1915(k) of the Act must be delivered in settings consistent with 42 CFR 441.301(c)(4).

SECTION 5
HMO REQUIREMENTS

5.1 Prompt Payment. HMO shall pay Provider pursuant to the State Contract and applicable State and federal law and regulations, including but not limited to Mississippi Code Section 83-9-5, 42 CFR 447.46, 42 CFR 447.45(d)(2), 42 CFR 447.45(d)(3), 42 CFR 447.45(d)(5) and 42 CFR 447.45(d)(6), as applicable and as may be amended from time to time. If a third party liability exists, payment of claims shall be determined in accordance with federal and/or State third party liability law and the terms of the State Contract. Unless HMO otherwise requests assistance from Provider, HMO will be responsible for third party collections in accordance with the terms of the State Contract.

5.2 No Incentives to Limit Medically Necessary Services. HMO shall not structure compensation provided to individuals or entities that conduct utilization management and concurrent review activities so as to provide incentives for the individual or entity to deny, limit, or discontinue Medically Necessary services to any Covered Person.

5.3 Provider Discrimination Prohibition. HMO shall not discriminate with respect to participation, reimbursement, or indemnification of a provider who is acting within the scope of the provider's license or certification under applicable State law, solely on the basis of such license or certification. HMO shall not discriminate against Provider for serving high-risk Covered Persons or if Provider specializes in conditions requiring costly treatments. This provision shall not be construed as prohibiting HMO from limiting a provider's participation to the extent necessary to meet the needs of Covered Persons. This provision also is not intended and shall not interfere with measures established by HMO that are designed to maintain quality of care practice standards and control costs.

5.4 Communications with Covered Persons. Covered Persons are entitled to the full range of their Providers' opinions and counsel about the availability of Medically Necessary Services under the provisions of the State Contract. Any contractual provisions, including gag clauses or rules, that restrict a Provider's ability to advise Covered Persons about Medically Necessary treatment options violate federal law and regulations.

HMO shall not prohibit or otherwise restrict Provider, when acting within the lawful scope of practice, from advising or advocating on behalf of a Covered Person for the following:

i) The Covered Person's health status, medical care, or treatment options, including any alternative treatment that may be self-administered;

ii) Any information the Covered Person needs in order to decide among all relevant treatment options;

iii) The risks, benefits, and consequences of treatment or non-treatment;

iv) The Covered Person's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions; or

v) Information regarding the nature of treatment options including those that may not reflect HMO's position or may not be covered by HMO.

HMO also shall not prohibit a Provider from advocating on behalf of a Covered Person in any grievance system, utilization review process, or individual authorization process to obtain necessary health care services.

5.5 Termination, Revocation and Sanctions. In addition to its termination rights under the Agreement, HMO shall have the right to revoke any functions or activities HMO delegates to Provider under the Agreement or impose other sanctions consistent with the State Contract if in HMO's reasonable judgment Provider's performance under the Agreement is inadequate. HMO shall also have the right to suspend, deny, refuse to renew or terminate

Provider in accordance with the terms of the State Contract and applicable law and regulation. However, HMO shall not exclude or terminate a Provider from participation in HMO's Provider Network due to the fact that the Provider has a practice that includes a substantial number of patients with expensive medical conditions, and shall not terminate a Provider for filing a Complaint, Grievance, or Appeal on a Covered Person's behalf.

5.6 Rights of DOM. DOM shall have the right to invoke against Provider any remedy set forth in the State Contract, including the right to require the termination of the Agreement, for each and every reason for which it may invoke such a remedy against HMO or require termination of the State Contract. Suspected Fraud and Abuse by Provider will be investigated by DOM.

SECTION 6
OTHER REQUIREMENTS

6.1 Compliance with State Contract. All tasks performed under the Agreement shall be performed in accordance with the requirements of the applicable State Contract, as set forth in this Appendix, applicable provider manuals, and protocols, policies and procedures that HMO has provided or delivered to Provider. The applicable provisions of the State Contract are incorporated into the Agreement by reference. Nothing in the Agreement relieves HMO of its responsibility under the State Contract. If any provision of the Agreement is in conflict with provisions of the State Contract, the terms of the State Contract shall control and the terms of the Agreement in conflict with those of the State Contract will be considered waived.

6.2 Monitoring. HMO shall perform ongoing monitoring (announced or unannounced) of services rendered by Provider under the Agreement and shall perform periodic formal reviews of Provider according to a schedule established by the State, consistent with industry standards or State managed care organization laws and regulations or requirements under the State Contract. As a result of such monitoring activities, HMO shall identify to Provider any deficiencies or areas for improvement mandated under the State Contract and Provider and HMO shall take appropriate corrective action. Provider shall comply with any corrective action plan initiated by HMO and/or required by the MississippiCAN Program. In addition, Provider shall monitor and report the quality of services delivered under the Agreement and initiate a plan of correction where necessary to improve quality of care, in accordance with that level of care which is recognized as acceptable professional practice in the respective community in which HMO and Provider practice and/or the performance standards established under the State Contract.

6.3 Enrollment. The parties acknowledge and agree that DOM is responsible for enrollment, reenrollment and disenrollment of Covered Persons.

6.4 No Exclusivity. Nothing in the Agreement or this Appendix shall be construed as prohibiting or penalizing Provider for contracting with a managed care organization other than HMO or as prohibiting or penalizing HMO for contracting with other providers. HMO may not require Providers who agree to participate in the MississippiCAN Program to contract with HMO's other lines of business.

6.5 **Delegation.** The parties agree that, prior to execution of the Agreement, HMO evaluated Provider's ability to perform any duties delegated to Provider under the Agreement. Any delegated duties and reporting responsibilities shall be set forth in the Agreement or other written delegation agreement or addendum between the parties. HMO shall have the right to revoke any functions or activities HMO delegates to Provider under the Agreement if in HMO's reasonable judgment Provider's performance under the Agreement is inadequate.

MississippiCHIP
Regulatory Requirements Appendix

MississipiCHIP

REGULATORY REQUIREMENTS APPENDIX

PROVIDER

THIS MISSISSIPPICHIP PROGRAM REGULATORY REQUIREMENTS APPENDIX (this "Appendix") supplements and is made part of the provider agreement (the "Agreement") between HMO contracting on behalf of itself and the other entities that are its affiliates (collectively, "CCO") and the party named in the Agreement ("Provider").

SECTION 1
APPLICABILITY

This Appendix applies with respect to the provision of direct or health care related services provided by Provider under the Mississippi Children's Health Insurance Program (the "MississippiCHIP Program") as governed by the State's designated regulatory agencies. In the event of a conflict between this Appendix and other appendices or any provision of the Agreement, the provisions of this Appendix shall control except with regard to benefit plans outside the scope of this Appendix or unless otherwise required by law. In the event CCO is required to amend or supplement this Appendix as required or requested by the State to comply with federal or State regulations, CCO will unilaterally initiate such additions, deletions or modifications. All provider agreements must be in writing and must include all specific activities and report responsibilities delegated to the Provider by CCO.

SECTION 2
DEFINITIONS

Unless otherwise defined in this Appendix, all capitalized terms shall be as defined in the Agreement. For purposes of this Appendix, the following terms shall have the meanings set forth below; provided, however, in the event any definition set forth in this Appendix or the Agreement is inconsistent with any definition under the MississippiCHIP Program Contract, the definition shall have the meaning set forth under the MississippiCHIP Program Contract.

2.1 **Abuse:** Any practice that is inconsistent with sound fiscal, business, or medical practices, and results in an unnecessary cost to CHIP, CCO, a subcontractor, or a provider or in reimbursement for services that are not Medically Necessary or that fail to meet professionally recognized standards for healthcare.

2.2 **Adverse Benefit Determination:** The denial or limited authorization of a requested service, including determinations on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit; the reduction, suspension, or termination of previously authorized services; the denial, in whole or in part, of payment for a service; CCO's failure to provide services in a timely manner; CCO's failure to resolve Complaints, Grievances, or Appeals within the specified time frames; for residents in a rural area with only one MCO, the denial of a Covered Person's request to exercise his or her right, under 42 C.F.R. §438.52(b)(2)(ii); the denial of a Covered Person's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other enrollee financial liabilities; and determinations by skilled nursing facilities and nursing facilities to transfer or discharge residents and adverse determinations made by a State with regard to the preadmission

screening and annual resident review requirements of Section 1919(e)(7) of the Act, if applicable.

2.3 **Agreement:** An agreement between the CCO and an individual, business, university, government entity, affiliate, or nonprofit organization to perform part or all of CCO's responsibilities under the MississippiCHIP Program Contract. Agreements must be approved in writing by DOM prior to the start date of the Agreement.

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

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

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

2.7 **Benchmark Plan:** The State School Employee's Health Insurance Plan.

2.8 **Child:** An individual who is under nineteen (19) years of age who is not eligible for Medicaid benefits and is not covered by other health insurance. Child is also referred to as Member.

2.9 **CHIP:** The Children's Health Insurance Program as defined in Title XXI of the Social Security Act.

2.10 **Complaint:** An expression of dissatisfaction received orally or in writing that is of a less serious or formal nature that is resolved within one (1) business day of receipt.

2.11 **Coordinated Care Organization (CCO):** An organization that meets the requirements for participation as a Contractor in CHIP and manages the purchase and provision of health care services under CHIP. For purposes of this Appendix, CCO is a CCO.

2.12 **Co-Payment:** The fixed amount certain CHIP Members pay for a covered health care service. The amount may vary based on healthcare service being provided.

2.13 **Cost Sharing:** In accordance with 42 C.F.R. §457.10, premium charges, enrollment fees, deductibles, coinsurance, Co-Payments, or other similar fees that the Member has responsibility for paying.

2.14 **Covered Services:** Health care services or products for which a Member is enrolled with CCO to receive coverage under the MississippiCHIP Program Contract, including all services required by the State Contract and State and federal law.

2.15 Disenrollment: Action taken by DOM, or its Agent, to remove a Member's name from the monthly Member Listing Report following DOM's receipt and approval of a request for Disenrollment or a determination that the Member is no longer eligible for Enrollment in Contractor.

2.16 DOM: The Division of Medicaid, Office of the Governor, State of Mississippi.

2.17 Fraud: Fraud is any type of intentional deception or misrepresentation made by an entity or person with the knowledge that the deception could result in some unauthorized benefit to the entity, him or herself, or some other person. The Fraud can be committed by many entities, including a vendor, a subcontractor, a provider, a State employee, or a Member among others.

2.18 Grievance: An expression of dissatisfaction about any matter or aspect of CCO or its operation, other than an Adverse Benefit Determination as defined herein. Grievances may include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the Covered Person's rights regardless of whether remedial action is requested. Grievance includes a Covered Person's right to dispute an extension of time proposed by CCO to make an authorization decision.

2.19 Marketing: The activities that promote visibility and awareness for the MississippiCHIP Program and the CCOs participating in the program. All marketing activities are subject to prior review and approval by DOM and may not contain misleading information.

2.20 Medical Record: A single complete record, which documents the entire treatment plan developed for, and medical services received by, the Member including inpatient, outpatient, referral services and emergency medical services whether provided by Contracted Providers or Non-Contracted Providers.

2.21 Member: An individual who meets all of the eligibility requirements for CHIP, enrolls in a CCO under CHIP, and receives health benefits coverage through CHIP.

2.22 MississippiCHIP Program: The Mississippi Medicaid child health program for select individuals under the age of nineteen (19) years of age who are not eligible for Medicaid benefits and are not covered by other health insurances.

2.23 MississippiCHIP Program Contract: The DOM contract with CCO, for the purpose of providing and paying for Covered Services to Members enrolled in the MississippiCHIP Program.

2.24 Primary Care Provider (PCP): Any physician or health care practitioner or group operating within the scope of his or her licensure who is responsible for supervising, prescribing and providing primary care and primary case management services in the MississippiCHIP Program, whose practice is limited to the general practice of medicine or who is an Internist, Pediatrician, Obstetrician/Gynecologist, Family and General Practitioner, Nurse Practitioners (who meet requirements of Section 4.B, Choice of a Health Care Professional), Physician Assistants, specialists who perform primary care functions upon request, and other providers approved by DOM.

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

2.26 Provider Network: The Panel of health service Providers with which the CCO contracts for the provision of covered services to Members and Non-Contracted Providers administering services to Member.

2.27 State: The State of Mississippi or its designated regulatory agencies.

2.28 State Child Health Plan: The State of Mississippi's plan submitted to HHS for the administration of CHIP.

2.29 Third Party Liability/Resource: Any resource available to a Member for the payment of medical expenses associated with the provision of covered services, including but not limited to, insurers and workers' compensation plan.

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

2.31 Well-Baby and Well-Child Care Services: Regular or preventive diagnostic and treatment services necessary to ensure the health of babies, children, and adolescents as defined by DOM in the State Child Health Plan. For the purposes of Cost Sharing, the term has the meaning assigned at 42 C.F.R. § 457.520.

SECTION 3
PROVIDER REQUIREMENTS

The MississippiCHIP Program, through contractual requirements and federal and State statutes and regulations, requires that providers who provide services to Members enrolled in the MississippiCHIP Program comply with certain requirements as set forth below and elsewhere in this Appendix.

3.1 Definitions Related to the Provision of Covered Services. Provider shall follow the applicable MississippiCHIP Program Contract's requirements for the provision of Covered Services. Provider's decisions affecting the delivery of acute or chronic care services to Members shall be made on an individualized basis and in accordance with the following definitions:

i) Emergency Medical Condition: In accordance with Section 1932(b) of the Act and 42 CFR §457.10, a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in any of the following: (1) 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; (2) serious impairment to body functions; or (3) serious dysfunction of any body organ or part.

ii) Emergency Services: Covered inpatient and outpatient services, inclusive of dialysis services, furnished by a provider who is qualified to furnish those health services and that

are needed to evaluate or stabilize an Emergency Medical Condition in accordance with 42 CFR 438.114.

iii) Medically Necessary Services: As set forth in the Social Security Act, Section 1905 (42 U.S.C. 1396d(a)), Medically Necessary Services are defined as services, supplies, or equipment provided by a licensed health care professional that are:

a) Appropriate and consistent with the diagnosis or treatment of the patient's condition, illness, or injury;

b) In accordance with the standards of good medical practice consistent with the individual patient's condition(s);

c) Not primarily for the personal comfort or convenience of the Member, family, or Provider;

d) The most appropriate services, supplies, equipment, or levels of care that can be safely and efficiently provided to the Member;

e) Furnished in a setting appropriate to the patient's medical need and condition and, when applied to the care of an inpatient, further mean that the Member's medical symptoms or conditions require that the services cannot be safely provided to the Member as an outpatient;

f) Not experimental or investigational or for research or education;

g) Provided by an appropriatelylicensed practitioner; and

h) Documented in the patient's record in a reasonable manner, including the relationship of the diagnosis to the service.

Medically Necessary Services may also be those services for children that are necessary to correct or ameliorate defects and physical and mental illnesses and conditions discovered during an interperiodic or Well-Baby and Well-Child Care Services, whether such services are covered or exceed the benefit limits in the Medicaid State Plan and Title 23 of Mississippi Administrative Code.

3.2 Accessibility Standards. Provider shall provide for timely access for Member appointments in accordance with the appointment availability requirements established under the MississippiCHIP Program Contract, as further described in the applicable provider manual.

Type	Appointment Scheduling Time Frames
PCP (well care visit)	Not to exceed thirty (30) calendar days
PCP (routine sick visit)	Not to exceed seven (7) calendar days
PCP (urgent care visit)	Not to exceed twenty-four (24) hours
Specialists	Not to exceed forty-five (45) calendar days

Dental Providers (routine visits)	Not to exceed forty-five (45) calendar days
Dental Providers (urgent Care)	Not to exceed forty-eight (48) hours
Behavioral Health Providers (routine visit)	Not to exceed fourteen (14) calendar days
Behavioral Health Providers (urgent visit)	Not to exceed twenty-four (24) hours
Behavioral Health Providers (post-discharge from an acute psychiatric hospital when the Contractor is aware of the	Not to exceed seven (7) calendar days
Urgent Care Providers	Not to exceed twenty-four (24) hours
Emergency Providers	Immediately (twenty-four (24) hours a day, seven (7) days a week) and without Prior

3.3 Hours of Operation; Appointments. Provider shall offer hours of operation that are no less than the hours of operation offered to commercial beneficiaries. As applicable, Provider will make Covered Services available 24 hours a day, 7 days a week when medically necessary.

3.4 PCP Responsibilities. If applicable, and Provider is a PCP, Provider shall comply with the following:

i) PCPs who serve Members under the age of nineteen (19) are responsible for conducting all Well-Baby and Well-Child Care services. Should the PCP be unable to conduct the necessary Well-Baby and Well-Child Care services screens, the PCP is responsible for arranging to have the necessary Well-Baby and Well-Child Care services screens conducted by another network provider and ensure that all relevant medical information, including the results of the Well-Baby and Well-Child Care services screens, are incorporated into the Member's PCP Medical Record.

ii) PCPs who serve Members under the age of nineteen (19) report encounter data associated with Well-Baby and Well-Child Care services, using a format approved by DOM, to Contractor within one hundred and eighty (180) calendar days from the date of service.

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

a) Contact Members identified in the quarterly Encounter lists as not complying with Well-Baby, Well-Child Care, and immunization schedules for Children;

b) Identify to Contractor any such Members who have not come into compliance with Well-Baby, Well-Child Care, and immunization schedules within one (1) month of such notification to the site by Contractor; and

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

iv) PCP shall provide Well-Baby and Well-Child Care Services, including vision screening, laboratory

tests and hearing screenings, according to recommendations of the U.S. Preventive Services Task Force. Vision and hearing screenings shall be included as part of periodic Well-Child assessments. PCP shall have written policies and procedures related to the provision of the full-range of Well-Baby Care, Well-Child Care, and childhood and adolescent immunization services as defined in, and in accordance with, the State Child Health Plan, 42 C.F.R. §457.495, and this provisions of the MississippiCHIP Program Contract. Services shall include, without limitation, 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). PCP shall make all reasonable efforts to identify all Members whose Medical Records do not indicate up-to-date immunizations and shall ensure that these Members receive necessary immunizations. Immunizations are purchased and distributed through the Mississippi State Department of Health. CCO shall reimburse PCP for the administration of the immunizations.

CCO requires that PCP cooperate to the maximum extent possible with the efforts to improve the health status of Mississippi citizens, and to actively work to improve the percentage of Members receiving appropriate screenings, and meet or exceed DOM's targets.

a) The following minimum elements must be included in the periodic health screening assessment of children:

i. Comprehensive health and development history (including assessment of both physical and mental development);

ii. Measurements (e.g. head circumference for infants, height, weight, body mass index);

iii. Comprehensive unclothed physical examination;

iv. Immunizations appropriate to age and health history;

v. Assessment of nutritional status;

vi. Laboratory tests (including tuberculosis screening and Federally required blood lead screenings);

vii. Vision screening;

viii. Hearing screening;

ix. Dental and oral health assessment; and

x. Developmental and behavioral assessment.

v) If a suspected problem is detected by a screening examination, the child must be evaluated as necessary for further diagnosis. This diagnosis is used to determine treatment needs. PCP must establish a tracking system that provides information on compliance with Well-Baby and Well-Child Care services and immunization services provision requirements in the following areas:

a) Initial visit for newborns;

b) Well-Baby and Well-Child Care services and reporting of all assessment results; and

c) Diagnosis and/or treatment for Children.

vi) PCP must have an established process for reminders, follow-ups and outreach to Members that includes:

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

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

c) Protocols for conducting outreach with non-compliant Members, including home visits, as appropriate; and

d) A process for outreach and follow-up to Members with special health care needs.

vii) PCP may develop an alternate process for follow-up and outreach subject to prior written approval from CCO and DOM.

viii) **Specialists as PCPs**. Members with disabling conditions, chronic conditions, or with special health care needs may request that their PCP be a specialist. The designation of a specialist as a PCP must be pursuant to a treatment plan approved by Contractor; in consultation with the PCP to which the Member is currently assigned, the Member and, as appropriate, the specialist. When possible, the specialist must be a provider participating in Contractor's network. The specialist as a PCP must agree to provide or arrange for all primary care, including routine preventive care, and to provide those specialty medical services consistent with the Member's disabling condition, chronic illness, or special health care need in accordance with Contractor's standards and within the scope of the specialty training and clinical expertise. To accommodate the full spectrum of care, the specialist as a PCP must also have admitting privileges at a hospital in Contractor's network.

3.5 Provider Selection. To the extent applicable to Provider in performance under the Agreement, Provider shall comply with 42 CFR §438.214, as may be amended from time to time, which includes, but is not limited to the selection and retention of providers, credentialing and re-credentialing requirements and nondiscrimination. If CCO delegates credentialing to Provider, CCO will provide monitoring and oversight and Provider shall ensure that all licensed medical professionals are credentialed in accordance with CCO's and the MississippiCHIP Program Contract's credentialing requirements.

3.6 Records Retention. As required under State or federal law or the MississippiCHIP Program Contract, Provider shall maintain a record keeping system of current, detailed, and organized records for recording services, charges, dates and all other commonly accepted information elements sufficient to disclose the quality, quantity, appropriateness and timeliness of services rendered to Members. All financial records shall follow generally accepted accounting principles. Medical records and supporting management systems shall include all pertinent information related to the medical management of each Member. Other records shall be maintained as necessary to clearly reflect all actions taken by Provider related to services provided under the MississippiCHIP Program Contract. Such records, including, as applicable, grievance and appeals records shall be maintained for a period of not less than ten (10) years from the close of the Agreement, or such other period as required by law. If records are under review or audit or are the subject of litigation they must be retained for a minimum of ten (10) years following resolution of such action. Prior approval for the disposal of records must be requested and approved by CCO if the Agreement is continuous. Provider shall have written records retention policies and procedures and will make such policies and procedures available to CCO or DOM upon request. DOM requires ready access to any and all documents and records of transactions pertaining to the provisions of services provided by Provider and those copies of requested documents/records will be provided to DOM or its designee free of charge.

3.7 **Records Access.** Provider agrees to cooperate with CCO to maintain and share a health record of all services provided to a Covered Person, as appropriate and in accordance with applicable laws, regulations and professional standards. Provider acknowledges and agrees and shall require Provider to acknowledge and agree that DOM, the U.S. Department of Health and Human Services and other authorized federal and state personnel shall have complete access to all records pertaining to services provided to Members. Provider shall provide immediate access to facilities, records and supportive materials pertinent to the MississippiCHIP Program Contract for State or Federal fraud investigators.

3.8 **Government Audit; Investigations.** Provider acknowledges and agrees and shall require Provider to acknowledge and agree that the State or any of its duly authorized representatives, DOM, the U.S. Department of Health and Human Services, the Centers for Medicare & Medicaid Services, the Office of Inspector General, the General Accounting Office, or any other auditing agency or their authorized representatives and their designees, with prior approval by DOM, at any time during the term of the Agreement, shall, at all reasonable time and within regular business hours, with or without notice, have the right to inspect, audit or otherwise evaluate the quality, appropriateness, and timeliness of services provided under the terms of the MississippiCHIP Program Contract and any other applicable federal and State law and regulation.

This shall include, but not be limited to, the right to enter onto Provider's premises, access to and the right to audit, inspect, monitor, and examine any pertinent books, documents, papers, medical records, financial records, surveys and computer databases and/or to otherwise evaluate the performance of Provider related to Provider's performance under the Agreement. Such monitoring activities may also include, without limitation, on-site inspections of all service locations and facilities; auditing and/or review of all records developed under the MississippiCHIP Program Contract or the Agreement; reviewing management systems and procedures developed under the MississippiCHIP Program Contract or the Agreement; and review of any other areas of materials relevant or pertaining to the MississippiCHIP Program Contract or the Agreement. All reviews and audits shall be performed in such a manner as will not unduly delay the work of Provider. There will be no restrictions on the right of the State or federal authorities to conduct inspections and audits as necessary.

The Provider must fully cooperate with any and all reviews and/or audits by state or federal agencies, such as the Department of Audit, Department of Health and Human Services, Centers for Medicare and Medicaid Services, Office of Inspector General, General Accounting Office, or any other auditing agency approved by DOM, by assuring that appropriate employees and involved parties are available for interviews relating to the reviews or audits.

All records shall be maintained and available for review by authorized federal and state agencies during the entire term of the MississippiCHIP Program Contract and for a period of ten (10) years thereafter, unless an audit, litigation, or other legal action is in progress. When an audit or litigation is in progress or audit findings are unresolved, records shall be kept for a period of ten (10) years or until all issues are finally resolved, whichever is later. The Provider must have written policies and procedures for storing this information. Records must be kept in an original paper state or preserved on micro media or electronic format.

3.9 **Data; Reports.** Provider shall and shall require that Provider cooperate with and release to CCO any information necessary for CCO to perform its obligations under the MississippiCHIP Program Contract to the extent applicable to Provider in performance of the Agreement, including the timely submission of reports and information required by CCO, in the format specified by CCO and the State. Such reports shall include well-baby/well-child reporting, as well as complete and accurate encounter and utilization management data in accordance with the requirements of CCO and DOM. Data must be provided at the frequency and level of detail specified by CCO or the State. By submitting data to CCO, Provider represents and attests to CCO and the State that the data is accurate, complete and truthful, and upon

CCO's request Provider shall certify in writing, that the data is accurate, complete, and truthful, based on Provider's best knowledge, information and belief.

Provider shall be able to receive, maintain and utilize applicable data extracts from CCO or DOM and systematically update its database within five (5) calendar days of receipt of the files. Data extract files include but are not limited to the following, as applicable: 1. Daily Active Provider Extract; 2. Weekly Provider Affiliation Details Extract; 3. 834 Enrollment Files; 4. 835 Claims Payment Remittance Advice Transaction; 5. 277 Claims Acknowledgement; 6. NCPDP Formulary; 7. NCPDP Response File; 8. TPL Resource/Policy Information File, etc.; 9. Claims History Extracts; and 10. Prior Authorization Extracts.

3.10 Encounter Data. Provider shall agree to cooperate with CCO to comply with CCO's obligation to prepare encounter data submissions, reports, and clinical information including, without limitation, and well-baby/well-child reporting and encounters, as applicable, and such other reporting regarding Covered Services as may be required under the MississippiCHIP Program Contract. Encounter data must be accurate and include all services furnished to a Covered Person, including capitated provider's data and rendering provider information. Encounter data must be provided within the timeframes specified and in a form that meets CCO and State requirements. By submitting encounter data to CCO, Provider represents to CCO that the data is accurate, complete and truthful, and upon CCO's request Provider shall certify in writing, that the data is accurate, complete, and truthful, based on Provider's best knowledge, information and belief.

3.11 Claims Information. Provider shall promptly submit to CCO the information needed to make payment and shall identify third party liability coverage, including Medicare and other insurance, and if applicable seek such third party liability payment before submitting claims to CCO. Provider understands and agrees that each claim Provider submits to CCO constitutes a certification that the claim is true and accurate to the best of Provider's knowledge and belief and that the Covered Services are 1) Medically Necessary and 2) have been provided to the Member prior to submitting the claim.

Provider must submit claims within six (6) months from the date of service. Claims filed within the appropriate time frame but denied may be resubmitted to CCO within ninety (90) calendar days from the date of denial.

3.12 Third Party Resources. Provider shall report all Third Party Resources to CCO identified through the provision of medical services.

3.13 Privacy; HIPAA. Provider shall comply with all applicable privacy rule and security rule provisions of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), and associated implementing regulations, as may be amended from time to time, and shall safeguard information about Members in accordance with applicable federal and State privacy laws and rules including 42 CFR §438.224 and 42 CFR Part 431, Subpart F, as may be amended from time to time. Provider agrees that confidential information, including but not limited to, medical and other pertinent information relative to Members, shall not be disclosed to any person or organization for any purpose without the expressed, written authority of DOM or as otherwise required by law and that all such disclosures shall fully comply with HIPAA privacy and security standards.

3.14 Cultural Competency and Access. Provider shall participate in CCO's and DOM's efforts to

promote the delivery of services in a culturally competent manner to all Members, including those with limited English proficiency, physical or mental disabilities, diverse cultural and ethnic backgrounds and regardless of gender, sexual orientation or gender identity, and shall provide interpreter services in a Member's primary language and for the hearing impaired for all appointments and emergency services. Provider shall provide information to Members regarding treatment options and alternatives, as well as information on complaints and appeals, in a manner appropriate to the Member's condition and ability to understand. Provider shall provide physical access, reasonable accommodations, and accessible equipment for Covered Persons with physical or mental disabilities.

3.15 Approval of Marketing Materials. As required under State or federal law or the applicable MississippiCHIP Program Contract, any marketing materials developed and distributed by Provider as related to the performance of the Agreement must be submitted to CCO at least sixty (60) days prior to planned distribution for timely submission to DOM for prior approval. Provider agrees it will not proceed with the statement or communication until the required approval is obtained.

3.16 Independent Contractor Relationship. Provider expressly agrees that Provider is acting in an independent capacity in the performance of the Agreement and not as an officer, agent or employee of DOM, CMS or the State. Provider further expressly agrees that the Agreement shall not be construed as a partnership or joint venture between Provider and DOM, CMS or the State. Nothing in the Agreement shall be construed, nor shall it be deemed to create, any right or remedy in any third party.

3.17 Certification on Relationship to State, DOM and CMS. Provider certifies that no officer, director, employee, subcontractor or agent of Provider, or person with an ownership or control interest in Provider, is also employed by, or is a public official of, the State of Mississippi or any of its agencies, DOM or CMS.

3.18 Ownership and Control Information. If applicable, Provider shall cooperate with CCO in obtaining and providing information to DOM related to ownership and control, significant business transactions, and persons convicted of a criminal offense in compliance with§1128 of the Social Security Act, 42 USC §1320a-7 and 42 CFR Part 455, as amended and shall provide information upon request. Provider shall submit information related to ownership and control of subcontractors or wholly owned supplier within thirty-five (35) calendar days of a request for such information.

By executing the Agreement, Provider certifies that neither Provider nor any of its principals is presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in any State or federal health care program or from participating in transactions by any State or federal department or agency. CCO will terminate the Agreement upon becoming aware or receiving notice from DOM, whichever is earlier, that Provider is or has been excluded from participation in any State or federal health care program or by any State or federal agency.

3.19 Excluded Individuals and Entities. Provider certifies that neither it nor any of its employees, principals, nor any providers, subcontractors or consultants or persons with an ownership or controlling interest in the Provider (an owner including the Provider himself or herself), or an agent or managing employee of the Provider, with whom Provider contracts and who are providing items or services that are significant and material to Provider's obligations under the

Agreement is:

i) excluded from participation in federal health care programs under either Section 1128 or section 1128A of the Social Security Act; or

ii) debarred, suspended, proposed for debarment, declared ineligible, or otherwise voluntarily excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549; or an affiliate, as defined in the Federal Acquisition Regulation, of such a person.

Provider acknowledges and agrees and shall require that Provider acknowledge and agree that payment will not be made for any items or Covered Services provided by an excluded individual pursuant to 42 CFR §1001.1901(b) and is obligated to screen all employees, contractors, and subcontractors for exclusion as required under applicable State and Federal laws. Additionally, Provider acknowledges that pursuant to 42 CFR §1003.102(a)(2) civil monetary penalties may be imposed against Provider if he or she employs or enters into contracts with excluded individuals or entities to provide items or Covered Services to Member under the Agreement. Provider agrees not to employ or subcontract with individuals or entities whose owner, those with a controlling interest, or managing employees are on a State or Federal exclusion list to provide items or Covered Services under the Agreement. Provider shall immediately report to CCO any exclusion information discovered. Provider can search the HHS-OIG website, at no cost, by the names of any individuals or entities. The database is called LEIE and can be accessed at http://www.oig.hhs.gov/fraud/exclusions.asp. The GSA EPLS/SAM database can be accessed at https://www.sam.gov. Federal and State exclusion databases must be reviewed monthly to ensure that no employee or contractor has been excluded. Applicable state exclusion databases can be accessed through the State's Medicaid website. CCO will terminate the Agreement immediately upon becoming aware or receiving notice from DOM, whichever is earlier, that Provider's owners, agents, managing employees, or any provider is or has been excluded from federal health care programs or terminated from the Medicare or the Medicaid program in any state.

3.20 Licensure. Provider represents that it is currently licensed and/or certified under applicable State and federal statutes and regulations and by the appropriate State licensing body or standard-setting agency, as applicable. Provider represents that it does not have a Medicaid provider agreement with DOM that is terminated, suspended, denied, or not renewed as a result of any action of DOM, CMS, HHS, or the Medicaid Fraud Control Unit of the State's Attorney General. Provider shall maintain at all times throughout the term of the Agreement all necessary licenses, certifications, registrations and permits as are required to provide the health care services and/or other related activities delegated to Provider by CCO under the Agreement. If at any time during the term of the Agreement, Provider is not properly licensed as described in this Section, Provider shall discontinue providing services to Members.

3.21 National Provider ID (NPI). If applicable, Provider shall and shall require that Providers obtain a National Provider Identification Number (NPI) and when filing claims with Provider, the NPI number used is the same NPI number used when filing claims with DOM.

3.22 Funding. Provider recognizes that the obligation of DOM to proceed under its MississippiCHIP Program Contract with CCO is conditioned upon the appropriation of funds by the Mississippi

State Legislature and the receipt of State and/or Federal funds. If the funds anticipated for the continuing fulfillment of the agreement are, at any time, not forthcoming or insufficient, either through the failure of the Federal government to provide or the State of Mississippi to appropriate funds, or the discontinuance, or material alteration of the program under which the funds were provided or if funds are not otherwise available to DOM, DOM has the right upon ten (10) working days written notice to CCO to terminate the MississippiCHIP Program Contract.

3.23 Federal and State Funds Liability. Providers acknowledges and agrees that payments made to Provider for services provided under the Agreement are derived from federal and State funds and that any false claim or statement in documents or any concealment of material fact related to such services may be a cause for sanctions and prosecution under applicable federal and State laws. Provider shall be subject to all laws applicable to individuals and entities receiving State and federal funds and may be held civilly or criminally liable to both CCO and DOM in the event of nonperformance, misrepresentation, fraud, or abuse related to services provided pursuant to the MississippiCHIP Program Contract. Provider recognizes that payments made to the Provider are derived from federal and State funds, and are contingent upon and subject to availability and receipt of funds.

3.24 Insolvency. In the event CCO becomes insolvent or unable to pay Provider, Provider shall not seek compensation for services rendered from DOM, its officers, Agents, or employees, or the Members or their eligible dependents.

3.25 Termination. In the event of termination of the Agreement, Provider shall promptly supply to CCO all information necessary for the reimbursement of any outstanding MississippiCHIP Program claims.

3.26 Capitated Providers. If a Provider that is capitated terminates its agreement with CCO, for any reason, Provider will provide services to Members assigned to Provider up to the end of the month in which the effective date of termination falls.

3.27 Fraud, Waste, and Abuse Prevention. Provider shall cooperate fully with the CCO's policies and procedures designed to protect program integrity and prevent and detect potential or suspected fraud, waste, and abuse in the administration and delivery of services under the MississippiCHIP Program Contract and shall cooperate and assist DOM and any other State or federal agency charged with the duty of preventing, identifying, investigating, sanctioning or prosecuting suspected fraud, waste, and abuse in state and/or federal health care programs. Provider and CCO are responsible for reporting suspected fraud and abuse by participating and non-participating providers, as well as Members, when detected.

In accordance with CCO's policies and the Deficit Reduction Act of 2005 (DRA), Provider shall have written policies for its employees, contractors or agents that: (a) provide detailed information about the federal False Claims Act (established under sections 3729 through 3733 of title 31, United States Code), including if any entity makes or receives annual payments under the State Program of at least $5,000,000, such entity must establish certain minimum written policies and information communicated through an employee handbook relating to the Federal False Claims Act in accordance with 42 CFR 438.600; (b) cite administrative remedies for false claims and statements (established under chapter 38 of title 31, United States Code) and whistleblower protections under federal and state laws; (c) reference state laws pertaining to civil or criminal penalties for false

claims and statements; and (d) with respect to the role of such laws in preventing and detecting fraud, waste, and abuse in federal health care programs (as defined in section 1128B(f)), include as part of such written policies, detailed provisions regarding Provider's policies and procedures for detecting and preventing fraud, waste, and abuse. Provider agrees to train its staff on the aforesaid policies and procedures.

3.28 Quality Utilization Management. Pursuant to any applicable provider manuals and related protocols, or as elsewhere specified under the Agreement, Provider agrees to cooperate with CCO's quality improvement and utilization review and management activities. This shall include, but not be limited to, participation in any internal and external quality assurance, utilization review, peer review, and grievance procedures established by CCO or as required under the MississippiCHIP Program Contract to ensure that Members have due process for their complaints, grievances, appeals, fair hearings or requests for external review of adverse decisions made by CCO or Provider. Provider shall adhere to the quality assurance and utilization review standards of the MississippiCHIP Program and shall monitor quality and initiate corrective action to improve quality consistent with the generally accepted level of care.

3.29 Quality and Utilization Management Program. Provider shall cooperate with CCO in meeting the Quality Management and Utilization Management Program standards outlined in the MississippiCHIP Program Contract.

3.30 Referrals. Provider shall make referrals for social, vocational, education or human services when a need for such service is identified.

3.31 Restrictions on Referrals. Provider shall not make inappropriate referrals for designated health services to health care entities with which Provider or a member of Provider's family has a financial relationship, pursuant to federal anti-kickback and physician self-referral laws that prohibit such referrals.

3.32 Complaints, Grievances and Appeals. Information on how Provider or Provider's authorized representative shall submit complaints and file grievances and appeals, and the resolution process, is contained in the CCO MississippiCHIP Provider Manual.

3.33 Health Care Acquired/Preventable Conditions. Provider agrees that no payment shall be made for the provision of medical assistance for health care acquired conditions and other provider preventable conditions as may be identified by the State. As a condition of payment, Provider shall identify and report to CCO any provider preventable conditions in accordance with 42 CFR §§ 434.6(a)(12), 438 including but not limited to 438.3(g), and 447.26.

3.34 Compliance with Laws. Provider shall comply with all applicable federal and State laws and regulations and all provisions of the MississippiCHIP Program Contract that pertain to a Member's rights, including but not limited to the following, to the extent applicable to Provider in performance of the Agreement:

i) Title VI of the Civil Rights Act of 1964; (b) Title XIX of the Social Security Act; Title IX of the Education Amendments of1972 (regarding education programs and activities); the Age Discrimination Act of 1975; the Rehabilitation Act of 1973; and The Genetic Information Non-Discrimination Act of 2008 (GINA); the Americans with Disabilities Act;

section 1557 of the Patient Protection and Affordable Care Act, and their implementing regulations, as may be amended from time to time.

ii) All federal and State professional and facility licensing and accreditation requirements/standards that apply to the services Provider perform pursuant to the Agreement, including but not limited to:

a) All applicable standards, orders or requirements issued under Section 306 of the Clean Air Act (42 USC 1857 (h)). Section 508 of the Clean Water Act (33 USC 1368), Executive Order 11738, and Environmental Protection Agency (EPA) regulations (40) CFR Part 15), which prohibit the use of facilities included on the EPA list of violating facilities. Any violations must be reported to DSHS, DHHS, and the EPA;

b) Any applicable mandatory standards and policies relating to energy efficiency that are contained in the State Energy Conservation Plan, including the Energy Policy & conservation Act (Pub. L. 94-165), and issued in compliance with the Federal Energy Policy & Conservation Act.

iii) All relevant federal and State statutes, regulations and orders related to equal opportunity in employment, including but not limited to compliance with E.O. 11246, "Equal Employment Opportunity," as amended by E.O. 11375, "Amending Executive Order 11246 Relating to Equal Employment Opportunity," and as supplemented by regulations at 41 CFR Part 60, "Office of Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor."

iv) If the Agreement is for an amount in excess of $100,000, Provider shall comply with all applicable standards, orders or regulations issued pursuant to the Clean Air Act, 42 U.S.C. 7401 et seq., and the Federal Water Pollution Control Act, as amended, 33 U.S.C. 1251 et seq. Any violations shall be reported to DHHS and the appropriate Regional Office of the Environmental Protection Agency.

v) Those specified for laboratory services in the Clinical Laboratory Improvement Amendments (CLIA). All laboratory service sites must have a CLIA certificate of registration or waiver, and a CLIA identification number.

vi) The American with Disabilities Act (ADA). Provider shall make reasonable accommodation for Members with disabilities in accord with the ADA for all Covered Services and shall assure physical and communication barriers do not inhibit Members with disabilities from obtaining Covered Services;

vii) Section 1128B(d)(1) of the Balanced Budget Act of 1997; and,

viii) Any other requirements associated with the receipt of federal funds.

ix) All Medicaid laws, regulations and program instructions to the extent applicable to Provider in Provider's performance of the Agreement. Provider understands that payment of a claim by CCO or the State is conditioned upon the claim and the underlying transaction complying with such laws, regulations, and program instructions (including, but not limited

to, federal requirements on fraud, waste and abuse, disclosure, debarment, termination and exclusion screening), and is conditioned on the Provider's compliance with all applicable conditions of participation in Medicaid. Provider understands and agrees that each claim the Provider submits to CCO constitutes a certification that the Provider has complied with all applicable Medicaid laws, regulations and program instructions in connection with such claims and the services provided therein. Provider's payment of a claim will be denied if Provider is terminated or excluded from participation in federal healthcare programs. Provider's payment of a claim may be temporarily suspended if the State or CCO provides notice that a credible allegation of fraud exists and there is a pending investigation. Provider's payment of a claim may also be temporarily suspended or adjusted if the Provider bills a claim with a code that does not match the service provided. CCO performs coding edit procedures based primarily on National Correct Coding Initiative (NCCI) policies and other nationally recognized and validated policies. Provider agrees that it will provide medical records to CCO upon its request in order to determine appropriateness of coding. Provider may dispute any temporarily suspended or adjusted payment consistent with the terms of the Agreement.

3.35 Non-Discrimination. Provider will not discriminate against, nor use any policy or practice that has the effect of discriminating against, Covered Persons on the basis of race, color, creed, sex, religion, age, national origin, ancestry, marital status, sexual orientation, gender identity, language, health status, disease or pre-existing condition (including genetic information), anticipated need for health care or physical or mental handicap, except where medically indicated. Examples of prohibited practices include, but are not limited to, the following:

i) Denying or not providing a Member any MississippiCHIP Covered Service. Health care and treatment necessary to preserve life must be provided to all Members who are not terminally ill or permanently unconscious, except where a competent Member objects to such care on his/her own behalf.

ii) Subjecting a Member to segregated, separate, or different treatment, including a different place or time from that provided to other Members or public or private patients, in any manner related to the receipt of any MississippiCHIP Covered Service, except where Medically Necessary.

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

3.36 Advance Directives. Provider shall comply with the advance directives requirements with 42 C.F.R §422.128 and with the Uniform Health-Care Decisions Act (Miss. Code Ann. § 41-41-201, *et. seq*.). When applicable, Provider shall comply with the advance directives requirements for hospitals, nursing facilities, providers of home and health care and personal care services, hospices, and HMOs as specified in 42 CFR Part 49, subpart I, 42 CFR § 417.436(d), 42 CFR § 422.128, and 42 CFR 438.3(i).

3.37 Physician Incentive Plans. In the event Provider participates in a physician incentive plan

("PIP") under the Agreement, Provider agrees that such PIPs must comply with 42 CFR § 417.479, 42 CFR § 438.3, 42 CFR § 422.208, and 42 CFR § 422.210, as may be amended from time to time. CCO or Provider may not make a specific payment directly or indirectly under a PIP to a physician or physician group as an inducement to reduce or limit Medically Necessary services furnished to an individual Member. PIPs must not contain provisions that provide incentives, monetary or otherwise, for the withholding of services that meet the definition of Medical Necessity. Provider shall disclose annually to CCO any PIP arrangement Provider may have with any physicians even if there is not substantial financial risk between CCO and such physicians.

3.38 Lobbying. Provider agrees to comply with the following requirements related to lobbying:

i) Prohibition on Use of Federal Funds for Lobbying: By signing the Agreement, Provider certifies to the best of Provider's knowledge and belief, pursuant to 31 U.S.C. § 1352 and 45 CFR Part 93, as may be amended from time to time, that no federally appropriated funds have been paid or will be paid to any person by or on Provider's behalf for the purpose of influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the award of any federal contract, the making of any federal grant, the making of any federal loan, the entering into of any cooperative agreement, or the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan, or cooperative agreement.

ii) Disclosure Form to Report Lobbying: If any funds other than federally appropriated funds have been paid or will be paid to any person for the purpose of influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the award of any federal contract, the making of any federal grant, the making of any federal loan, the entering into of any cooperative agreement, or the extension, continuation, renewal, amendment or modification of any federal contract, grant, loan, or cooperative agreement and the value of the Agreement exceeds $100,000, Provider shall complete and submit Standard Form-LLL, "Disclosure Form to Report Lobbying," in accordance with its instructions.

iii) Contractor shall abide by lobbying laws of the State of Mississippi.

3.39 Gratuities. Provider represents that it has not violated, is not violating, and promises that it will not violate the prohibitions against gratuities set forth in Section 6-204 (Gratuities) of the Mississippi Personal Service Contract Procurement Regulations.

3.40 Compliance with Mississippi Employment Protection Act (MEPA). Represents and warrants and shall require that Provider represent and warrant that it will ensure its compliance with the Mississippi Employment Protection Act, Section 71-11-1 et set of the Mississippi Code Annotated (Supp. 2008), and will register and participate in the status verification system for all newly hired employees. The term "employee" as used herein means any person that is hired to perform work within the State of Mississippi. As used herein, "status verification system" means the Illegal Immigration Reform and Immigration Responsibility Act of 1996 that is operated by the United States Department of Homeland Security, also known as the E-Verify Program, or any other

successor electronic verification system replacing the E-Verify Program. Provider agrees and shall require that Provider agree to maintain records of such compliance and, upon request of the State and approval of the Social Security Administration or Department of Homeland Security, where required, to provide a copy of each such verification to the State. Provider represents and warrants that any person assigned to perform services hereunder meets the employment eligibility requirements of all immigration laws of the State of Mississippi. Provider acknowledges and agrees that any breach of these warranties may subject Provider to the following: (a) termination of the Agreement and ineligibility for any state or public contract in Mississippi for up to three (3) years, with notice of such cancellation/termination being made public, or (b) the loss of any license, permit, certification or other document granted to Provider by an agency, department or governmental entity for the right to do business in Mississippi for up to one (1) year, or (c) both.

3.41 Insurance Requirements. As applicable, Provider shall and shall require that Provider secure and maintain during the term of the Agreement general liability insurance, professional liability insurance, and workers' compensation insurance for all employees connected with the provision of services under the Agreement. Such workers compensation insurance shall comply with Mississippi Workers' Compensation Laws. Such comprehensive general liability insurance and professional liability insurance shall provide coverage in an amount established by CCO pursuant to the Agreement or as required under the MississippiCHIP Program Contract.

3.42 Indemnification. To the extent applicable to Provider in performance under the Agreement, Provider shall indemnify, defend, protect, save and hold DOM and its employees and Members harmless from and against all injuries, deaths, losses, damages, claims, suits, demands, actions, recovery, liabilities, judgments, costs and expenses, including without limitation, court costs, investigative fees and expenses, and attorney fees, to the extent proximately caused by any negligent act or other intentional misconduct or omission of Provider, its agents, officers, employees or contractors arising from the Agreement. DOM may waive this requirement for public entities if Provider is a state agency or sub-unit as defined by the State or a public health entity with statutory immunity. This clause shall survive the termination of the Agreement for any reason, including breach due to insolvency.

3.43 Notice of Legal Action. Immediately upon obtaining knowledge or receiving notice of any legal action or notice listed below, Provider shall provide to CCO written notice of such legal action or notice and, upon request by CCO, a complete copy of all filings and other documents generated in connection with any such legal action:

i) Any action, suit or counterclaim filed against Provider;

ii) Any regulatory action, or proposed action, respecting Provider's business or operations;

iii) Any notice received by Provider from the Department of Insurance or the State Health Officer;

iv) The filing of a petition in bankruptcy by or against Provider, or the insolvency of Provider;

v) The conviction of any person who has an ownership or control interest in Provider, or who is an agent or managing employee of Provider, of a criminal offense related to that person's

involvement in any program under Medicare, Medicaid, or Title XX of the Social Security Act; or

vi) A malpractice action against any Provider delivering service under an agreement.

3.44 Hold Harmless. Except for any applicable cost-sharing requirements under the MississippiCHIP Program Contract, Provider shall look solely to CCO for payment of Covered Services provided to Members pursuant to the Agreement and the MississippiCHIP Program Contract and hold DOM, the State, the U.S. Department of Health and Human Services and Members harmless in the event that CCO cannot or will not pay for such Covered Services. In accordance with 42 CFR § 447.15, as may be amended from time to time, the Member is not liable to Provider for any services for which CCO is liable and as specified under the State's relevant health insurance or managed care statutes, rules or administrative agency guidance. Provider shall not require any copayment or cost sharing for Covered Services provided under the Agreement unless expressly permitted under the MississippiCHIP Program Contract. Provider shall also be prohibited from charging Members for missed appointments if such practice is prohibited under the MississippiCHIP Program Contract or applicable law. Neither the State, DOM, nor Member shall be in any manner liable for the debts and obligations of CCO and under no circumstances shall CCO, or any providers used to deliver services covered under the terms of the MississippiCHIP Program Contract, charge Members for Covered Services.

3.45 Assignment/Delegation. Provider shall not assign or delegate the Agreement without the express written consent of CCO or DOM. If Provider subcontracts or delegates any functions of the Agreement, in accordance with the terms of the Agreement and with the express written consent of CCO or DOM, the subcontract or delegation must be in writing and include all of the requirements of this Appendix, and applicable requirements of the State Contract, and applicable laws and regulations. The transfer of five percent (5%) or more of the beneficial ownership in Provider at any time during the term of this Agreement shall be deemed an assignment under this Agreement.

3.46 Behavioral Health Providers. Behavioral Health Providers shall ensure that all Covered Persons receiving inpatient psychiatric services are scheduled for outpatient follow-up and/or continuing treatment prior to discharge from the inpatient psychiatric hospital if the Provider is aware of the Covered Person's inpatient hospitalization status. Behavioral Health Providers will be provided daily reports identifying Covered Persons known to be admitted to an inpatient facility. Behavioral Health Services will be delivered in compliance with the requirements of 42 CFR 438 subpart K insofar as those requirements are applicable.

3.47 Provider Eligibility. Provider must be enrolled in the Mississippi CHIP program and must use the same National Provider Identifier (NPI) number to participate in CCO's Network. Upon notification from the State that Provider's enrollment has been denied or terminated, CCO must terminate Provider immediately and will notify affected Covered Persons that Provider is no longer participating in the network. CCO will exclude from its network any provider who has been terminated or suspended from the Medicare, Medicaid or CHIP program in any state.

3.48 Disclosure. Provider must be screened and enrolled in the State's CHIP program and submit disclosures to the DOM related to ownership and control, significant business transactions, and persons convicted of crimes in accordance with 42 CFR Part 455 .Provider must submit information related to ownership and control of subcontractors or wholly owned suppliers within thirty-five (35)

calendar days of a request for such information in accordance with 42 CFR 455.105. Additionally, Provider must cooperate with DOM for submission of fingerprints upon a request from DOM or CMS in accordance with 42 CFR 455.434.

3.49 Electronic Visit Verification. Provider shall cooperate with State requirements for electronic visit verification for personal care services and home health services, as applicable.

3.50 Clinical Laboratory Improvements Act (CLIA) Certification or Waiver. As applicable, if Provider performs any laboratory tests on human specimens for the purpose of diagnosis and/or treatment, Provider agrees to acquire and maintain the appropriate CLIA certification or waiver for the type of laboratory testing performed. Provider further agrees to provide a copy of the certification if requested by CCO. A State authorized license or permit that meets the CLIA requirements may be substituted for the CLIA certificate pursuant to State law. Medicare and Medicaid programs require the applicable CLIA certification or waiver for the type of services performed as a condition of payment. Provider must include the appropriate CLIA certificate or waiver number on claims submitted for payment for laboratory services.

3.51 Overpayment. Provider shall to report to CCO when it has received an overpayment and will return the overpayment to CCO within 60 calendar days after the date on which the overpayment was identified. Provider will notify CCO in writing of the reason for the overpayment.

SECTION 4
CCO REQUIREMENTS

4.1 Communications with Members. Members are entitled to the full range of their Providers' opinions and counsel about the availability of Medically Necessary Services under the provisions of the MississippiCHIP Program Contract. Any contractual provisions, including gag clauses or rules, that restrict a Provider's ability to advise Members about Medically Necessary treatment options violate federal law and regulations. CCO shall not prohibit or otherwise restrict Provider, when acting within the lawful scope of practice, from advising or advocating on behalf of a Member for the following:

i) The Member’s health status, medical care, or treatment options, including any alternative treatment that may be self-administered;

ii) Any information the Member needs in order to decide among all relevant treatment options;

iii) The risks, benefits, and consequences of treatment or non-treatment;

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

v) Information regarding the nature of treatment options including those that may not reflect CCO’s position or may not be covered by CCO.

CCO shall not prohibit a Provider from advocating on behalf of a Member in any grievance system,

utilization review process, or individual authorization process to obtain necessary health care services.

4.2 Prompt Payment. CCO shall pay Provider pursuant to the MississippiCHIP Program Contract and applicable State and federal law and regulations, including but not limited to Miss. Code Ann. §83-9-5, 42 CFR §447.46, 42 CFR §447.45(d)(2), 42 CFR §447.45(d)(3), 42 CFR §447.45(d)(5) and 42 CFR §447.45(d)(6), as applicable and as may be amended from time to time. If a third party liability exists, payment of claims shall be determined in accordance with federal and/or State third party liability law and the terms of the MississippiCHIP Program Contract. Unless CCO otherwise requests assistance from Provider, CCO will be responsible for third party collections in accordance with the terms of the MississippiCHIP Program Contract.

4.3 No Incentives to Limit Medically Necessary Services. CCO shall not structure compensation provided to individuals or entities that conduct utilization management and concurrent review activities so as to provide incentives for the individual or entity to deny, limit, or discontinue Medically Necessary services to any Member.

4.4 Provider Discrimination Prohibition. CCO shall not discriminate with respect to participation, reimbursement, or indemnification of a provider who is acting within the scope of the provider's license or certification under applicable State law, solely on the basis of such license or certification. CCO shall not discriminate against Provider for serving high-risk Members or if Provider specializes in conditions requiring costly treatments. This provision shall not be construed as prohibiting CCO from limiting a provider's participation to the extent necessary to meet the needs of Members. This provision also is not intended and shall not interfere with measures established by CCO that are designed to maintain quality of care practice standards and control costs. CCO shall not provide false or misleading information to any person or entity in an attempt to recruit Providers for CCO's network.

4.5 Termination, Revocation and Sanctions. In addition to its termination rights under the Agreement, CCO shall have the right to revoke any functions or activities CCO delegates to Provider under the Agreement or impose other sanctions consistent with the MississippiCHIP Program Contract if in CCO's reasonable judgment Provider's performance under the Agreement is inadequate. CCO shall also have the right to suspend, deny, refuse to renew or terminate the subcontract in accordance with the terms of the MississippiCHIP Program Contract and applicable law and regulation. However, CCO shall not exclude or terminate a Provider from participation in CCO's Provider Network due to the fact that the Provider has a practice that includes a substantial number of patients with expensive medical conditions, and shall not terminate a Provider for filing a Complaint, Grievance, or Appeal on a Member's behalf.

SECTION 5
OTHER REQUIREMENTS

5.1 Compliance with MississippiCHIP Program Contract. All tasks performed under the Agreement shall be performed in accordance with the requirements of the MississippiCHIP Program Contract, as applicable, as set forth in this Appendix, applicable provider manuals, and protocols, policies and procedures that CCO has provided or delivered to Provider. The applicable provisions of the MississippiCHIP Program Contract are incorporated into the Agreement by reference. Nothing in the Agreement or this Appendix relieves CCO of its responsibility under the

MississippiCHIP Program Contract. If any provision of the Agreement is in conflict with provisions of the MississippiCHIP Program Contract, the terms of the MississippiCHIP Program Contract shall control and the terms of the Agreement in conflict with those of the MississippiCHIP Program Contract will be considered waived.

5.2 Monitoring. In accordance with 42CFR § 457.950, CCO shall perform ongoing monitoring (announced or unannounced) of services rendered by Provider under the Agreement and shall perform periodic formal reviews of Provider according to a schedule established by the State, consistent with industry standards or State managed care organization laws and regulations or requirements under the MississippiCHIP Program Contract. As a result of such monitoring activities, and/or as a result of the inspecting, auditing and monitoring activities of DOM or other authorities pursuant to section 4.4 above, CCO shall identify to Provider any deficiencies or areas for improvement mandated under the MississippiCHIP Program Contract and Provider and CCO shall take appropriate corrective action within the relevant timeframe permitted, as applicable. Provider shall comply with any corrective action plan initiated by CCO and/or required by the MississippiCHIP Program. In addition, Provider shall monitor and report the quality of services delivered under the Agreement and initiate a plan of correction where necessary to improve quality of care, in accordance with that level of care which is recognized as acceptable professional practice in the respective community in which CCO and Provider practice and/or the performance standards established under the MississippiCHIP Program Contract.

5.3 Enrollment. The parties acknowledge and agree that DOM is responsible for enrollment, reenrollment and disenrollment of Members.

5.4 No Exclusivity. Nothing in the Agreement or this Appendix shall be construed as prohibiting or penalizing Provider for contracting with a managed care organization other than CCO or as prohibiting or penalizing CCO for contracting with other providers. The CCO may not require Providers who agree to participate in the MississippiCHIP Program to contract with the Contractor's other lines of business.

5.5 Revoking Delegation. The parties agree that, prior to execution of the Agreement, CCO evaluated Provider's ability to perform any duties delegated to Provider under the Agreement. Any delegated duties and reporting responsibilities shall be set forth in the Agreement or other written delegation agreement or addendum between the parties. In addition to its termination rights under the Agreement, CCO shall have the right to revoke any functions, assignment authority, or activities CCO delegates to Provider under the Agreement or impose other sanctions if in CCO's reasonable judgment Provider's performance under the Agreement is inadequate or untimely.

5.6 Rights of DOM. DOM shall have the right to invoke against Provider any remedy set forth in the MississippiCHIP Program Contract, including the right to require the termination of the Agreement, for each and every reason for which it may invoke such a remedy against CCO or require termination of the MississippiCHIP Program Contract. Suspected Fraud and Abuse by Provider will be investigated by DOM.

Mississippi
Regulatory Requirements Appendix

Mississippi Regulatory Requirements Appendix

This Mississippi Regulatory Requirements Appendix (the "Appendix") is made part of the agreement ("Agreement") entered into between **CCO,** contracting on behalf of itself, **HMO**, and the other entities that are CCO's Affiliates (collectively referred to as "CCO") and the health care professional or entity named in the Agreement ("Provider").

This Appendix applies to all products or benefit plans sponsored, issued or administered by or accessed through CCO to the extent such products are regulated under Mississippi laws; provided, however, that the requirements in this Appendix will not apply to the extent they are preempted by the Medicare Modernization Act or other applicable law.

CCO and Provider each agree to be bound by the terms and conditions contained in this Appendix. In the event of a conflict or inconsistency between this Appendix and any term or condition contained in the Agreement, this Appendix shall control, except with regard to Benefit Plans outside the scope of this Appendix.

If any of the capitalized terms in this Appendix are used or defined (or the equivalent terms are used or defined) in the Agreement, then the terms used in this Appendix will have the same meaning as the terms (or equivalent terms) used or defined in the Agreement. For example, "Benefit Plans," as used in this Appendix, will have the same meaning as "benefit contracts"; "Customer," as used in this Appendix, will have the same meaning as "member," "enrollee," or "covered person"; "Payer," as used in this Appendix, will have the same meaning as "participating entity"; "Provider," as used in this Appendix, will have the same meaning as "Facility," "Medical Group," "Ancillary Provider," "Physician," or "Practitioner." Additionally, if the Agreement uses pronouns to refer to the contracted entities, then "CCO" will have the same meaning as "we" or "us," and "Provider" will have the same meaning as "you" or "your."

This Appendix will be deemed to be updated to incorporate any changes to the laws and regulations referenced herein, including any changes to definitions referenced herein, effective as of the date of such changes.

1. Customer Hold Harmless and Continuation of Services. Provider agrees that in no event, including but not limited to nonpayment by CCO, Payer or intermediary, insolvency of CCO, Payer or intermediary, or breach of this Agreement, shall Provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against a Customer or a person (other than CCO, Payer or intermediary) acting on behalf of the Customer for services provided pursuant to this Agreement. This Agreement does not prohibit Provider from collecting coinsurance, deductibles or copayments, as specifically provided in the evidence of coverage, or fees for uncovered services delivered on a fee-for-service basis to Customers. Nor does this Agreement prohibit Provider (except for a health care professional who is employed full-time on the staff of CCO and has agreed to provide services exclusively to CCO's Customers and no others) and a Customer from agreeing to continue services solely at the expense of the Customer, as long as the provider has clearly informed the Customer that CCO or Payer

may not cover or continue to cover a specific service or services. Except as provided herein, this Agreement does not prohibit Provider from pursuing any available legal remedy.

In the event of CCO, Payer or intermediary insolvency or other cessation of operations, Covered Services to Customers will continue through the period for which a premium has been paid to CCO or Payer on behalf of the Customer or until the Customer's discharge from an inpatient facility, whichever time is greater. Covered Services to Customers confined in an inpatient facility on the date of insolvency or other cessation of operations will continue until their continued confinement in an inpatient facility is no longer medically necessary.

The provisions in this section 1 shall be construed in favor of the Customer, shall survive the termination of the Agreement regardless of the reason for termination, including the insolvency of CCO or Payer, and shall supersede any oral or written contrary agreement between Provider and a Customer or the representative of a Customer if the contrary agreement is inconsistent with the hold harmless and continuation of Covered Services provisions required by this section 1.

In no event shall Provider collect or attempt to collect from a Customer any money owed to Provider by CCO or Payer.

2. CCO Programs. As applicable, Provider shall comply with CCO's administrative policies and programs, including but not limited to terms, including payment, utilization review, quality assessment and improvement programs, credentialing, grievance procedures, data reporting requirements, confidentiality requirements and any applicable federal or state programs.

3. Treatment Options. CCO shall not prohibit Provider from discussing treatment options with Customers irrespective of CCO's position on the treatment options, or from advocating on behalf of Customers within the utilization review or grievance processes established by CCO or a person contracting with CCO.

4. Records. Provider shall make health records available to appropriate state and federal authorities involved in assessing the quality of care or investigating the grievances or complaints of Customers, and to comply with the applicable state and federal laws related to the confidentiality of medical or health records.

5. Termination. CCO and Provider shall provide advance written notice to each other in the form and for the length of time as provided in the Agreement but in no case less than sixty (60) before terminating the Agreement without cause. CCO shall make a good faith effort to provide written notice of a termination within thirty (30) days of receipt or issuance of a notice of termination to all Customers who are patients seen on a regular basis by Provider whose Agreement is terminating, irrespective of whether the termination was for cause or without cause. Where a contract termination involves a primary care professional, all Customers who are patients of that primary care professional shall also be notified. Within five (5) working days of the date that Provider either gives or receives notice of termination, Provider shall supply CCO with a list of those patients of Provider that are covered by a Benefit Plan subject to this Appendix.

6. Assignment. The rights and responsibilities under this Agreement shall not be assigned or delegated by Provider without the prior written consent of CCO.

7. Provision of Covered Services. Provider shall furnish Covered Services to all Customers without regard to the Customer's enrollment in the plan as a private purchaser of the plan or as a participant in publicly financed programs of health care services. This requirement does not apply to circumstances when Provider should not render services due to limitations arising from lack of training, experience, skill or licensing restrictions.

8. Coinsurance, Copayments and Deductibles. Provider shall collect applicable coinsurance, copayments or deductibles from Customers pursuant to the Benefit Plan and, as applicable, Provider shall notify Customers of their personal financial obligations for non-covered services.

9. No Penalty for Reporting to Authorities. CCO shall not penalize Provider because Provider, in good faith, reports to state or federal authorities any act or practice by CCO that jeopardizes patient health or welfare.

10. Definitions. To the extent a definition or other provision in the Agreement conflicts with the Benefit Plan or the Managed Care Plan Network Adequacy Regulation (the "Regulation"), the Benefit Plan or the Regulation will control.

11. Prompt Pay. Provider and CCO shall comply with the prompt payment requirements set forth in the Mississippi Code Section 83-9-5(1)(h). Claims will be paid within twenty-five (25) days after receipt where claims are submitted electronically, and within thirty-five (35) days after receipt where claims are submitted in paper format.

12. Reciprocal Time Limitations. If the Agreement includes a time limit in which Provider is required to submit a claim for payment, CCO or Payer shall have the same time limit following payment of the claim to perform any review or audit for reconsidering the validity of the claim and requesting reimbursement for payment of an invalid claim or overpayment of a claim. If CCO or Payer does not limit the time in which Provider is required to submit a claim for payment, CCO may not request reimbursement or offset another claim payment for reimbursement of an invalid claim or overpayment of a claim more than twelve (12) months after the payment of an invalid or overpaid claim. This provision does not apply to claims submitted in the context of misrepresentation, omission, concealment, or fraud by Provider.

13. Intermediaries. The following provisions apply to intermediaries as defined in the Regulation.

a) Intermediaries and participating providers with whom they contract shall comply with all the applicable requirements of sections 1-10 of this Appendix (section 14.06 of the Regulation).
b) CCO's statutory responsibility to monitor the offering of Covered Services to Customers shall not be delegated or assigned to the intermediary.

c) CCO shall have the right to approve or disapprove participation status of a subcontracted provider in its own or a contracted network for the purpose of delivering Covered Services to the carrier's Customers.
d) CCO shall maintain copies of all intermediary health care subcontracts at its principal place of business in the state, or ensure that it has access to all intermediary subcontracts, including the right to make copies to facilitate regulatory review, upon twenty (20) days prior written notice from CCO.
e) If applicable, an intermediary shall transmit utilization documentation and claims paid documentation to CCO. CCO shall monitor the timeliness and appropriateness of payments made to providers and health care services received by Customers.
f) If applicable, an intermediary shall maintain the books, records, financial information and documentation of services provided to Customers at its principal place of business in the state and preserve them in a manner that facilitates regulatory review.
g) An intermediary shall allow the commissioner access to the intermediary's books, records, financial information and any documentation of services provided to Customers, as necessary to determine compliance with the Regulation.
h) CCO shall have the right, in the event of the intermediary's insolvency, to require the assignment to CCO of the provisions of a provider's contract addressing the provider's obligation to furnish covered services.

Medical
Small Group Agreement

INTRODUCTION

Our agreement consists of this contract, the appendices, and the additional materials we reference in the attached Appendix 1.

Guiding principles

We strive to operate in accordance with the following principles:

- *We want to work together with America's best physicians to improve the health care experience of our customers.*
- *We respect and support the physician/patient relationship while adhering fairly to the contract for benefits we provide our customers.*
- *Whether a particular treatment is covered under a benefit contract should not determine if the treatment is provided. Physicians and health care professionals should provide the care they believe is necessary regardless of coverage.*
- *You should discuss treatment options with patients regardless of coverage. We encourage that communication.*
- *Physicians should describe any factors that could affect their ability to render appropriate care. Matters such as professional training, financial incentives, availability constraints, religious or philosophical beliefs, and similar matters are all things that a physician should consider discussing with a patient. We encourage these communications. We urge full disclosure.*
- *Fairness and efficiency will govern the ways in which we administer our products. We will make our determinations promptly. Our commitments to our customers will be clear. We will honor our agreements. When it comes to coverage determinations, the language of the benefit contract will take precedence.*

Next steps

Please read this agreement. If you have questions, write to or call:

[**address]**

(xxx) xxx-xxxx]

You can visit our website at portal.com for additional details on items described in the agreement. If the agreement is acceptable to you, please sign both of the enclosed copies of the contract, and send both copies to the address above.

MEDICAL GROUP CONTRACT

CCO is entering into this agreement with you. It is doing so on behalf of itself, HMO and its other affiliates for certain products and services we offer our customers, all of which we describe in the attached Appendix 2.

This agreement applies to you and to your professional staff (the physicians and other professionals who are your employees, or your independent contractors providing services to your patients, and who are subject to credentialing by us) and the services you provide at the locations in the attached Appendix 4. When this agreement refers to "you", it also refers to your professional staff. Your professional staff is bound to the same requirements of this agreement as you are. You represent to us that you have the authority to bind your professional staff to this agreement.

What you will do

You need to be credentialed in accordance with our Credentialing Plan, as referenced in Appendix 1, for the duration of this agreement.

You must notify us in a timely manner about certain services you provide in accordance with our Administrative Guide so that we can provide our customers with the services we have committed to provide. If you do not so notify us about these services, you will not be reimbursed for the services, and you may not charge our customer.

Within one year of the effective date of this agreement, you must conduct business with us entirely on an electronic basis to the extent that we are able to conduct business electronically (described in the Administrative Guide), including but not limited to determining whether your patient is currently a customer, verifying the customer's benefit, and submitting your claim. We will communicate enhancements at portal.com as they become available and will make information available to you as to which products are supported by portal.com.

You must submit your claims within 90 days of the date of service. After we receive your claim, if we request additional information in order to process your claim, you must submit this additional information within 90 days of our request. If your claim or the additional information is not submitted within these timeframes, you will not be reimbursed for the services, and you may not charge our customer.

You will submit claims only for services performed by you or your staff. Pass through billing is not payable under this agreement and may not be billed to our customer. For laboratory services, you will only be reimbursed for the services that you are certified through the Clinical Laboratory Improvement Amendments (CLIA) to perform, and you must not bill our customers for laboratory services for which you are not certified.

You will submit claims that supply all applicable information. These claims are complete claims. Further information about complete claims is provided in our Administrative Guide.

If you disagree with our payment determination on a claim, you may submit an appeal as described in our Administrative Guide.

You will not charge our customers anything for the services you provide, if those services are covered services under their benefit contract, but the applicable co-pay, coinsurance or deductible amount. If the services you provide are denied or otherwise not paid due to your failure to notify us, to file a timely claim, to submit a complete claim, to respond to our request for information, or based on our reimbursement policies and methodologies, you may not charge our customer. If the services you provide are denied for reason of not being medically necessary, you may not charge our customer unless our customer has, with knowledge of our determination of a lack of medical necessity, agreed in writing to be responsible for payment of those charges. If the services you provide are not covered under our customer's benefit contract, you may, of course, bill our customer directly. You will not require a customer to pay a "membership fee" or other fee in order to access you for covered services (except for co-payments, coinsurance and/or deductibles provided for under the customer's benefit contract) and will not discriminate against any customer based on the failure to pay such a fee.

You will cooperate with our reasonable requests to provide information that we need. We may need this information to perform our obligations under this agreement, under our programs and agreements with our customers, or as required by regulatory or accreditation agencies.

You will refer customers only to other network physicians and providers, except as permitted under our customer's benefit contract, or as otherwise authorized by us or the participating entity.

What we will do

We or the other applicable participating entity will promptly adjudicate and pay your complete claim for services covered by our customer's benefit contract. If you submit claims that are not complete,

- You may be asked for additional information so that your claim may be adjudicated; or
- Your claim may be denied and you will be notified of the denial and the reason for it; or
- We may in our discretion attempt to complete the claim and have it paid by us or the other applicable participating entity based on the information that you gave in addition to the information we have.

If governing law requires us to pay interest or another penalty for a failure to pay your complete claim for covered services within a certain time frame, we will follow those requirements. The interest or other penalty required by law will be the only additional obligation for not satisfying in a timely manner a payment obligation to you. In addition, if we completed a claim of yours that was not complete, there shall be no interest or other late payment obligation to you even if we subsequently adjust the payment amount based on additional information that you provide.

The applicable participating entity will reimburse you for the services you deliver that our customer's benefit contract covers. The amount you receive will be based on the lesser of your

billed charges or our fee schedule, which is described at Appendix 1 and is subject to the reimbursement (coding) policies and methodologies of us and the participating entities. Our reimbursement policies and methodologies are updated periodically and will be made available to you online or upon request. To request a copy of our reimbursement policies and methodologies, write to [address]. Your reimbursement is also subject to our rules concerning retroactive eligibility, subrogation and coordination of benefits (as described in the Administrative Guide). We recognize CPT reporting guidelines as developed by the American Medical Association, as well as ICD diagnostic codes and hospital-based revenue codes. Following these guidelines does not imply a right to reimbursement for all services as coded or reported.

Ordinarily, fee amounts listed in the Payment Appendix(ices) are based upon primary fee sources. We reserve the right to use gap-fill fee sources where primary fee sources are not available.

We routinely update our fee schedule in response to additions, deletions and changes to CPT codes by the American Medical Association, price changes for immunizations and injectable medications, and in response to similar changes (additions and revisions) to other service coding and reporting conventions that are widely used in the health care industry, such as those maintained by the Centers for Medicare and Medicaid Services (for example, HCPCS). Ordinarily, our fee schedule is updated using similar methodologies for similar services. We will not generally attempt to communicate routine maintenance of this nature and will generally implement updates within 90 days from the date of publication.

We will give you 90 days written or electronic notice of non-routine fee schedule changes which will substantially alter the overall methodology or reimbursement level of the fee schedule. In the event such changes will reduce your overall reimbursement under this agreement, you may terminate this agreement by giving 60 days written notice to us, provided that the notice is given by you within 30 days after the notice of the fee schedule change.

If either of us believes that a claim has not been paid correctly, either of us may seek correction of the payment within a 12-month period following the date the claim was paid, except that overpayments as a result of abusive or fraudulent billing practices may be pursued by us beyond the 12-month time frame mentioned above. In the event of an overpayment, we will correct these errors by adjusting future claim payment and/or by billing you for the amount of the overpayment.

Your professional staff and Practice Locations

You represent to us that all of the members of your professional staff, as of the date you executed this agreement, are listed in Appendix 3. All of the members of your professional staff will participate in our network through this agreement, except in cases in which one of your professional staff is not accepted for participation or is removed from participation under our credentialing program, or removed from participation by us immediately due to that professional being sanctioned by any governmental agency or authority (including Medicare or Medicaid), or having lost a license to provide all or some of the professional services under this agreement, or no longer having hospital admitting privileges in any participating hospital. Your professional staff will cooperate with our credentialing program.

If a new professional joins your professional staff, you will give us 60 days notice and provide the information included in Appendix 3. You will assure that the new professional will promptly submit a credentialing application to us (unless the new professional is already credentialed with us) and cooperate with our credentialing program.

You will assure that a member of your professional staff who has not been approved or is not in good standing under our credentialing program will not provide covered services to our customers. In the event that professional does provide covered services, you will not bill us, our customer, or anyone acting on our customer's behalf for the service, and you will assure that the professional also does not bill for the service.

If a professional leaves your professional staff, you will notify us within ten business days after you become aware that the professional will leave. The notice will include the date that the professional will depart from your professional staff. If you know the future contact information for the professional and whether the professional will continue to practice after leaving your professional staff, you will make reasonable commercial efforts to include that information in the notice and will provide that information to us if we request it.

This agreement applies to your practice locations identified in Appendix 4. If you begin providing services at other locations (either by opening such locations yourself, or by acquiring, merging or coming under common ownership and control with an existing provider of services that was not already under contract with us or one of our affiliates to participate in a network of health care providers), those additional locations will become subject to this agreement 30 days after we receive notice from you.

If you acquire or are acquired by, merged with, or otherwise become affiliated with another provider of health care services that is already under contract with us or one of our affiliates to participate in a network of health care providers, this agreement and the other agreement will each remain in effect and will continue to apply as they did prior to the acquisition, merger or affiliation, unless otherwise agreed to in writing by all parties to those agreements.

If you decide to transfer some or all of your assets to another entity, and the result of the transfer would be that all or some of the services subject to this agreement would be rendered by the other entity rather than by you, you must first request that we approve an assignment of this agreement as it relates to those services and the other entity must agree to assume this agreement.

How long our agreement lasts; how it gets amended; and how it can end

Assuming you are credentialed by us, and we execute this agreement, you will receive a copy from us with the effective date noted below the signature block. It continues until one of us terminates it.

We can amend this agreement or any of the appendices on 90 days written or electronic notice by sending you a copy of the amendment. Your signature is not required to make the amendment

effective. However, if you do not wish to continue your participation with our network as changed by an amendment that is not required by law or regulation but that includes a material adverse change to this agreement, then you may terminate this agreement on 60 days written notice to us so long as you send this termination notice within 30 days of your receipt of the amendment.

In addition, this agreement has an initial term of three years, and it will automatically renew after the initial term, for renewal terms of one year each. Either you or we can terminate this agreement, effective at the end of the initial term or effective at the end of any renewal term, by providing at least 90 days prior written notice. Either you or we can terminate this agreement at any time if the other party has materially breached this agreement, by providing 60 days written notice, except that if the breach is cured before our agreement ends, the agreement will continue.

Either of us can immediately terminate this agreement if the other becomes insolvent or has bankruptcy proceedings initiated.

Finally, we can immediately terminate this agreement if any governmental agency or authority (including Medicare or Medicaid) sanctions you.

We both agree that termination notices under this agreement must be sent by certified mail, return receipt requested, to [address], or to the post office address you provided us. We both will treat termination notices as "received" on the third business day after they are sent.

About data and confidentiality

We agree that your medical records do not belong to us. You agree the information contained in the claims you submit is ours. We both will protect the confidentiality of our customers' information in accordance with applicable state and federal laws, rules, and regulations.

We are both prohibited from disclosing to third parties any fee schedule or rate information. There are three exceptions:

- You can disclose to our customer information relating to our payment methodology for a service the customer is considering (e.g., global fee, fee for service), but not specific rates (unless for purposes of benefit administration).
- We and the participating entities may use this information to administer our customers' benefit contracts and to pay your claims. We also may permit access to information by auditors and other consultants who need the information to perform their duties, subject to a confidentiality agreement.
- We both may produce this information in response to a court order, subpoena or regulatory requirement to do so, provided that we use reasonable efforts to seek to maintain confidential treatment for the information, or to a third party for an appropriate business purpose, provided that the disclosure is pursuant to a confidentiality agreement and the recipient of the disclosure is not a competitor of either of us.

What if we do not agree

The parties will work together in good faith to resolve any and all disputes between them ("Disputes") following the dispute procedures set out in our Administrative Guide. Disputes may include, but not be limited to the existence, validity, scope or termination of this Agreement or any term thereof, and all questions of arbitrability, with the exception of any question regarding the availability of class arbitration or consolidated arbitration, which is expressly waived below. Disputes also include any dispute in which you are acting as the assignee of one or more customer. In such cases, these procedures will apply, including without limitation the requirement for arbitration.

If the Dispute pertains to a matter which is generally administered by certain CCO procedures, such as a credentialing or quality improvement plan, the policies and procedures set forth in that plan must be fully exhausted by you before you may invoke any right to arbitration under this section.

For Disputes regarding payment of claims, a party must have timely initiated and completed the claim reconsideration and appeal process as set forth in the Administrative Guide in order to initiate the Dispute process.

If the parties are unable to resolve any Dispute within 60 days after notice, either party may submit the Dispute to binding arbitration conducted by the American Arbitration Association ("AAA"). The arbitrators will use the AAA Healthcare Payor Provider Arbitration Rules, as amended. However, if a case involves a Dispute in which a party seeks an award of $1,000,000 or greater or seeks termination of this Agreement, a panel of three arbitrators will be used. The arbitrator(s) will be selected from the AAA National Healthcare Roster or the AAA's National Roster of Arbitrators. Unless otherwise agreed in writing, arbitration must be initiated within one year after the date on which written notice of the Dispute was given, or any appeal process described in the Administrative Guide, whichever is later. If arbitration is not initiated in that time frame, the right to pursue the Dispute in any forum is waived.

Any arbitration proceeding under this Agreement will be conducted in [name of county] County, [state]. The arbitrator(s) may construe or interpret but must not vary or ignore the terms of this Agreement and will be bound by controlling law. The arbitrator(s) have no authority to award punitive, exemplary, indirect or special damages, except in connection with a statutory claim that explicitly provides for that relief.

Except as may be required by law, neither a party, including without limitation, the parties' representatives, consultants and counsel of record in the arbitration, nor an arbitrator may disclose the existence, content, or results of any arbitration hereunder, or any Confidential Arbitration Information without the prior written consent of all parties. "Confidential Arbitration Information" means any written submissions in an arbitration by either party, discovery exchanged, evidence submitted, transcriptions or other records of hearings in the matter and any orders and awards issued, and any reference to whether either party won, lost, prevailed, or did not prevail against the other party in any arbitration proceeding, as well as any settlement agreement related to an

arbitration. However, judgment on the award may be entered under seal in any court having jurisdiction thereof, by either party.

The parties expressly intend that any arbitration be conducted on an individual basis, so that no third parties may be consolidated or joined or allowed to proceed with class arbitration. The parties agree that any arbitration ruling allowing class arbitration, or requiring consolidated arbitration involving any third party(ies), would be contrary to the terms of this Agreement and require immediate judicial review. Notwithstanding anything in this Agreement to the contrary, this paragraph may not be severed from this provision of the Agreement under any circumstances, including but not limited to unlawfulness, invalidity or unenforceability.

The decision of the arbitrator(s) on the points in dispute will be binding. The parties acknowledge that because this Agreement affects interstate commerce, the Federal Arbitration Act applies. In the event any court determines that this arbitration procedure is not binding or otherwise allows litigation involving a Dispute to proceed, the parties hereby waive any and all right to trial by jury in, or with respect to, the litigation. The litigation would instead proceed with the judge as the finder of fact.

In the event a party wishes to terminate this Agreement based on an assertion of uncured material breach, and the other party disputes whether grounds for the termination exist, the matter will be resolved through arbitration under this provision. While the arbitration remains pending, the termination for breach will not take effect.

This provision will survive any termination of this Agreement.

What is our relationship to one another

You are an independent contractor. This means we do not have an employer-employee, principal-agent, partnership, joint venture, or similar arrangement. It also means that you make independent health care treatment decisions. We do not. We do not reserve any right to control those treatment decisions. It further means that each of us is responsible for the costs, damages, claims, and liabilities that result from our own acts.

You will look to the applicable participating entity for reimbursement for the products and services under our agreement. This means that we are not financially responsible for claims payment for groups that are self-funded or that are not affiliated with us.

We may assign this agreement to any entity that is an affiliate of CCO at the time of the assignment.

This is it

This contract, the appendices and the items referenced in the attached Appendix 1, constitute our entire understanding. It replaces any other agreements or understandings with regard to the same subject matter - - oral or written - - that you have with us or any of our affiliates.

Federal law and the applicable law of the jurisdiction where you provide health care services govern our agreement. Such laws and the rules and regulations promulgated under them, when they are applicable, control and supersede our agreement. The Regulatory Appendix referenced in Appendix 1, and any attachment to it, is expressly incorporated to govern our agreement and is binding on both of us. In the event of any inconsistent or contrary language between the Regulatory Appendix (when it applies) and any other part of our agreement, including but not limited to appendices, amendments and exhibits, the Regulatory Appendix will control.

Conclusion

If you agree with these terms, please execute both copies of the agreement below and return them to us. With your signature, you confirm you understand the contract, including the dispute resolution procedures described in the section of this agreement entitled "What if we do not agree", the appendices and the items referenced in the attached Appendix 1.

THIS AGREEMENT CONTAINS A BINDING ARBITRATION PROVISION THAT MAY BE ENFORCED BY THE PARTIES.

AGREED BY:

Medical Group:

Address to be used for giving notice under the agreement:

Signature _____

Print Name and Title: _____

DBA (if applicable): _____

Date: _____ TIN_____

National Provider Identification (NPI) Number:_____

Street _____

City: _____

State: _____Zip Code _____

E-mail: _____

CCO, on behalf of itself, HMO and its other affiliates, as signed by its authorized representative:

Signature _____

Print Name: _____

Title: _____

Date: _____

For office use only:
Month, day and year in which agreement is first effective: ___ ___ / ___ ___ / ___ ___

Appendix 1

We include as part of our agreement the following additional materials that bind you and us:

Appendix 2	**Definitions, Products and Services** This appendix sets forth definitions for our "customer" and "participating entities" as well as lists the type of benefit contracts offered to our customers.
Payment Appendices	**Fee Information Document** includes: Fee Specifications Document, Fee Schedule Sample, and Additional Information About Your Fee Schedule. Further information about the fee schedule (such as additional fee samples) can be requested by writing to [address] or through our website at portal.com.
Appendix 3	This document provides information about the members of your professional staff.
Appendix 4	This document provides information about your practice locations.
State Regulatory Requirements Appendix	In some instances, states add requirements to our agreement that are set forth in this appendix.
Medicare Regulatory Requirements Appendix	(This appendix applies only if you are in our Medicare network.) Your participation in our network for customers with Medicare benefit contracts is subject to additional Medicare requirements set forth in this appendix.
Medicaid and/or CHIP Regulatory Requirements Appendix(ices)	(These appendix(ices) apply only if you are in our Medicaid and/or CHIP network.) Your participation in our network for customers with Medicaid or CHIP benefit contracts is subject to additional requirements set forth in these appendix(ices).
Administrative Guide	Our Administrative Guide governs the mechanics of our relationship. Our Administrative Guide may be viewed by going to portal.com, and it will also be made available to you upon request. We may make changes to the Administrative Guide or other administrative protocols upon 30 days electronic or written notice to you. Additionally, for some of the benefit contracts for which you may provide covered services under this agreement, you are subject to additional requirements of one or more additional provider manuals ("Additional Manuals"). When this agreement refers to protocols or reimbursement policies it is also referring to the Additional Manuals. An Additional Manual may be a separate document or it may be a supplement to the Provider Administrative Guide ("Administrative Guide"). For benefit contracts subject to an Additional Manual, the Additional Manual controls if it conflicts with any of the following: (1) a provision of this

<table>
<tr><td></td><td>agreement or of the Administrative Guide; or (2) a CCO protocol or reimbursement policy. However, the Additional Manual does not control where it conflicts with applicable statutes or regulations.

The Additional Manuals will be made available to you on a designated website and upon request. The names of the Additional Manuals, the websites to view and download them, and the benefit contracts to which they apply, are listed in Table 1 below. We may change the location of a website or the customer identification card identifier used to identify customers subject to a given Additional Manual; if we do so, we will inform you.

We may make changes to the Additional Manuals subject to this provision in accordance with the provisions of this agreement relating to protocol and reimbursement policy changes.

Table 1.
<table>
<tr><th>Benefit Contract</th><th>Description of Applicable Additional Manual</th><th>Website</th></tr>
<tr><td colspan="3">[No Additional Manuals Apply]</td></tr>
<tr><td>[Mississippi CHIP Benefit Contracts</td><td>Administrative Guide for Mississippi Children’s Health Insurance Program (CHIP)</td><td>portal.com]</td></tr>
<tr><td>[Mississippi Medicaid Benefit Contracts</td><td>Administrative Guide for Mississippi Medicaid</td><td>portal.com]</td></tr>
</table>
</td></tr>
<tr><td>Credentialing Plan</td><td>To review our credentialing plan, visit portal.com.
This plan requires your professional staff to be covered by malpractice insurance in amounts with carriers and on terms and conditions that are customary for professionals like them in your community. To request access to, or a copy of, our credentialing plan, write to [address].</td></tr>
</table>

Appendix 2
Definitions, Products and Services

Section 1. Customer. Individuals who are enrolled in benefit contracts insured or administered by us or any participating entity are included in our use of the phrase "customer" in this agreement.

Section 2. Participating entities. The following entities have access to our agreement:

[Mississippi Medicaid Benefit Contracts.]
[Mississippi CHIP Benefit Contracts.]

Section 3. Products and services.

a. We may allow participating entities to access your services under this agreement for the benefit contract types described in each line item below, unless otherwise specified in section 3b of this Appendix 2:

[Mississippi Medicaid Benefit Contracts.]

[Mississippi CHIP Benefit Contracts.]

b. Notwithstanding the above section 3a of this Appendix 2, this agreement will not apply to the benefit contract types described in the following line items:

- [[Mississippi Medicaid Benefit Contracts.]
- [Mississippi CHIP Benefit Contracts.]
- Medicaid or CHIP Benefit Contracts other than those separately addressed in this Appendix 2.
-

Page Intentionally left blank

Note: Excluding certain benefit contracts or programs from this agreement does not preclude the parties or their affiliates from having or entering into a separate agreement providing for your participation in a network for such benefit contracts or programs.

Section 4. Definitions:

Note: We may adopt a different name for a particular benefit contract, and/or may modify information referenced in the definitions in this Appendix 2 regarding customer identification cards. If that happens, section 3a or section 3b of this Appendix 2 will continue to apply to those benefit contracts as it did previously, and we will provide you with the updated information. Additionally, we may revise the definitions in this Appendix 2 to reflect changes in the names or roles of our business units, provided that doing so does not change your participation status in benefit contracts impacted by that change, and further provided that we provide you with the updated information.

MEDICAID, CHIP AND OTHER STATE PROGRAMS:

- **Medicaid Benefit Contracts** means benefit contracts that offer coverage to beneficiaries of a program that is authorized by Title XIX of the federal Social Security Act, and jointly financed by the federal and state governments and administered by the state.

- **Mississippi Medicaid Benefit Contracts** means Medicaid Benefit Contracts issued in Mississippi that have a reference to "CCO" on the valid identification card of any Customer eligible for and enrolled in that benefit contract.

- **Children's Health Insurance Program ("CHIP") Benefit Contracts** means benefit contracts under the program authorized by Title XXI of the federal Social Security Act that is jointly financed by the federal and state governments and administered by the state.

- **Mississippi CHIP Benefit Contracts** means CHIP Benefit Contracts issued in Mississippi that include a reference to "CCO" and "MSCHIP" on the face of the valid identification card of any Customer eligible for and enrolled in that Benefit Contract.

- **Other Governmental Benefit Contracts** means benefit contracts that are funded wholly or substantially by a state or district government or a subdivision of a state (such as a city or county), but do not include benefit contracts for:
  - i) employees of a state government or a subdivision of a state and their dependents;
  - ii) students at a public university, college or school;
  - iii) employer-based coverage of private sector employees, even if the employer receives a government subsidy to help fund the coverage;
  - iv) Medicaid beneficiaries;
  - v) Children's Health Insurance Program (CHIP) beneficiaries; and
  - vi) Medicare and Medicaid Enrollees (MME).

[Payment Appendix – Mississippi Medicaid

Applicability

This Payment Appendix applies to covered services rendered by you to customers covered under the following types of benefit contracts, as described in this agreement:

- Mississippi Medicaid Benefit Contracts.

Section 1
Payment for Covered Services

1.1 Payment. Your contract rates for covered services are the lesser of (i) your customary charges or (ii) the following, in order of applicability:

a) [X]% of the Mississippi Medicaid conversion factor published by the applicable state agency for anesthesia services;

b) [Y]% of the Mississippi Medicaid fee schedule published by the applicable state agency;

c) In the event a fee source listed above in clause (a) or (b) does not publish a specific fee amount, then CCO will pay [Z]% of Medical Group's Customary Charges for Covered Services.

d) For certain CPT/HCPCS codes, we may pay an amount higher than the amount listed in this section 1.1, and in the future, we may reduce that higher amount paid for those CPT/HCPCS codes, but not less than the amount payable in clauses (a), (b) and (c) above.

The actual payment amount is also subject to matters described in this agreement, such as reimbursement policies.

You will submit claims using a CMS 1500, its successor form or its electronic equivalent. All claims submitted under this Payment Appendix must use CPT Codes, HCPCS Codes, ICD-10 Codes or its successor and other codes in compliance with HIPAA standard data set requirements. Claims submitted without HIPAA standard data set requirements may be denied.

If an applicable state or federal program is available to provide items or payment directly to you for specific covered services for customers subject to this Payment Appendix that would otherwise be payable under this Payment Appendix, the applicable program will apply and not this Payment Appendix. (For example, the Vaccines For Children program currently provides vaccines free of charge, and therefore no amount will be payable under this Payment Appendix for vaccines within the Vaccines For Children program. However, the administration of such vaccine may be payable under this Payment Appendix, if payment is not provided to physicians under the Vaccines For Children program for vaccine administration.)

The contract rates established by this Payment Appendix are all-inclusive, including without limitation any applicable taxes, for all covered services provided to the customer. Unless specifically indicated otherwise, amounts listed in this fee schedule represent global fees and may be subject to reductions based on appropriate modifiers (for example, professional and technical modifiers).

1.2 Routine Maintenance. We routinely update the fee schedule in response to changes published by the state agency, such as fee amount changes. Provided that the state does not change its methodology, we implement fee schedule changes in our systems within 45 days from the date the change is published in the Medicaid agency's official correspondence to us or is otherwise formally communicated by the Medicaid agency to us. We will make the changes effective in our system on the effective date of the change by the primary fee source. However, claims already processed prior to the change being implemented by us will not be reprocessed unless otherwise required by law.

We also routinely update the fee schedule in response to coding changes as described in this agreement. When implementing coding updates, we will apply the same percentage(s) as set forth above in section 1.1 and the then-current value of the published code to determine the contract rate. We will use reasonable commercial efforts to implement such changes within 90 days from the date of publication. However, claims already processed prior to the change being implemented by us will not be reprocessed unless otherwise required by law.

1.3 Medicaid Agency Payment Changes. If the Medicaid agency changes the manner in which it reimburses or changes the Medicaid primary fee source such that we are required to make significant programming or platform changes in order to implement the Medicaid agency changes, we will implement the new state methodologies effective on the date that is published in the Medicaid agency's official correspondence to us or as otherwise formally communicated by the Medicaid agency to us. You agree that, in such a case, you will accept the current payment as set forth in this Payment Appendix until such a time as we can implement the Medicaid agency change. At such time as we are able to implement the change, we will communicate the change via a copy of a new payment appendix. The changes will be incorporated into this Payment Appendix for all dates of service on or after those changes are effective in the Medicaid program.

If we are unable, through commercially reasonable efforts, to incorporate the Medicaid agency payment changes in their entirety, we will so notify you within 90 days from the date the change is published in the Medicaid agency's official correspondence to us, or otherwise formally communicated by the Medicaid agency. The parties will then negotiate in good faith for a period of up to 60 days to amend the agreement to replace this Payment Appendix with a new payment appendix and stated effective date for the new contract rates. If the parties have not reached an agreement upon such an amendment within the aforementioned 60 day period, either party may initiate dispute resolution according to this agreement.

]

[Payment Appendix – Mississippi CHIP

Mississippi CHIP Fee Information Document: [Fee Schedule ID]

This Payment Appendix applies to covered services rendered by you to customers covered under the following types of benefit contracts, as described in this agreement:

- Mississippi CHIP Benefit Contracts

]

Appendix 3
Professional Roster

IMPORTANT NOTE: You acknowledge your obligation under the agreement to notify us of any change in your professionals. Failure to do so may result in denial of claims or incorrect payment.

You represent that you have provided us with a Professional Roster that includes all of the following data elements for the physicians and other professionals on your staff:

- Name of Professional (first name, middle initial, last name)
- Degree (MD, DO, NP, PA, other)
- Gender (M/F)
- Provider Specialty(ies) (primary, secondary, additional specialties)
- Willing to be listed/assigned as a Primary Care Professional "PCP" (Y/N)
- State License Number
- Medicaid ID Number
- NPI Number
- Foreign Language(s)
- Admitting Hospital(s)

If any data element is not applicable to a specific professional, you will indicate "not applicable" in the appropriate field. Acceptable formats include in writing, electronically in Excel, ANSI, or text (comma delineated) formats.

Appendix 4
Your Practice Locations

Medical Group attests that this Appendix identifies all services and locations covered under this Agreement.

BILLING ADDRESS
All sites of service billing under all TINs listed in Appendix 4 must be included as par providers.

Practice Name_____
Street Address_____
City_____ State_____ Zip_____
Tax ID Number (TIN)_____
National Provider ID (NPI) _____

PRACTICE LOCATIONS (complete one for each service location)		
Clinic Name	Clinic Name	Clinic Name
Street Address	Street Address	Street Address
City	City	City
State and Zip Code	State and Zip Code	State and Zip Code
Phone Number	Phone Number	Phone Number
TIN (If different from above)	TIN (If different from above)	TIN (If different from above)
National Provider ID (NPI)	National Provider ID (NPI)	National Provider ID (NPI)

<>

Clinic Name	Clinic Name	Clinic Name
Street Address	Street Address	Street Address
City	City	City
State and Zip Code	State and Zip Code	State and Zip Code
Phone Number	Phone Number	Phone Number
TIN (If different from above)	TIN (If different from above)	TIN (If different from above)

National Provider ID (NPI)	National Provider ID (NPI)	National Provider ID (NPI)

Medical
Mississippi Medicaid Program
Regulatory Requirements Appendix

MISSISSIPPI MEDICAID PROGRAM

REGULATORY REQUIREMENTS APPENDIX

PROVIDER

THIS MISSISSIPPI MEDICAID PROGRAM REGULATORY REQUIREMENTS APPENDIX (this "Appendix") supplements and is made part of the provider agreement (the "Agreement") between HMO ("HMO") or one of its Affiliates and the party named in the Agreement ("Provider").

SECTION 1
APPLICABILITY

The requirements of this Appendix apply to Medicaid benefit plans sponsored, issued or administered by HMO under the Mississippi Coordinated Access Network Program (the "MississippiCAN Program") governed by the State's designated regulatory agencies. In the event of a conflict between this Appendix and other appendices or any provision of the Agreement, the provisions of this Appendix shall control except with regard to benefit plans outside the scope of this Appendix or unless otherwise required by law. In the event HMO is required to amend or supplement this Appendix as required or requested by the State to comply with federal or State regulations, HMO will unilaterally initiate such additions, deletions or modifications. All provider agreements must be in writing and must include all specific activities and report responsibilities delegated to the Provider by HMO.

SECTION 2
DEFINITIONS

Unless otherwise defined in this Appendix, all capitalized terms shall be as defined in the Agreement. For purposes of this Appendix, the following terms shall have the meanings set forth below; provided, however, in the event any definition set forth in this Appendix or the Agreement is inconsistent with any definitions under the MississippiCAN Program, the definitions shall have the meaning set forth under the MississippiCAN Program.

2.1 **Adverse Benefit Determination:** The denial or limited authorization of a requested service, including determinations on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit; the reduction, suspension, or termination of previously authorized services; the denial, in whole or in part, of payment for a service; HMO's failure to provide services in a timely manner; HMO's failure to resolve Complaints, Grievances, or Appeals within the specified time frames; for residents in a rural area with only one MCO, the denial of a Covered Person's request to exercise his or her right, under 42 C.F.R. §438.52(b)(2)(ii); the denial of a Covered Person's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other enrollee financial liabilities; and determinations by skilled nursing facilities and nursing facilities to transfer or discharge residents and adverse determinations made by a State with regard to the preadmission screening and annual resident review requirements of Section 1919(e)(7) of the Act, if applicable.

2.2 **Affiliate:** Those entities controlling, controlled by, or under common control with HMO.

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

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

2.5 **CMS:** Center for Medicare and Medicaid Services is an agency within the U.S. Department of Health & Human Services responsible for administration of several key federal health care programs.

2.6 **Complaint:** An expression of dissatisfaction received orally or in writing that is of a less serious or formal nature that is resolved within one (1) business day of receipt.

2.7 **Covered Person:** An individual who meets all of the eligibility requirements for Mississippi Medicaid and is currently enrolled with HMO for the provision of services under a MississippiCAN Program. A Covered Person may also be referred to as an Enrollee, Member or Customer under the Agreement.

2.8 **Covered Services:** Health care services or products for which a Covered Person is enrolled with HMO to receive coverage under the State Contract, including all services required by the State Contract and State and federal law.

2.9 **DOM:** Division of Medicaid, Office of the Governor, State of Mississippi.

2.10 **Early, Periodic, Screening, Diagnosis, and Treatment (EPSDT) Services:** Defined by DOM to include:

i) Age appropriate, comprehensive health and development history that includes physician and mental health assessments along with counseling and anticipatory guidance and risk factor reduction interventions;
ii) Calculation of Body Mass Index;
iii) Growth measurements and head circumference;
iv) Nutritional counseling;
v) Developmental surveillance and Developmental and autism Spectrum Disorders Screenings as appropriate;
vi) Comprehensive unclothed exam;
vii) Appropriate laboratory tests (including blood level assessment appropriate to age and risk);

viii) Appropriate immunizations in accordance with Recommended Childhood and Adolescent Immunization Schedule adopted by DOM;
ix) A vision assessment;
x) A hearing assessment;
xi) A dental screening and/or referral to dental care;
xii) Health education; and
xiii) Referrals for identified abnormalities.

2.11 Fraud and Abuse: Fraud is any type of intentional deception or misrepresentation made by an entity or person with the knowledge that the deception could result in some unauthorized benefit to the entity, him or herself, or some other person. The Fraud can be committed by many entities, including a vendor, a subcontractor, a provider, a State employee, or a Covered Person, among others. Abuse is any practice that is inconsistent with sound fiscal, business, or medical practices, and results in an unnecessary cost to the Medicaid program, a vendor, a subcontractor or Provider or in reimbursement for services that are not Medically Necessary or that fail to meet professionally recognized standards for health care.

2.12 Grievance: An expression of dissatisfaction about any matter or aspect of HMO or its operation, other than an Adverse Benefit Determination as defined herein. Grievances may include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the Covered Person's rights regardless of whether remedial action is requested. Grievance includes a Covered Person's right to dispute an extension of time proposed by HMO to make an authorization decision.

2.13 Marketing: The activities that promote visibility and awareness for the MississippiCAN Program and HMO's participation in the program. All marketing activities are subject to prior review and approval by DOM and may not contain misleading information.

2.14 Medical Record: A single complete record, which documents the entire treatment plan developed for, and medical services received by, the Covered Person including inpatient, outpatient, referral services and emergency medical services whether provided by contracted Providers or non-contracted providers.

2.15 Mississippi Coordinated Access Network (MississippiCAN) Program: Mississippi Medicaid's coordinated care program for select Medicaid Beneficiaries.

2.16 Primary Care Provider (PCP): Any physician or health care practitioner or group operating within the scope of his or her licensure who is responsible for supervising, prescribing and providing primary care and primary case management services in the MississippiCAN Program, whose practice is limited to the general practice of medicine or who is an Internist, Pediatrician, Obstetrician, Gynecologist, Family Practitioner, General Practitioner, Certified Nurse Practitioners whose specialty is pediatrics, adult, family, certified nurse midwife, obstetrics/gynecology, or a physician assistant.

2.17 Prior Authorization: A determination to approve a Provider's request, pursuant to services covered in the MississippiCAN Program, to provide a service or course of

treatment of a specific duration and scope to a Member prior to the initiation or continuation of the service.

2.18 Provider Network: The Panel of health service Providers with which HMO contracts for the provision of covered services to Covered Persons and Non-Contracted Providers administering services to Covered Persons.

2.19 State: The State of Mississippi or its designated regulatory agencies.

2.20 State Contract: HMO's contract with the State for the purpose of providing and paying for Covered Services to Covered Persons enrolled in the MississippiCAN Program.

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

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

SECTION 3
PROVIDER REQUIREMENTS

The MississippiCAN Program, through the State Contract and federal and State statutes and regulations, requires the Agreement to contain certain conditions that HMO and Provider agree to undertake, which include the following:

3.1 Definitions Related to the Provision of Covered Services. Provider shall follow the applicable State Contract's requirements for the provision of Covered Services. Provider's decisions affecting the delivery of acute or chronic care services to Covered Persons shall be made on an individualized basis and in accordance with the following definitions:

i) Emergency Medical Condition: A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in any of the following: (a) 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; (b) serious impairment to body functions; or (c) serious dysfunction of any body organ or part.

ii) Emergency Services: Covered inpatient and outpatient services, inclusive of dialysis services, furnished by a provider who is qualified to furnish those health

services and that are needed to evaluate or stabilize an Emergency Medical Condition in accordance with 42 CFR 438.114.

iii) Medically Necessary Services: As set forth in the Social Security Act, Section 1905 (42 USC 1396d(a)), Medically Necessary Services are defined as services, supplies, or equipment provided by a licensed health care professional that are:

a) Appropriate and consistent with the diagnosis or treatment of the Covered Person's condition, illness, or injury;

b) In accordance with the standards of good medical practice consistent with the individual Covered Person's condition(s);

c) Not primarily for the personal comfort or convenience of the Member, family, or Provider;

d) The most appropriate services, supplies, equipment, or levels of care that can be safely and efficiently provided to the Covered Person;

e) Furnished in a setting appropriate to the Covered Person's medical need and condition and, when applied to the care of an inpatient, further mean that the Covered Person's medical symptoms or conditions require that the services cannot be safely provided to the Covered Person as an outpatient;

f) Not experimental or investigational or for research or education;

g) Provided by an appropriately licensed practitioner; and

h) Documented in the patient's record in a reasonable manner, including the relationship of the diagnosis to the service.

Medically Necessary Services may also be those services for children that are necessary to correct or ameliorate defects and physical and mental illnesses and conditions discovered during an interperiodic or periodic EPSDT screen, whether such services are covered or exceed the benefit limits in the Medicaid State Plan and Title 23 of Mississippi Administrative Code.

iv) Urgent Care: Urgent care services are utilized because the Covered Person's primary care physician is not available. An urgent condition is not life threatening but may need prompt attention. Urgent care services are for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe it requires emergency room care.

3.2 Provider Eligibility. Provider must be enrolled in the Mississippi Medicaid program and must use the same National Provider Identifier (NPI) number to participate in HMO's Network. Upon notification from the State that Provider's enrollment has been denied or terminated, HMO must terminate Provider immediately and will notify affected Covered Persons that Provider is no longer participating in the network. HMO will exclude from its

network any provider who has been terminated or suspended from the Medicare or Medicaid program in any state.

3.3 Accessibility Standards. Provider shall provide for timely access for Covered Person appointments in accordance with the appointment availability requirements established under the State Contract, as further described in the applicable provider manual.

Type	Appointment Scheduling Time Frames
PCP (well care visit)	Not to exceed thirty (30) calendar days
PCP (routine sick visit)	Not to exceed seven (7) calendar days
PCP (urgent care visit)	Not to exceed twenty-four (24) hours
Specialists	Not to exceed forty-five (45) calendar days
Dental Providers (routine visits)	Not to exceed forty-five (45) calendar days
Dental Providers (urgent Care)	Not to exceed forty-eight (48) hours
Behavioral Health Providers (routine visit)	Not to exceed fourteen (14) calendar days
Behavioral Health Providers (urgent visit)	Not to exceed twenty-four (24) hours
Behavioral Health Providers (post-discharge from an acute psychiatric hospital when the Contractor is aware of the Member's discharge)	Not to exceed seven (7) calendar days
Urgent Care Providers	Not to exceed twenty-four (24) hours
Emergency Providers	Immediately (twenty-four (24) hours a day, seven (7) days a week) and without Prior Authorization

3.4 Hours of Operation; Appointments. Provider shall offer hours of operation that are no less than the hours of operation offered to commercial beneficiaries or comparable to Medicaid fee-for-service if Provider serves only Medicaid beneficiaries. As applicable, Provider will make Covered Services available 24 hours a day, 7 days a week when medically necessary.

3.5 Hold Harmless. Except for any applicable cost-sharing requirements under the State Contract, Provider shall look solely to HMO for payment of Covered Services provided to Covered Persons pursuant to the Agreement and the State Contract and hold the State, DOM, the U.S. Department of Health and Human Services and Covered Persons harmless in the event that HMO cannot or will not pay for such Covered Services. In accordance with 42 CFR 447.15, as may be amended from time to time, the Covered Person is not liable to Provider for any services for which HMO is liable and as specified under the State's relevant health insurance or managed care statutes, rules or administrative agency guidance. Provider shall not require any copayment or cost sharing for Covered Services provided under the Agreement unless expressly permitted under the State Contract.

Provider shall also be prohibited from charging Covered Persons for missed appointments if such practice is prohibited under the State Contract or applicable law. Neither the State, DOM nor Covered Persons shall be in any manner liable for the debts and obligations of HMO and under no circumstances shall HMO, or any providers used to deliver services covered under the terms of the State Contract, charge Covered Persons for Covered Services.

Covered Person may be responsible for non-covered item(s) and/or service(s), only if the Provider ensures that written documentation in compliance with the Advance Beneficiary Notification (ABN) is received from the Covered Person that an item(s) or service(s) rendered is a non-covered item and/or service(s) and that the Covered Person will be financially responsible for the item(s) and/or service(s). If HMO determines a Covered Person was charged for Covered Services inappropriately, such payment may be recovered, as applicable.

This provision shall survive any termination of the Agreement, including breach of the Agreement due to insolvency.

3.6 **Indemnification.** To the extent applicable to Provider in performance of the Agreement, Provider shall indemnify, defend, protect, save and hold DOM and its employees and Covered Persons harmless from and against all injuries, deaths, losses, damages, claims, suits, liabilities, judgments, costs and expenses, including, without limitation, court costs, investigative fees and expenses and attorney fees, to the extent proximately caused by any negligent act or other intentional misconduct or omission of Provider, its agents, officers, employees or contractors arising from the Agreement. DOM may waive this requirement for public entities if Provider is a state agency or sub-unit as defined by the State or a public health entity with statutory immunity. This clause shall survive the termination of the Agreement for any reason, including breach due to insolvency.

3.7 **Provider Selection.** To the extent applicable to Provider in performance of the Agreement, Provider shall comply with 42 CFR 438.214, as may be amended from time to time, which includes, but is not limited to the selection and retention of providers, credentialing and recredentialing requirements and nondiscrimination. If HMO delegates credentialing to Provider, HMO will provide monitoring and oversight and Provider shall ensure that all licensed medical professionals are credentialed in accordance with HMO's and the State Contract's credentialing requirements.

3.8 **Restrictions on Referrals.** Provider shall not make inappropriate referrals for designated health services to health care entities with which Provider or a member of Provider's family has a financial relationship, pursuant to federal anti-kickback and physician self-referral laws that prohibit such referrals.

3.9 **Records Retention.** As required under State or federal law or the State Contract, Provider shall maintain an adequate record keeping system for recording services, charges, dates and all other commonly accepted information elements sufficient to disclose the quality, quantity, appropriateness and timeliness of services rendered to Covered Persons. All financial records shall follow generally accepted accounting principles. Medical records and supporting management systems shall include all pertinent information related to the

medical management of each Covered Person. Other records shall be maintained as necessary to clearly reflect all actions taken by Provider related to services provided under the State Contract. Such records, including, as applicable, grievance and appeal records shall be maintained for a period of not less than ten (10) years from the close of the Agreement, or such other period as required by law. If records are under review or audit, they must be retained for a minimum of ten (10) years following resolution of such action. Prior approval for the disposal of records must be requested and approved by HMO if the Agreement is continuous.

3.10 Records Access. Provider agrees to cooperate with HMO to maintain and share a health record of all services provided to a Covered Person, as appropriate and in accordance with applicable laws, regulations and professional standards. Provider acknowledges and agrees that the State, DOM, the U.S. Department of Health and Human Services and other authorized federal and state personnel shall have complete access to all records pertaining to services provided to Covered Persons. Provider shall provide immediate access to facilities, records and supportive materials pertinent to the State Contract for State or Federal fraud investigators. Copies of requested documents shall be provided to the State, DOM, the U.S. Department of Health and Human Services and other authorized federal and state personnel or their designees free of charge.

3.11 Government Audit; Investigations. Provider acknowledges and agrees that the State and the U.S. Department of Health and Human Services, the Centers for Medicare & Medicaid Services, the Office of Inspector General, the General Accounting Office, or any other auditing agency and their designees or their authorized representatives, with prior approval by DOM, shall, at all reasonable time, with or without notice, have the right to inspect, audit or otherwise evaluate the quality, appropriateness, and timeliness of services provided under the terms of the State Contract and any other applicable rules, including the right to inspect and audit any records or documents of Provider and its subcontractors, and the right to inspect the premises, physical facilities, and equipment where Medicaid-related activities or work is conducted. The right to audit under this section exists for 10 years from the end date of the State Contract or from the date of completion of any audit, whichever is later. There shall be no restrictions on the right of the State or federal government to conduct whatever inspections and audits are necessary to assure quality, appropriateness or timeliness of services provided pursuant to the State Contract and the reasonableness of their costs.

3.12 Privacy; HIPAA. Provider shall comply with all applicable privacy rule and security rule provisions of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), and associated implementing regulations, as may be amended from time to time, and shall safeguard information about Covered Persons in accordance with applicable federal and State privacy laws and rules including 42 CFR 438.224 and 42 CFR Part 431, Subpart F, as may be amended from time to time. HMO agrees and shall require Provider to agree that confidential information, including but not limited to medical and other pertinent information relative to Covered Persons, shall not be disclosed to any person or organization for any purpose without the expressed, written authority of DOM or as otherwise required by law and that all such disclosures shall fully comply with HIPAA privacy and security standards.

3.13 Compliance with Law. Provider shall comply with all applicable federal and State laws and regulations, and all provisions of the State Contract, that pertain to a Covered Person's rights, including but not limited to the following to the extent applicable to Provider in performance of the Agreement:

i) Title VI of the Civil Rights Act of 1964; Title XIX of the Social Security Act; 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 Genetic Information Non-Discrimination Act of 2008 (GINA); the Americans with Disabilities Act; section 1557 of the Patient Protection and Affordable Care Act, and their implementing regulations, as may be amended from time to time.

ii) All relevant federal and State statutes, regulations and orders related to equal opportunity in employment, including but not limited to compliance with E.O. 11246, "Equal Employment Opportunity," as amended by E.O. 11375, "Amending Executive Order 11246 Relating to Equal Employment Opportunity," and as supplemented by regulations at 41 CFR part 60, "Office of Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor."

iii) All federal and State professional and facility licensing and accreditation requirements/standards that apply to the services HMO and Provider perform pursuant to the Agreement, including but not limited to:

a) All applicable standards, orders or requirements issued under Section 306 of the Clean Air Act (42 USC 1857 (h)). Section 508 of the Clean Water Act (33 USC 1368), Executive Order 11738, and Environmental Protection Agency (EPA) regulations (40) CFR Part 15), which prohibit the use of facilities included on the EPA list of violating facilities. Any violations must be reported to DSHS, DHHS, and the EPA;

b) Any applicable mandatory standards and policies relating to energy efficiency that are contained in the State Energy Conservation Plan, including the Energy Policy & conservation Act (Pub. L. 94-165), and issued in compliance with the Federal Energy Policy & Conservation Act.

c) Those specified for laboratory services in the Clinical Laboratory Improvement Amendments (CLIA). All laboratory service sites must have a CLIA certificate of registration or waiver, and a CLIA identification number.

d) Section 1128B(d)(1) of the Balanced Budget Act of 1997; and,

e) Any other requirements associated with the receipt of federal funds.

iv) All Medicaid laws, regulations and program instructions to the extent applicable to Provider in Provider's performance of the Agreement. Provider understands that payment of a claim by HMO or the State is conditioned upon the claim and the underlying transaction complying with such laws, regulations, and program

instructions (including, but not limited to, federal requirements on fraud, waste and abuse, disclosure, debarment, termination and exclusion screening), and is conditioned on the Provider's compliance with all applicable conditions of participation in Medicaid. Provider understands and agrees that each claim the Provider submits to HMO constitutes a certification that the Provider has complied with all applicable Medicaid laws, regulations and program instructions in connection with such claims and the services provided therein. Provider's payment of a claim will be denied if Provider is terminated or excluded from participation in federal healthcare programs. Provider's payment of a claim may be temporarily suspended if the State or HMO provides notice that a credible allegation of fraud exists and there is a pending investigation. Provider's payment of a claim may also be temporarily suspended or adjusted if the Provider bills a claim with a code that does not match the service provided. HMO performs coding edit procedures based primarily on National Correct Coding Initiative (NCCI) policies and other nationally recognized and validated policies. Provider agrees that it will provide medical records to HMO upon its request in order to determine appropriateness of coding. Provider may dispute any temporarily suspended or adjusted payment consistent with the terms of the Agreement.

3.14 Physician Incentive Plans. In the event Provider participates in a physician incentive plan ("PIP") under the Agreement, Provider agrees that such PIPs must comply with 42 CFR 417.479, 42 CFR 438.3(i), 42 CFR 422.208, and 42 CFR 422.210, as may be amended from time to time. Neither HMO nor Provider may make a specific payment directly or indirectly under a PIP to a physician or physician group as an inducement to reduce or limit Medically Necessary services furnished to an individual Covered Person. PIPs must not contain provisions that provide incentives, monetary or otherwise, for the withholding of services that meet the definition of Medical Necessity.

3.15 Lobbying. Provider agrees to comply with the following requirements related to lobbying:

i) Prohibition on Use of Federal Funds for Lobbying: By signing the Agreement, Provider certifies to the best of Provider's knowledge and belief, pursuant to 31 U.S.C. Section 1352 and 45 CFR Part 93, as may be amended from time to time, that no federally appropriated funds have been paid or will be paid to any person by or on Provider's behalf for the purpose of influencing or attempting to influence an officer or employee of any agency, a member of Congress, an officer or employee of Congress, or an employee of a member of Congress in connection with the award of any federal contract, the making of any federal grant, the making of any federal loan, the entering into of any cooperative agreement, or the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan, or cooperative agreement.

ii) Disclosure Form to Report Lobbying: If any funds other than federally appropriated funds have been paid or will be paid to any person for the purpose of influencing or attempting to influence an officer or employee of any agency, a member of Congress, an officer or employee of Congress, or an employee of a member of Congress in connection with the award of any federal contract, the making of any federal grant, the

making of any federal loan, the entering into of any cooperative agreement, or the extension, continuation, renewal, amendment or modification of any federal contract, grant, loan, or cooperative agreement and the value of the Agreement exceeds $100,000, Provider shall complete and submit Standard Form-LLL, "Disclosure Form to Report Lobbying," in accordance with its instructions.

3.16 Excluded Individuals and Entities. Provider certifies that neither it nor any of its employees, principals, nor any providers, subcontractors or consultants or persons with an ownership or controlling interest in the Provider (an owner including the Provider himself or herself), or an agent or managing employee of the Provider, with whom Provider contracts and who are providing items or services that are significant and material to Provider's obligations under the Agreement is:

i) excluded from participation in federal health care programs under either Section 1128 or section 1128A of the Social Security Act; or

ii) debarred, suspended or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in nonprocurement activities under regulations issued under Executive Order no. 12549 or under guidelines implementing Executive Order No. 12549; or an affiliate, as defined in the Federal Acquisition Regulation, of such a person.

Provider acknowledges and agrees that payment will not be made for any items or Covered Services provided by an excluded individual pursuant to 42 CFR 1001.1901(b) and is obligated to screen all employees, contractors, and subcontractors for exclusion as required under applicable State and Federal laws. Additionally, Provider acknowledges that pursuant to 42 CFR 1003.102(a)(2) civil monetary penalties may be imposed against Provider if he or she employs or enters into contracts with excluded individuals or entities to provide items or Covered Services to Covered Persons under this Agreement. Provider agrees not to employ or subcontract with individuals or entities whose owner, those with a controlling interest, or managing employees are on a State or Federal exclusion list to provide items or Covered Services under this Agreement. Provider shall immediately report to HMO any exclusion information discovered. Provider can search the HHS-OIG website, at no cost, by the names of any individuals or entities. The database is called LEIE and can be accessed at http://www.oig.hhs.gov/fraud/exclusions.asp. The GSA EPLS/SAM database can be accessed at https://www.sam.gov. Federal and State exclusion databases must be reviewed monthly to ensure that no employee or contractor has been excluded. Applicable state exclusion databases can be accessed through the State's Medicaid website. HMO will terminate the Agreement immediately and exclude from its network any provider who has been excluded from federal health care programs or terminated from the Medicare or the Medicaid program in any state. HMO may also terminate the Agreement if Provider or Provider's owners, agents, or managing employees are found to be excluded on a State or Federal exclusion list.

3.17 Disclosure. Provider must be screened and enrolled in the State's Medicaid program and submit disclosures to the DOM related to ownership and control, significant business transactions, and persons convicted of crimes in accordance with 42 CFR Part 455 .Provider must submit information related to ownership and control of subcontractors or

wholly owned suppliers within thirty-five (35) calendar days of a request for such information in accordance with 42 CFR 455.105. Additionally, Provider must cooperate with DOM for submission of fingerprints upon a request from DOM or CMS in accordance with 42 CFR 455.434.

By executing this Agreement, Provider certifies that neither Provider nor any of its principals is presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in any State or federal health care program or from participating in transactions by any State or federal department or agency. HMO will terminate the Agreement upon becoming aware or receiving notice from DOM, whichever is earlier, that Provider is or has been excluded from participation in any State or federal health care program or by any State or federal agency.

3.18 Cultural Competency and Access. Provider shall participate in HMO's and the State's efforts to promote the delivery of services in a culturally competent manner to all Covered Persons, including those with limited English proficiency, physical or mental disabilities, diverse cultural and ethnic backgrounds and regardless of gender, sexual orientation or gender identity, and shall provide interpreter services in a Covered Person's primary language and for the hearing impaired for all appointments and emergency services. Provider shall provide information to Covered Persons regarding treatment options and alternatives, as well as information on complaints and appeals, in a manner appropriate to the Covered Person's condition and ability to understand. Provider shall provide physical access, reasonable accommodations, and accessible equipment for Covered Persons with physical or mental disabilities.

3.19 Marketing. As required under State or federal law or the applicable State Contract, any marketing materials developed and distributed by Provider as related to the performance of the Agreement must be submitted to HMO at least sixty (60) days prior to planned distribution for timely submission to DOM for prior approval. Provider agrees it will not proceed with the statement or communication until the required approval is obtained.

3.20 Fraud, Waste and Abuse Prevention. Provider shall cooperate fully with HMO's policies and procedures designed to protect program integrity and prevent and detect potential or suspected fraud, waste, and abuse in the administration and delivery of services under the State Contract and shall cooperate and assist DOM and any other State or federal agency charged with the duty of preventing, identifying, investigating, sanctioning or prosecuting suspected fraud, waste, and abuse in state and/or federal health care programs.

In accordance with HMO's policies and the Deficit Reduction Act of 2005 (DRA), Provider shall have written policies for its employees, contractors or agents that: (a) provide detailed information about the federal False Claims Act (established under sections 3729 through 3733 of title 31, United States Code), including if any entity makes or receives annual payments under the State Program of at least $5,000,000, such entity must establish certain minimum written policies and information communicated through an employee handbook relating to the Federal False Claims Act in accordance with 42 CFR 438.600; (b) cite administrative remedies for false claims and statements (established under chapter 38 of title 31, United States Code) and whistleblower protections under federal and state laws; (c) reference state laws pertaining to civil or criminal penalties for false claims

and statements; and (d) with respect to the role of such laws in preventing and detecting fraud, waste, and abuse in federal health care programs (as defined in section 1128B(f)), include as part of such written policies, detailed provisions regarding Provider's policies and procedures for detecting and preventing fraud, waste, and abuse. Provider agrees to train its staff on the aforesaid policies and procedures.

3.21 Data; Reports. Provider shall cooperate with and release to HMO any information necessary for HMO to perform its obligations under the State Contract to the extent applicable to Provider in performance of the Agreement, including the timely submission of reports and information required by HMO, in the format specified by HMO and the State. Such reports shall include child health check-up reporting, if applicable, as well as complete and accurate encounter data in accordance with the requirements of HMO and the State. Data must be provided at the frequency and level of detail specified by HMO or the State. By submitting data to HMO, Provider represents and attests to HMO and the State that the data is accurate, complete and truthful, and upon HMO's request Provider shall certify in writing, that the data is accurate, complete, and truthful, based on Provider's best knowledge, information and belief.

Provider shall be able to receive, maintain and utilize applicable data extracts from HMO or DOM and systematically update its database within five (5) calendar days of receipt of the files. Data extract files include but are not limited to the following, as applicable: 1. Daily Active Provider Extract; 2. Weekly Provider Affiliation Details Extract; 3. 834 Enrollment Files; 4. 835 Claims Payment Remittance Advice Transaction; 5. 277 Claims Acknowledgement; 6. NCPDP Formulary; 7. NCPDP Response File; 8. TPL Resource/Policy Information File, etc.; 9. Claims History Extracts; and 10. Prior Authorization Extracts.

3.22 Encounter Data. Provider agrees to cooperate with HMO to comply with HMO's obligation to prepare encounter data submissions, reports, and clinical information including, without limitation, child and adolescent health check-up reporting, EPSDT encounters, and cancer screening encounters, as applicable, and such other reporting regarding Covered Services as may be required under the State Contract. Encounter data must be accurate and include all services furnished to a Covered Person, including capitated provider's data and rendering provider information. Encounter data must be provided within the timeframes specified and in a form that meets HMO and State requirements. By submitting encounter data to HMO, Provider represents to HMO that the data is accurate, complete and truthful, and upon HMO's request Provider shall certify in writing, that the data is accurate, complete, and truthful, based on Provider's best knowledge, information and belief.

3.23 Claims Information. Provider shall promptly submit to HMO the information needed to make payment and shall identify third party liability coverage, including Medicare and other insurance, and if applicable seek such third party liability payment before submitting claims to HMO. Provider understands and agrees that each claim Provider submits to HMO constitutes a certification that the claim is true and accurate to the best of Provider's knowledge and belief and that the Covered Services are 1) Medically Necessary and 2) have been provided to the Covered Person prior to submitting the claim.

Effective July 1, 2014, Provider must submit claims within six (6) months from the date of service. Claims filed within the appropriate time frame but denied may be resubmitted to the Contractor within ninety (90) calendar days from the date of denial

3.24. Electronic Visit Verification. Provider shall cooperate with State requirements for electronic visit verification for personal care services and home health services, as applicable.

3.25 Licensure. Provider represents that it is currently licensed and/or certified under applicable State and federal statutes and regulations and by the appropriate State licensing body or standard-setting agency, as applicable. Provider represents that it is in compliance with all applicable State and federal statutory and regulatory requirements of the Medicaid program and that it is eligible to participate in the Medicaid program. Provider represents that it does not have a Medicaid provider agreement with DOM that is terminated, suspended, denied, or not renewed as a result of any action of DOM, CMS, HHS, or the Medicaid Fraud Control Unit of the State's Attorney General. Provider shall maintain at all times throughout the term of the Agreement all necessary licenses, certifications, registrations and permits as are required to provide the health care services and/or other related activities delegated to Provider by HMO under the Agreement. If at any time during the term of the Agreement, Provider is not properly licensed as described in this Section, Provider shall discontinue providing services to Covered Persons. As applicable, if Provider performs any laboratory tests on human specimens for the purpose of diagnosis and/or treatment, Provider agrees to acquire and maintain the appropriate CLIA certification or waiver for the type of laboratory testing performed. Provider further agrees to provide a copy of the certification if requested by HMO. A State authorized license or permit that meets the CLIA requirements may be substituted for the CLIA certificate pursuant to State law. Medicare and Medicaid programs require the applicable CLIA certification or waiver for the type of services performed as a condition of payment. Provider must include the appropriate CLIA certificate or waiver number on claims submitted for payment for laboratory services.

3.26 Quality; Utilization Management. Pursuant to any applicable provider manuals and related protocols, or as elsewhere specified under the Agreement, Provider agrees to cooperate with HMO's quality improvement and utilization review and management activities. This shall include, but not be limited to, participation in any internal and external quality assurance, utilization review, peer review, and grievance procedures established by HMO or as required under the State Contract to ensure that Covered Persons have due process for their complaints, grievances, appeals, fair hearings or requests for external review of adverse decisions made by HMO or Provider. Provider shall adhere to the quality assurance and utilization review standards of the MississippiCAN Program and shall monitor quality and initiate corrective action to improve quality consistent with the generally accepted level of care.

3.27 Non-Discrimination. Provider will not discriminate against, nor use any policy or practice that has the effect of discriminating against, Covered Persons on the basis of race, color, creed, sex, religion, age, national origin, ancestry, marital status, sexual orientation, gender identity, language, health status, disease or pre-existing condition (including genetic

information), anticipated need for health care or physical or mental handicap, except where medically indicated. Examples of prohibited practices include, but are not limited to, the following:

i) Denying or not providing a Covered Person any Medicaid Covered Service. Health care and treatment necessary to preserve life must be provided to all Covered Persons who are not terminally ill or permanently unconscious, except where a competent Covered Person objects to such care on his/her own behalf.

ii) Subjecting a Covered Person to segregated, separate, or different treatment, including a different place or time from that provided to other Covered Persons or public or private patients, in any manner related to the receipt of any Medicaid Covered Service, except where Medically Necessary.

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

3.28 Advance Directives. Provider shall comply with the advance directives requirements set forth in the Uniform Health-Care Decisions Act, Section 41-41-215 of the Mississippi Code. When applicable, Provider shall comply with the advance directives requirements for hospitals, nursing facilities, providers of home and health care and personal care services, hospices, and HMOs as specified in 42 CFR Part 49, subpart I, 42 CFR § 417.436(d), 42 CFR § 422.128, and 42 CFR 438.3(i).

3.29 National Provider ID (NPI). Provider shall obtain a National Provider Identification Number (NPI) and when filing claims with HMO, the NPI used is the same NPI used when filing claims with DOM.

3.30 Termination. In the event of termination of the Agreement, Provider shall promptly supply to HMO all information necessary for the reimbursement of any outstanding Medicaid claims.

3.31 Complaints; Grievances and Appeals. Information on how Provider or Provider's authorized representative can submit complaints and file grievances and appeals, and the resolution process, is contained in the applicable provider manual.

3.32 Health Care Acquired/Preventable Conditions. Provider agrees that no payment shall be made for the provision of medical assistance for health care acquired conditions and other provider preventable conditions as may be identified by the State. As a condition of payment, Provider shall identify and report to HMO any provider preventable conditions in accordance with 42 CFR §§ 434.6(a)(12), 438 including but not limited to 438.3(g), and 447.26.

3.33 Quality and Utilization Management Program. Provider shall cooperate with HMO in meeting the Quality Management and Utilization Management Program standards outlined

in the State Contract including, without limitation, any external evaluations and assessments of HMO's performance authorized by DOM under the State Contract and conducted by DOM's contracted External Quality Review Organization (EQRO) or other designee.

3.34 Referrals. Provider shall make referrals for social, vocational, education or human services when a need for such service is identified.

3.35 Insolvency. In the event HMO becomes insolvent or unable to pay Provider, Provider shall not seek compensation for services rendered from the State, DOM, their officers, Agents, or employees, or the Covered Persons or their eligible dependents.

3.36 Third Party Resources. Provider will report all third party resources to HMO identified through the provision of medical services.

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

3.38 Capitated Providers. If Provider is capitated and terminates its agreement with HMO, for any reason, Provider will provide services to Covered Persons assigned to Provider up to the end of the month in which the effective date of termination falls.

3.39 Certification on Relationship to State, DOM and CMS. Provider certifies that no officer, director, employee, subcontractor or agent of Provider, or person with an ownership or control interest in Provider, is also employed by, or is a public official of, the State of Mississippi or any of its agencies, DOM or CMS.

3.40 Funding. Provider recognizes that the obligation of DOM to proceed under its Contract with HMO is conditioned upon the appropriation of funds by the Mississippi State

Legislature and the receipt of State and/or Federal funds. If the funds anticipated for the continuing fulfillment of the agreement are, at any time, not forthcoming or insufficient, either through the failure of the Federal government to provide or the State of Mississippi to appropriate funds, or the discontinuance, or material alteration of the program under which the funds were provided or if funds are not otherwise available to DOM, DOM has the right upon ten (10) working days written notice to HMO to terminate the Contract.

3.41 Gratuities. Provider represents that it has not violated, is not violating, and promises that it will not violate the prohibitions against gratuities set forth in Section 6-204 (Gratuities) of the Mississippi Personal Service Contract Procurement Regulations.

3.42 Assignment/Delegation. Provider shall not assign or delegate the Agreement without the express written consent of HMO or DOM. If Provider subcontracts or delegates any functions of the Agreement, in accordance with the terms of the Agreement and with the express written consent of HMO or DOM, the subcontract or delegation must be in writing and include all of the requirements of this Appendix, and applicable requirements of the State Contract, and applicable laws and regulations. The transfer of five percent (5%) or more of the beneficial ownership in Provider at any time during the term of this Agreement shall be deemed an assignment under this Agreement.

3.43 Notice of Legal Action. Immediately upon obtaining knowledge or receiving notice of any legal action or notice listed below, Provider shall provide to HMO written notice of such legal action or notice and, upon request by HMO, a complete copy of all filings and other documents generated in connection with any such legal action:

i. Any action, suit or counterclaim filed against Provider;

ii. Any regulatory action, or proposed action, respecting Provider's business or operations;

iii. Any notice received by Provider from the Department of Insurance or the State Health Officer;

iv. The filing of a petition in bankruptcy by or against Provider, or the insolvency of Provider;

v. The conviction of any person who has an ownership or control interest in Provider, or who is an agent or managing employee of Provider, of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or Title XX of the Social Security Act; or

vi. A malpractice action against any Provider delivering service under an agreement.

3.44 Federal and State Funds Liability. Providers acknowledges and agrees that payments made to Provider for services provided under the Agreement are derived from federal and State funds and that any false claim or statement in documents or any concealment of material fact related to such services may be a cause for sanctions and prosecution under applicable federal and State laws. Provider shall be subject to all laws applicable to

individuals and entities receiving State and federal funds and may be held civilly or criminally liable to both HMO and DOM in the event of nonperformance, misrepresentation, fraud, or abuse related to services provided pursuant to the State Contract. Provider recognizes that payments made to the Provider are derived from federal and State funds, and are contingent upon and subject to availability and receipt of funds.

3.45 Insurance Requirements. As applicable, Provider shall secure and maintain during the term of the Agreement insurance appropriate to the services to be performed under the Agreement. Provider shall require that its providers secure and maintain during the term of the Agreement general liability insurance, professional liability insurance, and workers' compensation insurance for all employees connected with the provision of services under the Agreement. Such workers compensation insurance shall comply with Mississippi Workers' Compensation Laws. Such comprehensive general liability insurance and professional liability insurance shall provide coverage in an amount established by HMO pursuant to the Agreement or as required under the State Contract.

3.46 Overpayment. Provider shall to report to HMO when it has received an overpayment and will return the overpayment to HMO within 60 calendar days after the date on which the overpayment was identified. Provider will notify HMO in writing of the reason for the overpayment.

SECTION 4
ADDITIONAL PROVIDER REQUIREMENTS FOR SPECIFIC ACTIVITIES

4.1 Behavioral Health Providers. Behavioral Health Providers shall ensure that all Covered Persons receiving inpatient psychiatric services are scheduled for outpatient follow-up and/or continuing treatment prior to discharge from the inpatient psychiatric hospital if the Provider is aware of the Covered Person's inpatient hospitalization status. Behavioral Health Providers will be provided daily reports identifying Covered Persons known to be admitted to an inpatient facility. Behavioral Health Services will be delivered in compliance with the requirements of 42 CFR 438 subpart K insofar as those requirements are applicable.

4.2 PCP Responsibilities. Providers acting as PCPs shall meet the following requirements:

i) PCPs who serve Covered Persons under the age of twenty-one (21) are responsible for conducting all EPSDT screens for individuals on their Panel under the age of twenty-one (21). Should the PCP be unable to conduct the necessary EPSDT screens, the PCP is responsible for arranging to have the necessary EPSDT screens conducted by another network Provider and ensure that all relevant medical information, including the results of the EPSDT screens, are incorporated into the Covered Person's PCP Medical Record.

ii) PCPs who serve Members under the age of twenty-one (21) report encounter data associated with EPSDT screens, using a format approved by DOM, to the Contractor within ninety (90) calendar days from the date of service.

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

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

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

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

4.3 Specialists as PCPs. Covered Persons with disabling conditions, chronic illnesses, or child(ren) with special health care needs may request that their PCP be a specialist. The designation of a specialist as a PCP must be pursuant to a treatment plan approved by HMO, in consultation with the PCP to which the Covered Person is currently assigned, the Covered Person and, as appropriate, the specialist.

The specialist as a PCP shall provide or arrange for all primary care, including routine preventive care, and to provide those specialty medical services consistent with the Covered Person's disabling condition, chronic illness, or special health care need in accordance with HMO's standards and within the scope of the specialty training and clinical expertise.

The specialist as a PCP shall have admitting privileges at a hospital in HMO's network.

4.4 Long-Term Services and Supports (LTSS) Providers. Any LTSS Covered Services under the State Contract that could be authorized through a waiver under section 1915(c) of the Social Security Act (the "Act") or a State Program amendment authorized through sections 1915(i) or 1915(k) of the Act must be delivered in settings consistent with 42 CFR 441.301(c)(4).

SECTION 5
HMO REQUIREMENTS

5.1 Prompt Payment. HMO shall pay Provider pursuant to the State Contract and applicable State and federal law and regulations, including but not limited to Mississippi Code Section 83-9-5, 42 CFR 447.46, 42 CFR 447.45(d)(2), 42 CFR 447.45(d)(3), 42 CFR 447.45(d)(5) and 42 CFR 447.45(d)(6), as applicable and as may be amended from time to time. If a third party liability exists, payment of claims shall be determined in accordance with federal and/or State third party liability law and the terms of the State Contract. Unless HMO otherwise requests assistance from Provider, HMO will be responsible for third party collections in accordance with the terms of the State Contract.

5.2 No Incentives to Limit Medically Necessary Services. HMO shall not structure compensation provided to individuals or entities that conduct utilization management and concurrent review activities so as to provide incentives for the individual or entity to deny, limit, or discontinue Medically Necessary services to any Covered Person.

5.3 Provider Discrimination Prohibition. HMO shall not discriminate with respect to participation, reimbursement, or indemnification of a provider who is acting within the scope of the provider's license or certification under applicable State law, solely on the basis of such license or certification. HMO shall not discriminate against Provider for serving high-risk Covered Persons or if Provider specializes in conditions requiring costly treatments. This provision shall not be construed as prohibiting HMO from limiting a provider's participation to the extent necessary to meet the needs of Covered Persons. This provision also is not intended and shall not interfere with measures established by HMO that are designed to maintain quality of care practice standards and control costs.

5.4 Communications with Covered Persons. Covered Persons are entitled to the full range of their Providers' opinions and counsel about the availability of Medically Necessary Services under the provisions of the State Contract. Any contractual provisions, including gag clauses or rules, that restrict a Provider's ability to advise Covered Persons about Medically Necessary treatment options violate federal law and regulations.

HMO shall not prohibit or otherwise restrict Provider, when acting within the lawful scope of practice, from advising or advocating on behalf of a Covered Person for the following:

i) The Covered Person's health status, medical care, or treatment options, including any alternative treatment that may be self-administered;

ii) Any information the Covered Person needs in order to decide among all relevant treatment options;

iii) The risks, benefits, and consequences of treatment or non-treatment;

iv) The Covered Person's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions; or

v) Information regarding the nature of treatment options including those that may not reflect HMO's position or may not be covered by HMO.

HMO also shall not prohibit a Provider from advocating on behalf of a Covered Person in any grievance system, utilization review process, or individual authorization process to obtain necessary health care services.

5.5 Termination, Revocation and Sanctions. In addition to its termination rights under the Agreement, HMO shall have the right to revoke any functions or activities HMO delegates to Provider under the Agreement or impose other sanctions consistent with the State Contract if in HMO's reasonable judgment Provider's performance under the Agreement is inadequate. HMO shall also have the right to suspend, deny, refuse to renew or terminate

Provider in accordance with the terms of the State Contract and applicable law and regulation. However, HMO shall not exclude or terminate a Provider from participation in HMO's Provider Network due to the fact that the Provider has a practice that includes a substantial number of patients with expensive medical conditions, and shall not terminate a Provider for filing a Complaint, Grievance, or Appeal on a Covered Person's behalf.

5.6 Rights of DOM. DOM shall have the right to invoke against Provider any remedy set forth in the State Contract, including the right to require the termination of the Agreement, for each and every reason for which it may invoke such a remedy against HMO or require termination of the State Contract. Suspected Fraud and Abuse by Provider will be investigated by DOM.

SECTION 6
OTHER REQUIREMENTS

6.1 Compliance with State Contract. All tasks performed under the Agreement shall be performed in accordance with the requirements of the applicable State Contract, as set forth in this Appendix, applicable provider manuals, and protocols, policies and procedures that HMO has provided or delivered to Provider. The applicable provisions of the State Contract are incorporated into the Agreement by reference. Nothing in the Agreement relieves HMO of its responsibility under the State Contract. If any provision of the Agreement is in conflict with provisions of the State Contract, the terms of the State Contract shall control and the terms of the Agreement in conflict with those of the State Contract will be considered waived.

6.2 Monitoring. HMO shall perform ongoing monitoring (announced or unannounced) of services rendered by Provider under the Agreement and shall perform periodic formal reviews of Provider according to a schedule established by the State, consistent with industry standards or State managed care organization laws and regulations or requirements under the State Contract. As a result of such monitoring activities, HMO shall identify to Provider any deficiencies or areas for improvement mandated under the State Contract and Provider and HMO shall take appropriate corrective action. Provider shall comply with any corrective action plan initiated by HMO and/or required by the MississippiCAN Program. In addition, Provider shall monitor and report the quality of services delivered under the Agreement and initiate a plan of correction where necessary to improve quality of care, in accordance with that level of care which is recognized as acceptable professional practice in the respective community in which HMO and Provider practice and/or the performance standards established under the State Contract.

6.3 Enrollment. The parties acknowledge and agree that DOM is responsible for enrollment, reenrollment and disenrollment of Covered Persons.

6.4 No Exclusivity. Nothing in the Agreement or this Appendix shall be construed as prohibiting or penalizing Provider for contracting with a managed care organization other than HMO or as prohibiting or penalizing HMO for contracting with other providers. HMO may not require Providers who agree to participate in the MississippiCAN Program to contract with HMO's other lines of business.

6.5 **Delegation.** The parties agree that, prior to execution of the Agreement, HMO evaluated Provider's ability to perform any duties delegated to Provider under the Agreement. Any delegated duties and reporting responsibilities shall be set forth in the Agreement or other written delegation agreement or addendum between the parties. HMO shall have the right to revoke any functions or activities HMO delegates to Provider under the Agreement if in HMO's reasonable judgment Provider's performance under the Agreement is inadequate.

MississippiCHIP
Regulatory Requirements Appendix

MississipiCHIP

REGULATORY REQUIREMENTS APPENDIX

PROVIDER

THIS MISSISSIPPICHIP PROGRAM REGULATORY REQUIREMENTS APPENDIX (this "Appendix") supplements and is made part of the provider agreement (the "Agreement") between HMO contracting on behalf of itself and the other entities that are its affiliates (collectively, "CCO") and the party named in the Agreement ("Provider").

SECTION 1
APPLICABILITY

This Appendix applies with respect to the provision of direct or health care related services provided by Provider under the Mississippi Children's Health Insurance Program (the "MississippiCHIP Program") as governed by the State's designated regulatory agencies. In the event of a conflict between this Appendix and other appendices or any provision of the Agreement, the provisions of this Appendix shall control except with regard to benefit plans outside the scope of this Appendix or unless otherwise required by law. In the event CCO is required to amend or supplement this Appendix as required or requested by the State to comply with federal or State regulations, CCO will unilaterally initiate such additions, deletions or modifications. All provider agreements must be in writing and must include all specific activities and report responsibilities delegated to the Provider by CCO.

SECTION 2
DEFINITIONS

Unless otherwise defined in this Appendix, all capitalized terms shall be as defined in the Agreement. For purposes of this Appendix, the following terms shall have the meanings set forth below; provided, however, in the event any definition set forth in this Appendix or the Agreement is inconsistent with any definition under the MississippiCHIP Program Contract, the definition shall have the meaning set forth under the MississippiCHIP Program Contract.

2.1 **Abuse:** Any practice that is inconsistent with sound fiscal, business, or medical practices, and results in an unnecessary cost to CHIP, CCO, a subcontractor, or a provider or in reimbursement for services that are not Medically Necessary or that fail to meet professionally recognized standards for healthcare.

2.2 **Adverse Benefit Determination:** The denial or limited authorization of a requested service, including determinations on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit; the reduction, suspension, or termination of previously authorized services; the denial, in whole or in part, of payment for a service; CCO's failure to provide services in a timely manner; CCO's failure to resolve Complaints, Grievances, or Appeals within the specified time frames; for residents in a rural area with only one MCO, the denial of a Covered Person's request to exercise his or her right, under 42 C.F.R. §438.52(b)(2)(ii); the denial of a Covered Person's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other enrollee financial liabilities; and determinations by skilled nursing facilities and nursing facilities to transfer or discharge residents and adverse determinations made by a State with regard to the preadmission

screening and annual resident review requirements of Section 1919(e)(7) of the Act, if applicable.

2.3 **Agreement:** An agreement between the CCO and an individual, business, university, government entity, affiliate, or nonprofit organization to perform part or all of CCO's responsibilities under the MississippiCHIP Program Contract. Agreements must be approved in writing by DOM prior to the start date of the Agreement.

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

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

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

2.7 **Benchmark Plan:** The State School Employee's Health Insurance Plan.

2.8 **Child:** An individual who is under nineteen (19) years of age who is not eligible for Medicaid benefits and is not covered by other health insurance. Child is also referred to as Member.

2.9 **CHIP:** The Children's Health Insurance Program as defined in Title XXI of the Social Security Act.

2.10 **Complaint:** An expression of dissatisfaction received orally or in writing that is of a less serious or formal nature that is resolved within one (1) business day of receipt.

2.11 **Coordinated Care Organization (CCO):** An organization that meets the requirements for participation as a Contractor in CHIP and manages the purchase and provision of health care services under CHIP. For purposes of this Appendix, CCO is a CCO.

2.12 **Co-Payment:** The fixed amount certain CHIP Members pay for a covered health care service. The amount may vary based on healthcare service being provided.

2.13 **Cost Sharing:** In accordance with 42 C.F.R. §457.10, premium charges, enrollment fees, deductibles, coinsurance, Co-Payments, or other similar fees that the Member has responsibility for paying.

2.14 **Covered Services:** Health care services or products for which a Member is enrolled with CCO to receive coverage under the MississippiCHIP Program Contract, including all services required by the State Contract and State and federal law.

2.15 Disenrollment: Action taken by DOM, or its Agent, to remove a Member's name from the monthly Member Listing Report following DOM's receipt and approval of a request for Disenrollment or a determination that the Member is no longer eligible for Enrollment in Contractor.

2.16 DOM: The Division of Medicaid, Office of the Governor, State of Mississippi.

2.17 Fraud: Fraud is any type of intentional deception or misrepresentation made by an entity or person with the knowledge that the deception could result in some unauthorized benefit to the entity, him or herself, or some other person. The Fraud can be committed by many entities, including a vendor, a subcontractor, a provider, a State employee, or a Member among others.

2.18 Grievance: An expression of dissatisfaction about any matter or aspect of CCO or its operation, other than an Adverse Benefit Determination as defined herein. Grievances may include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the Covered Person's rights regardless of whether remedial action is requested. Grievance includes a Covered Person's right to dispute an extension of time proposed by CCO to make an authorization decision.

2.19 Marketing: The activities that promote visibility and awareness for the MississippiCHIP Program and the CCOs participating in the program. All marketing activities are subject to prior review and approval by DOM and may not contain misleading information.

2.20 Medical Record: A single complete record, which documents the entire treatment plan developed for, and medical services received by, the Member including inpatient, outpatient, referral services and emergency medical services whether provided by Contracted Providers or Non-Contracted Providers.

2.21 Member: An individual who meets all of the eligibility requirements for CHIP, enrolls in a CCO under CHIP, and receives health benefits coverage through CHIP.

2.22 MississippiCHIP Program: The Mississippi Medicaid child health program for select individuals under the age of nineteen (19) years of age who are not eligible for Medicaid benefits and are not covered by other health insurances.

2.23 MississippiCHIP Program Contract: The DOM contract with CCO, for the purpose of providing and paying for Covered Services to Members enrolled in the MississippiCHIP Program.

2.24 Primary Care Provider (PCP): Any physician or health care practitioner or group operating within the scope of his or her licensure who is responsible for supervising, prescribing and providing primary care and primary case management services in the MississippiCHIP Program, whose practice is limited to the general practice of medicine or who is an Internist, Pediatrician, Obstetrician/Gynecologist, Family and General Practitioner, Nurse Practitioners (who meet requirements of Section 4.B, Choice of a Health Care Professional), Physician Assistants, specialists who perform primary care functions upon request, and other providers approved by DOM.

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

2.26 Provider Network: The Panel of health service Providers with which the CCO contracts for the provision of covered services to Members and Non-Contracted Providers administering services to Member.

2.27 State: The State of Mississippi or its designated regulatory agencies.

2.28 State Child Health Plan: The State of Mississippi's plan submitted to HHS for the administration of CHIP.

2.29 Third Party Liability/Resource: Any resource available to a Member for the payment of medical expenses associated with the provision of covered services, including but not limited to, insurers and workers' compensation plan.

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

2.31 Well-Baby and Well-Child Care Services: Regular or preventive diagnostic and treatment services necessary to ensure the health of babies, children, and adolescents as defined by DOM in the State Child Health Plan. For the purposes of Cost Sharing, the term has the meaning assigned at 42 C.F.R. § 457.520.

SECTION 3
PROVIDER REQUIREMENTS

The MississippiCHIP Program, through contractual requirements and federal and State statutes and regulations, requires that providers who provide services to Members enrolled in the MississippiCHIP Program comply with certain requirements as set forth below and elsewhere in this Appendix.

3.1 Definitions Related to the Provision of Covered Services. Provider shall follow the applicable MississippiCHIP Program Contract's requirements for the provision of Covered Services. Provider's decisions affecting the delivery of acute or chronic care services to Members shall be made on an individualized basis and in accordance with the following definitions:

i) Emergency Medical Condition: In accordance with Section 1932(b) of the Act and 42 CFR §457.10, a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in any of the following: (1) 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; (2) serious impairment to body functions; or (3) serious dysfunction of any body organ or part.

ii) Emergency Services: Covered inpatient and outpatient services, inclusive of dialysis services, furnished by a provider who is qualified to furnish those health services and that

are needed to evaluate or stabilize an Emergency Medical Condition in accordance with 42 CFR 438.114.

iii) Medically Necessary Services: As set forth in the Social Security Act, Section 1905 (42 U.S.C. 1396d(a)), Medically Necessary Services are defined as services, supplies, or equipment provided by a licensed health care professional that are:

a) Appropriate and consistent with the diagnosis or treatment of the patient's condition, illness, or injury;

b) In accordance with the standards of good medical practice consistent with the individual patient's condition(s);

c) Not primarily for the personal comfort or convenience of the Member, family, or Provider;

d) The most appropriate services, supplies, equipment, or levels of care that can be safely and efficiently provided to the Member;

e) Furnished in a setting appropriate to the patient's medical need and condition and, when applied to the care of an inpatient, further mean that the Member's medical symptoms or conditions require that the services cannot be safely provided to the Member as an outpatient;

f) Not experimental or investigational or for research or education;

g) Provided by an appropriatelylicensed practitioner; and

h) Documented in the patient's record in a reasonable manner, including the relationship of the diagnosis to the service.

Medically Necessary Services may also be those services for children that are necessary to correct or ameliorate defects and physical and mental illnesses and conditions discovered during an interperiodic or Well-Baby and Well-Child Care Services, whether such services are covered or exceed the benefit limits in the Medicaid State Plan and Title 23 of Mississippi Administrative Code.

3.2 Accessibility Standards. Provider shall provide for timely access for Member appointments in accordance with the appointment availability requirements established under the MississippiCHIP Program Contract, as further described in the applicable provider manual.

Type	Appointment Scheduling Time Frames
PCP (well care visit)	Not to exceed thirty (30) calendar days
PCP (routine sick visit)	Not to exceed seven (7) calendar days
PCP (urgent care visit)	Not to exceed twenty-four (24) hours
Specialists	Not to exceed forty-five (45) calendar days

Dental Providers (routine visits)	Not to exceed forty-five (45) calendar days
Dental Providers (urgent Care)	Not to exceed forty-eight (48) hours
Behavioral Health Providers (routine visit)	Not to exceed fourteen (14) calendar days
Behavioral Health Providers (urgent visit)	Not to exceed twenty-four (24) hours
Behavioral Health Providers (post-discharge from an acute psychiatric hospital when the Contractor is aware of the	Not to exceed seven (7) calendar days
Urgent Care Providers	Not to exceed twenty-four (24) hours
Emergency Providers	Immediately (twenty-four (24) hours a day, seven (7) days a week) and without Prior

3.3 Hours of Operation; Appointments. Provider shall offer hours of operation that are no less than the hours of operation offered to commercial beneficiaries. As applicable, Provider will make Covered Services available 24 hours a day, 7 days a week when medically necessary.

3.4 PCP Responsibilities. If applicable, and Provider is a PCP, Provider shall comply with the following:

i) PCPs who serve Members under the age of nineteen (19) are responsible for conducting all Well-Baby and Well-Child Care services. Should the PCP be unable to conduct the necessary Well-Baby and Well-Child Care services screens, the PCP is responsible for arranging to have the necessary Well-Baby and Well-Child Care services screens conducted by another network provider and ensure that all relevant medical information, including the results of the Well-Baby and Well-Child Care services screens, are incorporated into the Member's PCP Medical Record.

ii) PCPs who serve Members under the age of nineteen (19) report encounter data associated with Well-Baby and Well-Child Care services, using a format approved by DOM, to Contractor within one hundred and eighty (180) calendar days from the date of service.

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

a) Contact Members identified in the quarterly Encounter lists as not complying with Well-Baby, Well-Child Care, and immunization schedules for Children;

b) Identify to Contractor any such Members who have not come into compliance with Well-Baby, Well-Child Care, and immunization schedules within one (1) month of such notification to the site by Contractor; and

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

iv) PCP shall provide Well-Baby and Well-Child Care Services, including vision screening, laboratory

tests and hearing screenings, according to recommendations of the U.S. Preventive Services Task Force. Vision and hearing screenings shall be included as part of periodic Well-Child assessments. PCP shall have written policies and procedures related to the provision of the full-range of Well-Baby Care, Well-Child Care, and childhood and adolescent immunization services as defined in, and in accordance with, the State Child Health Plan, 42 C.F.R. §457.495, and this provisions of the MississippiCHIP Program Contract. Services shall include, without limitation, 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). PCP shall make all reasonable efforts to identify all Members whose Medical Records do not indicate up-to-date immunizations and shall ensure that these Members receive necessary immunizations. Immunizations are purchased and distributed through the Mississippi State Department of Health. CCO shall reimburse PCP for the administration of the immunizations.

CCO requires that PCP cooperate to the maximum extent possible with the efforts to improve the health status of Mississippi citizens, and to actively work to improve the percentage of Members receiving appropriate screenings, and meet or exceed DOM's targets.

a) The following minimum elements must be included in the periodic health screening assessment of children:

i. Comprehensive health and development history (including assessment of both physical and mental development);

ii. Measurements (e.g. head circumference for infants, height, weight, body mass index);

iii. Comprehensive unclothed physical examination;

iv. Immunizations appropriate to age and health history;

v. Assessment of nutritional status;

vi. Laboratory tests (including tuberculosis screening and Federally required blood lead screenings);

vii. Vision screening;

viii. Hearing screening;

ix. Dental and oral health assessment; and

x. Developmental and behavioral assessment.

v) If a suspected problem is detected by a screening examination, the child must be evaluated as necessary for further diagnosis. This diagnosis is used to determine treatment needs. PCP must establish a tracking system that provides information on compliance with Well-Baby and Well-Child Care services and immunization services provision requirements in the following areas:

a) Initial visit for newborns;

b) Well-Baby and Well-Child Care services and reporting of all assessment results; and

c) Diagnosis and/or treatment for Children.

vi) PCP must have an established process for reminders, follow-ups and outreach to Members that includes:

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

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

c) Protocols for conducting outreach with non-compliant Members, including home visits, as appropriate; and

d) A process for outreach and follow-up to Members with special health care needs.

vii) PCP may develop an alternate process for follow-up and outreach subject to prior written approval from CCO and DOM.

viii) **Specialists as PCPs**. Members with disabling conditions, chronic conditions, or with special health care needs may request that their PCP be a specialist. The designation of a specialist as a PCP must be pursuant to a treatment plan approved by Contractor; in consultation with the PCP to which the Member is currently assigned, the Member and, as appropriate, the specialist. When possible, the specialist must be a provider participating in Contractor's network. The specialist as a PCP must agree to provide or arrange for all primary care, including routine preventive care, and to provide those specialty medical services consistent with the Member's disabling condition, chronic illness, or special health care need in accordance with Contractor's standards and within the scope of the specialty training and clinical expertise. To accommodate the full spectrum of care, the specialist as a PCP must also have admitting privileges at a hospital in Contractor's network.

3.5 Provider Selection. To the extent applicable to Provider in performance under the Agreement, Provider shall comply with 42 CFR §438.214, as may be amended from time to time, which includes, but is not limited to the selection and retention of providers, credentialing and re-credentialing requirements and nondiscrimination. If CCO delegates credentialing to Provider, CCO will provide monitoring and oversight and Provider shall ensure that all licensed medical professionals are credentialed in accordance with CCO's and the MississippiCHIP Program Contract's credentialing requirements.

3.6 Records Retention. As required under State or federal law or the MississippiCHIP Program Contract, Provider shall maintain a record keeping system of current, detailed, and organized records for recording services, charges, dates and all other commonly accepted information elements sufficient to disclose the quality, quantity, appropriateness and timeliness of services rendered to Members. All financial records shall follow generally accepted accounting principles. Medical records and supporting management systems shall include all pertinent information related to the medical management of each Member. Other records shall be maintained as necessary to clearly reflect all actions taken by Provider related to services provided under the MississippiCHIP Program Contract. Such records, including, as applicable, grievance and appeals records shall be maintained for a period of not less than ten (10) years from the close of the Agreement, or such other period as required by law. If records are under review or audit or are the subject of litigation they must be retained for a minimum of ten (10) years following resolution of such action. Prior approval for the disposal of records must be requested and approved by CCO if the Agreement is continuous. Provider shall have written records retention policies and procedures and will make such policies and procedures available to CCO or DOM upon request. DOM requires ready access to any and all documents and records of transactions pertaining to the provisions of services provided by Provider and those copies of requested documents/records will be provided to DOM or its designee free of charge.

3.7 **Records Access.** Provider agrees to cooperate with CCO to maintain and share a health record of all services provided to a Covered Person, as appropriate and in accordance with applicable laws, regulations and professional standards. Provider acknowledges and agrees and shall require Provider to acknowledge and agree that DOM, the U.S. Department of Health and Human Services and other authorized federal and state personnel shall have complete access to all records pertaining to services provided to Members. Provider shall provide immediate access to facilities, records and supportive materials pertinent to the MississippiCHIP Program Contract for State or Federal fraud investigators.

3.8 **Government Audit; Investigations.** Provider acknowledges and agrees and shall require Provider to acknowledge and agree that the State or any of its duly authorized representatives, DOM, the U.S. Department of Health and Human Services, the Centers for Medicare & Medicaid Services, the Office of Inspector General, the General Accounting Office, or any other auditing agency or their authorized representatives and their designees, with prior approval by DOM, at any time during the term of the Agreement, shall, at all reasonable time and within regular business hours, with or without notice, have the right to inspect, audit or otherwise evaluate the quality, appropriateness, and timeliness of services provided under the terms of the MississippiCHIP Program Contract and any other applicable federal and State law and regulation.

This shall include, but not be limited to, the right to enter onto Provider's premises, access to and the right to audit, inspect, monitor, and examine any pertinent books, documents, papers, medical records, financial records, surveys and computer databases and/or to otherwise evaluate the performance of Provider related to Provider's performance under the Agreement. Such monitoring activities may also include, without limitation, on-site inspections of all service locations and facilities; auditing and/or review of all records developed under the MississippiCHIP Program Contract or the Agreement; reviewing management systems and procedures developed under the MississippiCHIP Program Contract or the Agreement; and review of any other areas of materials relevant or pertaining to the MississippiCHIP Program Contract or the Agreement. All reviews and audits shall be performed in such a manner as will not unduly delay the work of Provider. There will be no restrictions on the right of the State or federal authorities to conduct inspections and audits as necessary.

The Provider must fully cooperate with any and all reviews and/or audits by state or federal agencies, such as the Department of Audit, Department of Health and Human Services, Centers for Medicare and Medicaid Services, Office of Inspector General, General Accounting Office, or any other auditing agency approved by DOM, by assuring that appropriate employees and involved parties are available for interviews relating to the reviews or audits.

All records shall be maintained and available for review by authorized federal and state agencies during the entire term of the MississippiCHIP Program Contract and for a period of ten (10) years thereafter, unless an audit, litigation, or other legal action is in progress. When an audit or litigation is in progress or audit findings are unresolved, records shall be kept for a period of ten (10) years or until all issues are finally resolved, whichever is later. The Provider must have written policies and procedures for storing this information. Records must be kept in an original paper state or preserved on micro media or electronic format.

3.9 **Data; Reports.** Provider shall and shall require that Provider cooperate with and release to CCO any information necessary for CCO to perform its obligations under the MississippiCHIP Program Contract to the extent applicable to Provider in performance of the Agreement, including the timely submission of reports and information required by CCO, in the format specified by CCO and the State. Such reports shall include well-baby/well-child reporting, as well as complete and accurate encounter and utilization management data in accordance with the requirements of CCO and DOM. Data must be provided at the frequency and level of detail specified by CCO or the State. By submitting data to CCO, Provider represents and attests to CCO and the State that the data is accurate, complete and truthful, and upon

CCO's request Provider shall certify in writing, that the data is accurate, complete, and truthful, based on Provider's best knowledge, information and belief.

Provider shall be able to receive, maintain and utilize applicable data extracts from CCO or DOM and systematically update its database within five (5) calendar days of receipt of the files. Data extract files include but are not limited to the following, as applicable: 1. Daily Active Provider Extract; 2. Weekly Provider Affiliation Details Extract; 3. 834 Enrollment Files; 4. 835 Claims Payment Remittance Advice Transaction; 5. 277 Claims Acknowledgement; 6. NCPDP Formulary; 7. NCPDP Response File; 8. TPL Resource/Policy Information File, etc.; 9. Claims History Extracts; and 10. Prior Authorization Extracts.

3.10 Encounter Data. Provider shall agree to cooperate with CCO to comply with CCO's obligation to prepare encounter data submissions, reports, and clinical information including, without limitation, and well-baby/well-child reporting and encounters, as applicable, and such other reporting regarding Covered Services as may be required under the MississippiCHIP Program Contract. Encounter data must be accurate and include all services furnished to a Covered Person, including capitated provider's data and rendering provider information. Encounter data must be provided within the timeframes specified and in a form that meets CCO and State requirements. By submitting encounter data to CCO, Provider represents to CCO that the data is accurate, complete and truthful, and upon CCO's request Provider shall certify in writing, that the data is accurate, complete, and truthful, based on Provider's best knowledge, information and belief.

3.11 Claims Information. Provider shall promptly submit to CCO the information needed to make payment and shall identify third party liability coverage, including Medicare and other insurance, and if applicable seek such third party liability payment before submitting claims to CCO. Provider understands and agrees that each claim Provider submits to CCO constitutes a certification that the claim is true and accurate to the best of Provider's knowledge and belief and that the Covered Services are 1) Medically Necessary and 2) have been provided to the Member prior to submitting the claim.

Provider must submit claims within six (6) months from the date of service. Claims filed within the appropriate time frame but denied may be resubmitted to CCO within ninety (90) calendar days from the date of denial.

3.12 Third Party Resources. Provider shall report all Third Party Resources to CCO identified through the provision of medical services.

3.13 Privacy; HIPAA. Provider shall comply with all applicable privacy rule and security rule provisions of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), and associated implementing regulations, as may be amended from time to time, and shall safeguard information about Members in accordance with applicable federal and State privacy laws and rules including 42 CFR §438.224 and 42 CFR Part 431, Subpart F, as may be amended from time to time. Provider agrees that confidential information, including but not limited to, medical and other pertinent information relative to Members, shall not be disclosed to any person or organization for any purpose without the expressed, written authority of DOM or as otherwise required by law and that all such disclosures shall fully comply with HIPAA privacy and security standards.

3.14 Cultural Competency and Access. Provider shall participate in CCO's and DOM's efforts to

promote the delivery of services in a culturally competent manner to all Members, including those with limited English proficiency, physical or mental disabilities, diverse cultural and ethnic backgrounds and regardless of gender, sexual orientation or gender identity, and shall provide interpreter services in a Member's primary language and for the hearing impaired for all appointments and emergency services. Provider shall provide information to Members regarding treatment options and alternatives, as well as information on complaints and appeals, in a manner appropriate to the Member's condition and ability to understand. Provider shall provide physical access, reasonable accommodations, and accessible equipment for Covered Persons with physical or mental disabilities.

3.15 Approval of Marketing Materials. As required under State or federal law or the applicable MississippiCHIP Program Contract, any marketing materials developed and distributed by Provider as related to the performance of the Agreement must be submitted to CCO at least sixty (60) days prior to planned distribution for timely submission to DOM for prior approval. Provider agrees it will not proceed with the statement or communication until the required approval is obtained.

3.16 Independent Contractor Relationship. Provider expressly agrees that Provider is acting in an independent capacity in the performance of the Agreement and not as an officer, agent or employee of DOM, CMS or the State. Provider further expressly agrees that the Agreement shall not be construed as a partnership or joint venture between Provider and DOM, CMS or the State. Nothing in the Agreement shall be construed, nor shall it be deemed to create, any right or remedy in any third party.

3.17 Certification on Relationship to State, DOM and CMS. Provider certifies that no officer, director, employee, subcontractor or agent of Provider, or person with an ownership or control interest in Provider, is also employed by, or is a public official of, the State of Mississippi or any of its agencies, DOM or CMS.

3.18 Ownership and Control Information. If applicable, Provider shall cooperate with CCO in obtaining and providing information to DOM related to ownership and control, significant business transactions, and persons convicted of a criminal offense in compliance with§1128 of the Social Security Act, 42 USC §1320a-7 and 42 CFR Part 455, as amended and shall provide information upon request. Provider shall submit information related to ownership and control of subcontractors or wholly owned supplier within thirty-five (35) calendar days of a request for such information.

By executing the Agreement, Provider certifies that neither Provider nor any of its principals is presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in any State or federal health care program or from participating in transactions by any State or federal department or agency. CCO will terminate the Agreement upon becoming aware or receiving notice from DOM, whichever is earlier, that Provider is or has been excluded from participation in any State or federal health care program or by any State or federal agency.

3.19 Excluded Individuals and Entities. Provider certifies that neither it nor any of its employees, principals, nor any providers, subcontractors or consultants or persons with an ownership or controlling interest in the Provider (an owner including the Provider himself or herself), or an agent or managing employee of the Provider, with whom Provider contracts and who are providing items or services that are significant and material to Provider's obligations under the

Agreement is:

i) excluded from participation in federal health care programs under either Section 1128 or section 1128A of the Social Security Act; or

ii) debarred, suspended, proposed for debarment, declared ineligible, or otherwise voluntarily excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549; or an affiliate, as defined in the Federal Acquisition Regulation, of such a person.

Provider acknowledges and agrees and shall require that Provider acknowledge and agree that payment will not be made for any items or Covered Services provided by an excluded individual pursuant to 42 CFR §1001.1901(b) and is obligated to screen all employees, contractors, and subcontractors for exclusion as required under applicable State and Federal laws. Additionally, Provider acknowledges that pursuant to 42 CFR §1003.102(a)(2) civil monetary penalties may be imposed against Provider if he or she employs or enters into contracts with excluded individuals or entities to provide items or Covered Services to Member under the Agreement. Provider agrees not to employ or subcontract with individuals or entities whose owner, those with a controlling interest, or managing employees are on a State or Federal exclusion list to provide items or Covered Services under the Agreement. Provider shall immediately report to CCO any exclusion information discovered. Provider can search the HHS-OIG website, at no cost, by the names of any individuals or entities. The database is called LEIE and can be accessed at http://www.oig.hhs.gov/fraud/exclusions.asp. The GSA EPLS/SAM database can be accessed at https://www.sam.gov. Federal and State exclusion databases must be reviewed monthly to ensure that no employee or contractor has been excluded. Applicable state exclusion databases can be accessed through the State's Medicaid website. CCO will terminate the Agreement immediately upon becoming aware or receiving notice from DOM, whichever is earlier, that Provider's owners, agents, managing employees, or any provider is or has been excluded from federal health care programs or terminated from the Medicare or the Medicaid program in any state.

3.20 Licensure. Provider represents that it is currently licensed and/or certified under applicable State and federal statutes and regulations and by the appropriate State licensing body or standard-setting agency, as applicable. Provider represents that it does not have a Medicaid provider agreement with DOM that is terminated, suspended, denied, or not renewed as a result of any action of DOM, CMS, HHS, or the Medicaid Fraud Control Unit of the State's Attorney General. Provider shall maintain at all times throughout the term of the Agreement all necessary licenses, certifications, registrations and permits as are required to provide the health care services and/or other related activities delegated to Provider by CCO under the Agreement. If at any time during the term of the Agreement, Provider is not properly licensed as described in this Section, Provider shall discontinue providing services to Members.

3.21 National Provider ID (NPI). If applicable, Provider shall and shall require that Providers obtain a National Provider Identification Number (NPI) and when filing claims with Provider, the NPI number used is the same NPI number used when filing claims with DOM.

3.22 Funding. Provider recognizes that the obligation of DOM to proceed under its MississippiCHIP Program Contract with CCO is conditioned upon the appropriation of funds by the Mississippi

State Legislature and the receipt of State and/or Federal funds. If the funds anticipated for the continuing fulfillment of the agreement are, at any time, not forthcoming or insufficient, either through the failure of the Federal government to provide or the State of Mississippi to appropriate funds, or the discontinuance, or material alteration of the program under which the funds were provided or if funds are not otherwise available to DOM, DOM has the right upon ten (10) working days written notice to CCO to terminate the MississippiCHIP Program Contract.

3.23 Federal and State Funds Liability. Providers acknowledges and agrees that payments made to Provider for services provided under the Agreement are derived from federal and State funds and that any false claim or statement in documents or any concealment of material fact related to such services may be a cause for sanctions and prosecution under applicable federal and State laws. Provider shall be subject to all laws applicable to individuals and entities receiving State and federal funds and may be held civilly or criminally liable to both CCO and DOM in the event of nonperformance, misrepresentation, fraud, or abuse related to services provided pursuant to the MississippiCHIP Program Contract. Provider recognizes that payments made to the Provider are derived from federal and State funds, and are contingent upon and subject to availability and receipt of funds.

3.24 Insolvency. In the event CCO becomes insolvent or unable to pay Provider, Provider shall not seek compensation for services rendered from DOM, its officers, Agents, or employees, or the Members or their eligible dependents.

3.25 Termination. In the event of termination of the Agreement, Provider shall promptly supply to CCO all information necessary for the reimbursement of any outstanding MississippiCHIP Program claims.

3.26 Capitated Providers. If a Provider that is capitated terminates its agreement with CCO, for any reason, Provider will provide services to Members assigned to Provider up to the end of the month in which the effective date of termination falls.

3.27 Fraud, Waste, and Abuse Prevention. Provider shall cooperate fully with the CCO's policies and procedures designed to protect program integrity and prevent and detect potential or suspected fraud, waste, and abuse in the administration and delivery of services under the MississippiCHIP Program Contract and shall cooperate and assist DOM and any other State or federal agency charged with the duty of preventing, identifying, investigating, sanctioning or prosecuting suspected fraud, waste, and abuse in state and/or federal health care programs. Provider and CCO are responsible for reporting suspected fraud and abuse by participating and non-participating providers, as well as Members, when detected.

In accordance with CCO's policies and the Deficit Reduction Act of 2005 (DRA), Provider shall have written policies for its employees, contractors or agents that: (a) provide detailed information about the federal False Claims Act (established under sections 3729 through 3733 of title 31, United States Code), including if any entity makes or receives annual payments under the State Program of at least $5,000,000, such entity must establish certain minimum written policies and information communicated through an employee handbook relating to the Federal False Claims Act in accordance with 42 CFR 438.600; (b) cite administrative remedies for false claims and statements (established under chapter 38 of title 31, United States Code) and whistleblower protections under federal and state laws; (c) reference state laws pertaining to civil or criminal penalties for false

claims and statements; and (d) with respect to the role of such laws in preventing and detecting fraud, waste, and abuse in federal health care programs (as defined in section 1128B(f)), include as part of such written policies, detailed provisions regarding Provider's policies and procedures for detecting and preventing fraud, waste, and abuse. Provider agrees to train its staff on the aforesaid policies and procedures.

3.28 Quality Utilization Management. Pursuant to any applicable provider manuals and related protocols, or as elsewhere specified under the Agreement, Provider agrees to cooperate with CCO's quality improvement and utilization review and management activities. This shall include, but not be limited to, participation in any internal and external quality assurance, utilization review, peer review, and grievance procedures established by CCO or as required under the MississippiCHIP Program Contract to ensure that Members have due process for their complaints, grievances, appeals, fair hearings or requests for external review of adverse decisions made by CCO or Provider. Provider shall adhere to the quality assurance and utilization review standards of the MississippiCHIP Program and shall monitor quality and initiate corrective action to improve quality consistent with the generally accepted level of care.

3.29 Quality and Utilization Management Program. Provider shall cooperate with CCO in meeting the Quality Management and Utilization Management Program standards outlined in the MississippiCHIP Program Contract.

3.30 Referrals. Provider shall make referrals for social, vocational, education or human services when a need for such service is identified.

3.31 Restrictions on Referrals. Provider shall not make inappropriate referrals for designated health services to health care entities with which Provider or a member of Provider's family has a financial relationship, pursuant to federal anti-kickback and physician self-referral laws that prohibit such referrals.

3.32 Complaints, Grievances and Appeals. Information on how Provider or Provider's authorized representative shall submit complaints and file grievances and appeals, and the resolution process, is contained in the CCO MississippiCHIP Provider Manual.

3.33 Health Care Acquired/Preventable Conditions. Provider agrees that no payment shall be made for the provision of medical assistance for health care acquired conditions and other provider preventable conditions as may be identified by the State. As a condition of payment, Provider shall identify and report to CCO any provider preventable conditions in accordance with 42 CFR §§ 434.6(a)(12), 438 including but not limited to 438.3(g), and 447.26.

3.34 Compliance with Laws. Provider shall comply with all applicable federal and State laws and regulations and all provisions of the MississippiCHIP Program Contract that pertain to a Member's rights, including but not limited to the following, to the extent applicable to Provider in performance of the Agreement:

i) Title VI of the Civil Rights Act of 1964; (b) Title XIX of the Social Security Act; Title IX of the Education Amendments of1972 (regarding education programs and activities); the Age Discrimination Act of 1975; the Rehabilitation Act of 1973; and The Genetic Information Non-Discrimination Act of 2008 (GINA); the Americans with Disabilities Act;

section 1557 of the Patient Protection and Affordable Care Act, and their implementing regulations, as may be amended from time to time.

ii) All federal and State professional and facility licensing and accreditation requirements/standards that apply to the services Provider perform pursuant to the Agreement, including but not limited to:

a) All applicable standards, orders or requirements issued under Section 306 of the Clean Air Act (42 USC 1857 (h)). Section 508 of the Clean Water Act (33 USC 1368), Executive Order 11738, and Environmental Protection Agency (EPA) regulations (40) CFR Part 15), which prohibit the use of facilities included on the EPA list of violating facilities. Any violations must be reported to DSHS, DHHS, and the EPA;

b) Any applicable mandatory standards and policies relating to energy efficiency that are contained in the State Energy Conservation Plan, including the Energy Policy & conservation Act (Pub. L. 94-165), and issued in compliance with the Federal Energy Policy & Conservation Act.

iii) All relevant federal and State statutes, regulations and orders related to equal opportunity in employment, including but not limited to compliance with E.O. 11246, "Equal Employment Opportunity," as amended by E.O. 11375, "Amending Executive Order 11246 Relating to Equal Employment Opportunity," and as supplemented by regulations at 41 CFR Part 60, "Office of Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor."

iv) If the Agreement is for an amount in excess of $100,000, Provider shall comply with all applicable standards, orders or regulations issued pursuant to the Clean Air Act, 42 U.S.C. 7401 et seq., and the Federal Water Pollution Control Act, as amended, 33 U.S.C. 1251 et seq. Any violations shall be reported to DHHS and the appropriate Regional Office of the Environmental Protection Agency.

v) Those specified for laboratory services in the Clinical Laboratory Improvement Amendments (CLIA). All laboratory service sites must have a CLIA certificate of registration or waiver, and a CLIA identification number.

vi) The American with Disabilities Act (ADA). Provider shall make reasonable accommodation for Members with disabilities in accord with the ADA for all Covered Services and shall assure physical and communication barriers do not inhibit Members with disabilities from obtaining Covered Services;

vii) Section 1128B(d)(1) of the Balanced Budget Act of 1997; and,

viii) Any other requirements associated with the receipt of federal funds.

ix) All Medicaid laws, regulations and program instructions to the extent applicable to Provider in Provider's performance of the Agreement. Provider understands that payment of a claim by CCO or the State is conditioned upon the claim and the underlying transaction complying with such laws, regulations, and program instructions (including, but not limited

to, federal requirements on fraud, waste and abuse, disclosure, debarment, termination and exclusion screening), and is conditioned on the Provider's compliance with all applicable conditions of participation in Medicaid. Provider understands and agrees that each claim the Provider submits to CCO constitutes a certification that the Provider has complied with all applicable Medicaid laws, regulations and program instructions in connection with such claims and the services provided therein. Provider's payment of a claim will be denied if Provider is terminated or excluded from participation in federal healthcare programs. Provider's payment of a claim may be temporarily suspended if the State or CCO provides notice that a credible allegation of fraud exists and there is a pending investigation. Provider's payment of a claim may also be temporarily suspended or adjusted if the Provider bills a claim with a code that does not match the service provided. CCO performs coding edit procedures based primarily on National Correct Coding Initiative (NCCI) policies and other nationally recognized and validated policies. Provider agrees that it will provide medical records to CCO upon its request in order to determine appropriateness of coding. Provider may dispute any temporarily suspended or adjusted payment consistent with the terms of the Agreement.

3.35 Non-Discrimination. Provider will not discriminate against, nor use any policy or practice that has the effect of discriminating against, Covered Persons on the basis of race, color, creed, sex, religion, age, national origin, ancestry, marital status, sexual orientation, gender identity, language, health status, disease or pre-existing condition (including genetic information), anticipated need for health care or physical or mental handicap, except where medically indicated. Examples of prohibited practices include, but are not limited to, the following:

i) Denying or not providing a Member any MississippiCHIP Covered Service. Health care and treatment necessary to preserve life must be provided to all Members who are not terminally ill or permanently unconscious, except where a competent Member objects to such care on his/her own behalf.

ii) Subjecting a Member to segregated, separate, or different treatment, including a different place or time from that provided to other Members or public or private patients, in any manner related to the receipt of any MississippiCHIP Covered Service, except where Medically Necessary.

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

3.36 Advance Directives. Provider shall comply with the advance directives requirements with 42 C.F.R §422.128 and with the Uniform Health-Care Decisions Act (Miss. Code Ann. § 41-41-201, *et. seq*.). When applicable, Provider shall comply with the advance directives requirements for hospitals, nursing facilities, providers of home and health care and personal care services, hospices, and HMOs as specified in 42 CFR Part 49, subpart I, 42 CFR § 417.436(d), 42 CFR § 422.128, and 42 CFR 438.3(i).

3.37 Physician Incentive Plans. In the event Provider participates in a physician incentive plan

("PIP") under the Agreement, Provider agrees that such PIPs must comply with 42 CFR § 417.479, 42 CFR § 438.3, 42 CFR § 422.208, and 42 CFR § 422.210, as may be amended from time to time. CCO or Provider may not make a specific payment directly or indirectly under a PIP to a physician or physician group as an inducement to reduce or limit Medically Necessary services furnished to an individual Member. PIPs must not contain provisions that provide incentives, monetary or otherwise, for the withholding of services that meet the definition of Medical Necessity. Provider shall disclose annually to CCO any PIP arrangement Provider may have with any physicians even if there is not substantial financial risk between CCO and such physicians.

3.38 Lobbying. Provider agrees to comply with the following requirements related to lobbying:

i) Prohibition on Use of Federal Funds for Lobbying: By signing the Agreement, Provider certifies to the best of Provider's knowledge and belief, pursuant to 31 U.S.C. § 1352 and 45 CFR Part 93, as may be amended from time to time, that no federally appropriated funds have been paid or will be paid to any person by or on Provider's behalf for the purpose of influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the award of any federal contract, the making of any federal grant, the making of any federal loan, the entering into of any cooperative agreement, or the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan, or cooperative agreement.

ii) Disclosure Form to Report Lobbying: If any funds other than federally appropriated funds have been paid or will be paid to any person for the purpose of influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the award of any federal contract, the making of any federal grant, the making of any federal loan, the entering into of any cooperative agreement, or the extension, continuation, renewal, amendment or modification of any federal contract, grant, loan, or cooperative agreement and the value of the Agreement exceeds $100,000, Provider shall complete and submit Standard Form-LLL, "Disclosure Form to Report Lobbying," in accordance with its instructions.

iii) Contractor shall abide by lobbying laws of the State of Mississippi.

3.39 Gratuities. Provider represents that it has not violated, is not violating, and promises that it will not violate the prohibitions against gratuities set forth in Section 6-204 (Gratuities) of the Mississippi Personal Service Contract Procurement Regulations.

3.40 Compliance with Mississippi Employment Protection Act (MEPA). Represents and warrants and shall require that Provider represent and warrant that it will ensure its compliance with the Mississippi Employment Protection Act, Section 71-11-1 et set of the Mississippi Code Annotated (Supp. 2008), and will register and participate in the status verification system for all newly hired employees. The term "employee" as used herein means any person that is hired to perform work within the State of Mississippi. As used herein, "status verification system" means the Illegal Immigration Reform and Immigration Responsibility Act of 1996 that is operated by the United States Department of Homeland Security, also known as the E-Verify Program, or any other

successor electronic verification system replacing the E-Verify Program. Provider agrees and shall require that Provider agree to maintain records of such compliance and, upon request of the State and approval of the Social Security Administration or Department of Homeland Security, where required, to provide a copy of each such verification to the State. Provider represents and warrants that any person assigned to perform services hereunder meets the employment eligibility requirements of all immigration laws of the State of Mississippi. Provider acknowledges and agrees that any breach of these warranties may subject Provider to the following: (a) termination of the Agreement and ineligibility for any state or public contract in Mississippi for up to three (3) years, with notice of such cancellation/termination being made public, or (b) the loss of any license, permit, certification or other document granted to Provider by an agency, department or governmental entity for the right to do business in Mississippi for up to one (1) year, or (c) both.

3.41 Insurance Requirements. As applicable, Provider shall and shall require that Provider secure and maintain during the term of the Agreement general liability insurance, professional liability insurance, and workers' compensation insurance for all employees connected with the provision of services under the Agreement. Such workers compensation insurance shall comply with Mississippi Workers' Compensation Laws. Such comprehensive general liability insurance and professional liability insurance shall provide coverage in an amount established by CCO pursuant to the Agreement or as required under the MississippiCHIP Program Contract.

3.42 Indemnification. To the extent applicable to Provider in performance under the Agreement, Provider shall indemnify, defend, protect, save and hold DOM and its employees and Members harmless from and against all injuries, deaths, losses, damages, claims, suits, demands, actions, recovery, liabilities, judgments, costs and expenses, including without limitation, court costs, investigative fees and expenses, and attorney fees, to the extent proximately caused by any negligent act or other intentional misconduct or omission of Provider, its agents, officers, employees or contractors arising from the Agreement. DOM may waive this requirement for public entities if Provider is a state agency or sub-unit as defined by the State or a public health entity with statutory immunity. This clause shall survive the termination of the Agreement for any reason, including breach due to insolvency.

3.43 Notice of Legal Action. Immediately upon obtaining knowledge or receiving notice of any legal action or notice listed below, Provider shall provide to CCO written notice of such legal action or notice and, upon request by CCO, a complete copy of all filings and other documents generated in connection with any such legal action:

i) Any action, suit or counterclaim filed against Provider;

ii) Any regulatory action, or proposed action, respecting Provider's business or operations;

iii) Any notice received by Provider from the Department of Insurance or the State Health Officer;

iv) The filing of a petition in bankruptcy by or against Provider, or the insolvency of Provider;

v) The conviction of any person who has an ownership or control interest in Provider, or who is an agent or managing employee of Provider, of a criminal offense related to that person's

involvement in any program under Medicare, Medicaid, or Title XX of the Social Security Act; or

vi) A malpractice action against any Provider delivering service under an agreement.

3.44 Hold Harmless. Except for any applicable cost-sharing requirements under the MississippiCHIP Program Contract, Provider shall look solely to CCO for payment of Covered Services provided to Members pursuant to the Agreement and the MississippiCHIP Program Contract and hold DOM, the State, the U.S. Department of Health and Human Services and Members harmless in the event that CCO cannot or will not pay for such Covered Services. In accordance with 42 CFR § 447.15, as may be amended from time to time, the Member is not liable to Provider for any services for which CCO is liable and as specified under the State's relevant health insurance or managed care statutes, rules or administrative agency guidance. Provider shall not require any copayment or cost sharing for Covered Services provided under the Agreement unless expressly permitted under the MississippiCHIP Program Contract. Provider shall also be prohibited from charging Members for missed appointments if such practice is prohibited under the MississippiCHIP Program Contract or applicable law. Neither the State, DOM, nor Member shall be in any manner liable for the debts and obligations of CCO and under no circumstances shall CCO, or any providers used to deliver services covered under the terms of the MississippiCHIP Program Contract, charge Members for Covered Services.

3.45 Assignment/Delegation. Provider shall not assign or delegate the Agreement without the express written consent of CCO or DOM. If Provider subcontracts or delegates any functions of the Agreement, in accordance with the terms of the Agreement and with the express written consent of CCO or DOM, the subcontract or delegation must be in writing and include all of the requirements of this Appendix, and applicable requirements of the State Contract, and applicable laws and regulations. The transfer of five percent (5%) or more of the beneficial ownership in Provider at any time during the term of this Agreement shall be deemed an assignment under this Agreement.

3.46 Behavioral Health Providers. Behavioral Health Providers shall ensure that all Covered Persons receiving inpatient psychiatric services are scheduled for outpatient follow-up and/or continuing treatment prior to discharge from the inpatient psychiatric hospital if the Provider is aware of the Covered Person's inpatient hospitalization status. Behavioral Health Providers will be provided daily reports identifying Covered Persons known to be admitted to an inpatient facility. Behavioral Health Services will be delivered in compliance with the requirements of 42 CFR 438 subpart K insofar as those requirements are applicable.

3.47 Provider Eligibility. Provider must be enrolled in the Mississippi CHIP program and must use the same National Provider Identifier (NPI) number to participate in CCO's Network. Upon notification from the State that Provider's enrollment has been denied or terminated, CCO must terminate Provider immediately and will notify affected Covered Persons that Provider is no longer participating in the network. CCO will exclude from its network any provider who has been terminated or suspended from the Medicare, Medicaid or CHIP program in any state.

3.48 Disclosure. Provider must be screened and enrolled in the State's CHIP program and submit disclosures to the DOM related to ownership and control, significant business transactions, and persons convicted of crimes in accordance with 42 CFR Part 455 .Provider must submit information related to ownership and control of subcontractors or wholly owned suppliers within thirty-five (35)

calendar days of a request for such information in accordance with 42 CFR 455.105. Additionally, Provider must cooperate with DOM for submission of fingerprints upon a request from DOM or CMS in accordance with 42 CFR 455.434.

3.49 Electronic Visit Verification. Provider shall cooperate with State requirements for electronic visit verification for personal care services and home health services, as applicable.

3.50 Clinical Laboratory Improvements Act (CLIA) Certification or Waiver. As applicable, if Provider performs any laboratory tests on human specimens for the purpose of diagnosis and/or treatment, Provider agrees to acquire and maintain the appropriate CLIA certification or waiver for the type of laboratory testing performed. Provider further agrees to provide a copy of the certification if requested by CCO. A State authorized license or permit that meets the CLIA requirements may be substituted for the CLIA certificate pursuant to State law. Medicare and Medicaid programs require the applicable CLIA certification or waiver for the type of services performed as a condition of payment. Provider must include the appropriate CLIA certificate or waiver number on claims submitted for payment for laboratory services.

3.51 Overpayment. Provider shall to report to CCO when it has received an overpayment and will return the overpayment to CCO within 60 calendar days after the date on which the overpayment was identified. Provider will notify CCO in writing of the reason for the overpayment.

SECTION 4
CCO REQUIREMENTS

4.1 Communications with Members. Members are entitled to the full range of their Providers' opinions and counsel about the availability of Medically Necessary Services under the provisions of the MississippiCHIP Program Contract. Any contractual provisions, including gag clauses or rules, that restrict a Provider's ability to advise Members about Medically Necessary treatment options violate federal law and regulations. CCO shall not prohibit or otherwise restrict Provider, when acting within the lawful scope of practice, from advising or advocating on behalf of a Member for the following:

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

ii) Any information the Member needs in order to decide among all relevant treatment options;

iii) The risks, benefits, and consequences of treatment or non-treatment;

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

v) Information regarding the nature of treatment options including those that may not reflect CCO's position or may not be covered by CCO.

CCO shall not prohibit a Provider from advocating on behalf of a Member in any grievance system,

utilization review process, or individual authorization process to obtain necessary health care services.

4.2 Prompt Payment. CCO shall pay Provider pursuant to the MississippiCHIP Program Contract and applicable State and federal law and regulations, including but not limited to Miss. Code Ann. §83-9-5, 42 CFR §447.46, 42 CFR §447.45(d)(2), 42 CFR §447.45(d)(3), 42 CFR §447.45(d)(5) and 42 CFR §447.45(d)(6), as applicable and as may be amended from time to time. If a third party liability exists, payment of claims shall be determined in accordance with federal and/or State third party liability law and the terms of the MississippiCHIP Program Contract. Unless CCO otherwise requests assistance from Provider, CCO will be responsible for third party collections in accordance with the terms of the MississippiCHIP Program Contract.

4.3 No Incentives to Limit Medically Necessary Services. CCO shall not structure compensation provided to individuals or entities that conduct utilization management and concurrent review activities so as to provide incentives for the individual or entity to deny, limit, or discontinue Medically Necessary services to any Member.

4.4 Provider Discrimination Prohibition. CCO shall not discriminate with respect to participation, reimbursement, or indemnification of a provider who is acting within the scope of the provider's license or certification under applicable State law, solely on the basis of such license or certification. CCO shall not discriminate against Provider for serving high-risk Members or if Provider specializes in conditions requiring costly treatments. This provision shall not be construed as prohibiting CCO from limiting a provider's participation to the extent necessary to meet the needs of Members. This provision also is not intended and shall not interfere with measures established by CCO that are designed to maintain quality of care practice standards and control costs. CCO shall not provide false or misleading information to any person or entity in an attempt to recruit Providers for CCO's network.

4.5 Termination, Revocation and Sanctions. In addition to its termination rights under the Agreement, CCO shall have the right to revoke any functions or activities CCO delegates to Provider under the Agreement or impose other sanctions consistent with the MississippiCHIP Program Contract if in CCO's reasonable judgment Provider's performance under the Agreement is inadequate. CCO shall also have the right to suspend, deny, refuse to renew or terminate the subcontract in accordance with the terms of the MississippiCHIP Program Contract and applicable law and regulation. However, CCO shall not exclude or terminate a Provider from participation in CCO's Provider Network due to the fact that the Provider has a practice that includes a substantial number of patients with expensive medical conditions, and shall not terminate a Provider for filing a Complaint, Grievance, or Appeal on a Member's behalf.

SECTION 5
OTHER REQUIREMENTS

5.1 Compliance with MississippiCHIP Program Contract. All tasks performed under the Agreement shall be performed in accordance with the requirements of the MississippiCHIP Program Contract, as applicable, as set forth in this Appendix, applicable provider manuals, and protocols, policies and procedures that CCO has provided or delivered to Provider. The applicable provisions of the MississippiCHIP Program Contract are incorporated into the Agreement by reference. Nothing in the Agreement or this Appendix relieves CCO of its responsibility under the

MississippiCHIP Program Contract. If any provision of the Agreement is in conflict with provisions of the MississippiCHIP Program Contract, the terms of the MississippiCHIP Program Contract shall control and the terms of the Agreement in conflict with those of the MississippiCHIP Program Contract will be considered waived.

5.2 Monitoring. In accordance with 42CFR § 457.950, CCO shall perform ongoing monitoring (announced or unannounced) of services rendered by Provider under the Agreement and shall perform periodic formal reviews of Provider according to a schedule established by the State, consistent with industry standards or State managed care organization laws and regulations or requirements under the MississippiCHIP Program Contract. As a result of such monitoring activities, and/or as a result of the inspecting, auditing and monitoring activities of DOM or other authorities pursuant to section 4.4 above, CCO shall identify to Provider any deficiencies or areas for improvement mandated under the MississippiCHIP Program Contract and Provider and CCO shall take appropriate corrective action within the relevant timeframe permitted, as applicable. Provider shall comply with any corrective action plan initiated by CCO and/or required by the MississippiCHIP Program. In addition, Provider shall monitor and report the quality of services delivered under the Agreement and initiate a plan of correction where necessary to improve quality of care, in accordance with that level of care which is recognized as acceptable professional practice in the respective community in which CCO and Provider practice and/or the performance standards established under the MississippiCHIP Program Contract.

5.3 Enrollment. The parties acknowledge and agree that DOM is responsible for enrollment, reenrollment and disenrollment of Members.

5.4 No Exclusivity. Nothing in the Agreement or this Appendix shall be construed as prohibiting or penalizing Provider for contracting with a managed care organization other than CCO or as prohibiting or penalizing CCO for contracting with other providers. The CCO may not require Providers who agree to participate in the MississippiCHIP Program to contract with the Contractor's other lines of business.

5.5 Revoking Delegation. The parties agree that, prior to execution of the Agreement, CCO evaluated Provider's ability to perform any duties delegated to Provider under the Agreement. Any delegated duties and reporting responsibilities shall be set forth in the Agreement or other written delegation agreement or addendum between the parties. In addition to its termination rights under the Agreement, CCO shall have the right to revoke any functions, assignment authority, or activities CCO delegates to Provider under the Agreement or impose other sanctions if in CCO's reasonable judgment Provider's performance under the Agreement is inadequate or untimely.

5.6 Rights of DOM. DOM shall have the right to invoke against Provider any remedy set forth in the MississippiCHIP Program Contract, including the right to require the termination of the Agreement, for each and every reason for which it may invoke such a remedy against CCO or require termination of the MississippiCHIP Program Contract. Suspected Fraud and Abuse by Provider will be investigated by DOM.

Mississippi
Regulatory Requirements Appendix

Mississippi Regulatory Requirements Appendix

This Mississippi Regulatory Requirements Appendix (the "Appendix") is made part of the agreement ("Agreement") entered into between **CCO,** contracting on behalf of itself, **HMO**, and the other entities that are CCO's Affiliates (collectively referred to as "CCO") and the health care professional or entity named in the Agreement ("Provider").

This Appendix applies to all products or benefit plans sponsored, issued or administered by or accessed through CCO to the extent such products are regulated under Mississippi laws; provided, however, that the requirements in this Appendix will not apply to the extent they are preempted by the Medicare Modernization Act or other applicable law.

CCO and Provider each agree to be bound by the terms and conditions contained in this Appendix. In the event of a conflict or inconsistency between this Appendix and any term or condition contained in the Agreement, this Appendix shall control, except with regard to Benefit Plans outside the scope of this Appendix.

If any of the capitalized terms in this Appendix are used or defined (or the equivalent terms are used or defined) in the Agreement, then the terms used in this Appendix will have the same meaning as the terms (or equivalent terms) used or defined in the Agreement. For example, "Benefit Plans," as used in this Appendix, will have the same meaning as "benefit contracts"; "Customer," as used in this Appendix, will have the same meaning as "member," "enrollee," or "covered person"; "Payer," as used in this Appendix, will have the same meaning as "participating entity"; "Provider," as used in this Appendix, will have the same meaning as "Facility," "Medical Group," "Ancillary Provider," "Physician," or "Practitioner." Additionally, if the Agreement uses pronouns to refer to the contracted entities, then "CCO" will have the same meaning as "we" or "us," and "Provider" will have the same meaning as "you" or "your."

This Appendix will be deemed to be updated to incorporate any changes to the laws and regulations referenced herein, including any changes to definitions referenced herein, effective as of the date of such changes.

1. Customer Hold Harmless and Continuation of Services. Provider agrees that in no event, including but not limited to nonpayment by CCO, Payer or intermediary, insolvency of CCO, Payer or intermediary, or breach of this Agreement, shall Provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against a Customer or a person (other than CCO, Payer or intermediary) acting on behalf of the Customer for services provided pursuant to this Agreement. This Agreement does not prohibit Provider from collecting coinsurance, deductibles or copayments, as specifically provided in the evidence of coverage, or fees for uncovered services delivered on a fee-for-service basis to Customers. Nor does this Agreement prohibit Provider (except for a health care professional who is employed full-time on the staff of CCO and has agreed to provide services exclusively to CCO's Customers and no others) and a Customer from agreeing to continue services solely at the expense of the Customer, as long as the provider has clearly informed the Customer that CCO or Payer

may not cover or continue to cover a specific service or services. Except as provided herein, this Agreement does not prohibit Provider from pursuing any available legal remedy.

In the event of CCO, Payer or intermediary insolvency or other cessation of operations, Covered Services to Customers will continue through the period for which a premium has been paid to CCO or Payer on behalf of the Customer or until the Customer's discharge from an inpatient facility, whichever time is greater. Covered Services to Customers confined in an inpatient facility on the date of insolvency or other cessation of operations will continue until their continued confinement in an inpatient facility is no longer medically necessary.

The provisions in this section 1 shall be construed in favor of the Customer, shall survive the termination of the Agreement regardless of the reason for termination, including the insolvency of CCO or Payer, and shall supersede any oral or written contrary agreement between Provider and a Customer or the representative of a Customer if the contrary agreement is inconsistent with the hold harmless and continuation of Covered Services provisions required by this section 1.

In no event shall Provider collect or attempt to collect from a Customer any money owed to Provider by CCO or Payer.

2. CCO Programs. As applicable, Provider shall comply with CCO's administrative policies and programs, including but not limited to terms, including payment, utilization review, quality assessment and improvement programs, credentialing, grievance procedures, data reporting requirements, confidentiality requirements and any applicable federal or state programs.

3. Treatment Options. CCO shall not prohibit Provider from discussing treatment options with Customers irrespective of CCO's position on the treatment options, or from advocating on behalf of Customers within the utilization review or grievance processes established by CCO or a person contracting with CCO.

4. Records. Provider shall make health records available to appropriate state and federal authorities involved in assessing the quality of care or investigating the grievances or complaints of Customers, and to comply with the applicable state and federal laws related to the confidentiality of medical or health records.

5. Termination. CCO and Provider shall provide advance written notice to each other in the form and for the length of time as provided in the Agreement but in no case less than sixty (60) before terminating the Agreement without cause. CCO shall make a good faith effort to provide written notice of a termination within thirty (30) days of receipt or issuance of a notice of termination to all Customers who are patients seen on a regular basis by Provider whose Agreement is terminating, irrespective of whether the termination was for cause or without cause. Where a contract termination involves a primary care professional, all Customers who are patients of that primary care professional shall also be notified. Within five (5) working days of the date that Provider either gives or receives notice of termination, Provider shall supply CCO with a list of those patients of Provider that are covered by a Benefit Plan subject to this Appendix.

6. Assignment. The rights and responsibilities under this Agreement shall not be assigned or delegated by Provider without the prior written consent of CCO.

7. Provision of Covered Services. Provider shall furnish Covered Services to all Customers without regard to the Customer's enrollment in the plan as a private purchaser of the plan or as a participant in publicly financed programs of health care services. This requirement does not apply to circumstances when Provider should not render services due to limitations arising from lack of training, experience, skill or licensing restrictions.

8. Coinsurance, Copayments and Deductibles. Provider shall collect applicable coinsurance, copayments or deductibles from Customers pursuant to the Benefit Plan and, as applicable, Provider shall notify Customers of their personal financial obligations for non-covered services.

9. No Penalty for Reporting to Authorities. CCO shall not penalize Provider because Provider, in good faith, reports to state or federal authorities any act or practice by CCO that jeopardizes patient health or welfare.

10. Definitions. To the extent a definition or other provision in the Agreement conflicts with the Benefit Plan or the Managed Care Plan Network Adequacy Regulation (the "Regulation"), the Benefit Plan or the Regulation will control.

11. Prompt Pay. Provider and CCO shall comply with the prompt payment requirements set forth in the Mississippi Code Section 83-9-5(1)(h). Claims will be paid within twenty-five (25) days after receipt where claims are submitted electronically, and within thirty-five (35) days after receipt where claims are submitted in paper format.

12. Reciprocal Time Limitations. If the Agreement includes a time limit in which Provider is required to submit a claim for payment, CCO or Payer shall have the same time limit following payment of the claim to perform any review or audit for reconsidering the validity of the claim and requesting reimbursement for payment of an invalid claim or overpayment of a claim. If CCO or Payer does not limit the time in which Provider is required to submit a claim for payment, CCO may not request reimbursement or offset another claim payment for reimbursement of an invalid claim or overpayment of a claim more than twelve (12) months after the payment of an invalid or overpaid claim. This provision does not apply to claims submitted in the context of misrepresentation, omission, concealment, or fraud by Provider.

13. Intermediaries. The following provisions apply to intermediaries as defined in the Regulation.

a) Intermediaries and participating providers with whom they contract shall comply with all the applicable requirements of sections 1-10 of this Appendix (section 14.06 of the Regulation).
b) CCO's statutory responsibility to monitor the offering of Covered Services to Customers shall not be delegated or assigned to the intermediary.

c) CCO shall have the right to approve or disapprove participation status of a subcontracted provider in its own or a contracted network for the purpose of delivering Covered Services to the carrier's Customers.
d) CCO shall maintain copies of all intermediary health care subcontracts at its principal place of business in the state, or ensure that it has access to all intermediary subcontracts, including the right to make copies to facilitate regulatory review, upon twenty (20) days prior written notice from CCO.
e) If applicable, an intermediary shall transmit utilization documentation and claims paid documentation to CCO. CCO shall monitor the timeliness and appropriateness of payments made to providers and health care services received by Customers.
f) If applicable, an intermediary shall maintain the books, records, financial information and documentation of services provided to Customers at its principal place of business in the state and preserve them in a manner that facilitates regulatory review.
g) An intermediary shall allow the commissioner access to the intermediary's books, records, financial information and any documentation of services provided to Customers, as necessary to determine compliance with the Regulation.
h) CCO shall have the right, in the event of the intermediary's insolvency, to require the assignment to CCO of the provisions of a provider's contract addressing the provider's obligation to furnish covered services.

FQHC RHC Participation Agreement

[FQHC][RHC] Participation Agreement

This Agreement is entered into by and between CCO, contracting on behalf of itself, HMO and the other entities that are CCO Affiliates (collectively referred to as "CCO") and _____ ("Facility").

This Agreement is effective on the later of _____, ___ or the first day of the first calendar month that begins at least 30 days after the date this Agreement has been executed by all parties (the "Effective Date").

Through contracts with physicians and other providers of health care services, CCO maintains one or more networks of providers that are available to Customers. Facility is a provider of health care services.

CCO wishes to make Facility's services available to Customers. Facility wishes to provide those services, under the terms and conditions set forth in this Agreement.

The parties therefore enter into this Agreement.

Article I
Definitions

The following capitalized terms in this Agreement have the meanings set forth below:

1.1 **Benefit Plan** means a certificate of coverage, summary plan description, or other document or agreement, whether delivered in paper or electronic format, under which a Payer is obligated to provide coverage of Covered Services for a Customer.

1.2 **Covered Service** is a health care service or product for which a Customer is entitled to receive coverage from a Payer, pursuant to the terms of the Customer's Benefit Plan with that Payer.

1.3 **Customary Charge** is the fee for health care services charged by Facility that does not exceed the fee Facility would ordinarily charge another person regardless of whether the person is a Customer.

1.4 **Customer** is a person eligible and enrolled to receive coverage from a Payer for Covered Services.

1.5 **Facility Physician** is a physician, as defined by the laws of the jurisdiction in which Covered Services are provided and duly licensed and qualified under those laws, who practices as a shareholder, partner, employee or Subcontractor of Facility.

1.6 **Facility Non-Physician Provider** is a healthcare professional other than a Facility Physician, who is duly authorized under the laws of the jurisdiction in which Covered

Services are provided, and who renders Covered Services as an employee or Subcontractor of Facility.

1.7 **Facility Professional** is a Facility Physician or a Facility Non-Physician Provider.

1.8 **Payment Policies** are the guidelines adopted by CCO for calculating payment of claims to facilities (including claims of Facility under this Agreement). The Payment Policies operate in conjunction with the specific reimbursement rates and terms set forth in this Agreement. The Payment Policies may change from time to time as discussed in section 5.1 of this Agreement.

1.9 **Payer** is an entity obligated to a Customer to provide reimbursement for Covered Services under the Customer's Benefit Plan and authorized by CCO to access Facility's services under this Agreement.

1.10 **Protocols** are the programs and administrative procedures adopted by CCO or a Payer to be followed by Facility in providing services and doing business with CCO and Payers under this Agreement. Protocols may include, among other things, credentialing and recredentialing processes, utilization management and care management processes, quality improvement, peer review, Customer grievance, or concurrent review. Protocols may change from time to time as described in section 4.4 of this Agreement.

1.11 **Subcontractor** is an individual or entity contracted or otherwise engaged by a party to this Agreement. For purposes of Facility Professionals, a Subcontractor is a Facility Professional only with respect to services rendered to patients of Facility and billed under Facility's Taxpayer Identification Number(s). Additionally, a Subcontractor is not a Facility Professional with regard to any services rendered in a physician's office or other non-facility location other than those locations listed in Appendix 1.

1.12 **CCO Affiliates** are those entities controlling, controlled by, or under common control with CCO.

Article II
Representations and Warranties

2.1 **Representations and warranties of Facility**. Facility, by virtue of its execution and delivery of this Agreement, represents and warrants as follows:

i) Facility is a duly organized and validly existing legal entity in good standing under the laws of its jurisdiction of organization.

ii) Facility has all requisite corporate power and authority to conduct its business as presently conducted, and to execute, deliver and perform its obligations under this Agreement. The execution, delivery and performance of this Agreement by Facility have been duly and validly authorized by all action necessary under its organizational

documents and applicable corporate law. This Agreement has been duly and validly executed and delivered by Facility and (assuming the due authorization, execution and delivery of this Agreement by CCO) constitutes a valid and binding obligation of Facility, enforceable against Facility in accordance with its terms, except as enforceability may be limited by the availability of equitable remedies or defenses and by applicable bankruptcy, insolvency, reorganization, moratorium or similar laws affecting the enforcement of creditors' rights generally.

iii) The execution, delivery and performance of this Agreement by Facility do not and will not violate or conflict with (a) the organizational documents of Facility, (b) any material agreement or instrument to which Facility is a party or by which Facility or any material part of its property is bound, or (c) applicable law. Facility has the unqualified authority to bind, and does bind, itself and Facility Professionals to all of the terms and conditions of this Agreement, including any Appendices, Attachments and Exhibits, as applicable.

iv) Facility has obtained and holds all registrations, permits, licenses, and other approvals and consents, and has made all filings, that it is required to obtain from or make with all governmental entities under applicable law in order to conduct its business as presently conducted and to enter into and perform its obligations under this Agreement.

v) Facility has been given an opportunity to review the Protocols and Payment Policies. See the Additional Manuals Appendix for additional information regarding the Protocols and Payment Policies applicable to Customers enrolled in certain Benefit Plans.

vi) Each submission of a claim by Facility pursuant to this Agreement will be deemed to constitute the representation and warranty by Facility to CCO that (a) the representations and warranties of Facility set forth in this section 2.1 and elsewhere in this Agreement are true and correct as of the date the claim is submitted, (b) Facility has complied with the requirements of this Agreement with respect to the Covered Services involved and the submission of the claim, (c) the charge amount set forth on the claim is the Customary Charge and (d) the claim is a valid claim.

2.2 Representations and warranties of CCO. CCO, by virtue of its execution and delivery of this Agreement, represents and warrants as follows:

i) CCO is a duly organized and validly existing legal entity in good standing under the laws of its jurisdiction of organization.

ii) CCO has all requisite corporate power and authority to conduct its business as presently conducted, and to execute, deliver and perform its obligations under this Agreement. The execution, delivery and performance of this Agreement by CCO have been duly and validly authorized by all action necessary under its organizational documents and applicable corporate law. This Agreement has been duly and validly executed and delivered by CCO and (assuming the due authorization, execution and delivery of this

Agreement by Facility) constitutes a valid and binding obligation of CCO, enforceable against CCO in accordance with its terms, except as enforceability may be limited by the availability of equitable remedies or defenses and by applicable bankruptcy, insolvency, reorganization, moratorium or similar laws affecting the enforcement of creditors' rights generally.

iii) The execution, delivery and performance of this Agreement by CCO do not and will not violate or conflict with (a) the organizational documents of CCO, (b) any material agreement or instrument to which CCO is a party or by which CCO or any material part of its property is bound, or (c) applicable law.

iv) CCO has obtained and holds all registrations, permits, licenses, and other approvals and consents, and has made all filings, that it is required to obtain from or make with all governmental entities under applicable law in order to conduct its business as presently conducted and to enter into and perform its obligations under this Agreement.

Article III
Applicability of this Agreement

3.1 Facility's services.

i) This Agreement applies to Covered Services provided at Facility's service locations set forth in Appendix 1. If a service location is not listed in Appendix 1, this section 3.1 and this Agreement should nevertheless be understood as applying to Facility's actual service locations that existed when this Agreement was executed, rather than to a billing address, post office box, or any other address set forth in Appendix 1.

In the event Facility begins providing services at other service locations or under other Taxpayer Identification Number(s), those additional service locations or Taxpayer Identification Numbers will become subject to this Agreement only upon the written agreement of the parties. This subsection 3.1(i) applies to cases when Facility adds the location itself (such as through new construction or through conversion of a free-standing location to provider-based), and when Facility acquires, merges with, or otherwise becomes affiliated with an existing provider that was not already under contract with CCO or one of CCO's Affiliates to participate in a network of health care providers.

ii) In the event Facility acquires or is acquired by, merges with, or otherwise becomes affiliated with another provider of health care services that is already under contract with CCO or one of CCO's Affiliates to participate in a network of health care providers, this Agreement and the other agreement will each remain in effect and will continue to apply as they did prior to the acquisition, merger or affiliation, unless otherwise agreed to in writing by all parties to such agreements. Similarly, if Facility buys assets of, or leases space from, a facility that was under contract directly with CCO or one of CCO's Affiliates to participate in a network of health care providers at the time of the asset purchase or leasing arrangement, and Facility provides services at

that location, but does not assume the CCO contract held by the prior operator, Covered Services rendered at that location will be subject to the same rates and other key terms (including term and termination) as applied under the prior operator's contract.

iii) Facility may transfer all or some of its assets to another entity, with the result that all or some of the Covered Services subject to this Agreement will be rendered by the other entity rather than by Facility, but only if Facility requests that CCO approve the assignment of this Agreement as it relates to those Covered Services and only if the other entity agrees to assume this Agreement. This subsection 3.1(iii) does not limit CCO's right under section 9.4 of this Agreement to elect whether to approve the assignment of this Agreement. This subsection 3.1(iii) applies to arrangements under which another provider leases space from Facility, or enters into a subcontract with Facility to perform services, after the Effective Date of this Agreement, so that Covered Services that were subject to this Agreement as of the Effective Date of this Agreement are rendered and billed instead by the other provider rather than by Facility after the lease or subcontract takes place.

3.2 Payers and Benefit Plans. CCO may allow Payers to access Facility's services under this Agreement for certain Benefit Plans, as described in Appendix 2. CCO may modify Appendix 2 without amendment to include or exclude Benefit Plans in Appendix 2 by providing 30 days prior written or electronic notice to Facility.

In addition to changes allowed above, CCO may make additional changes to Appendix 2 as described in section 3 of that appendix.

Section 9.3 of this Agreement will apply to Covered Services provided to Customers covered by Benefit Plans that are added to the list in Appendix 2 of Benefit Plans excluded from this Agreement as described above.

3.3 Patients who are not Customers. This Agreement does not apply to services rendered to patients who are not Customers at the time the services were rendered. Section 6.6 of this Agreement addresses circumstances in which claims for services rendered to those patients are inadvertently paid.

3.4 Health care. This Agreement and Benefit Plans do not dictate the health care provided by Facility Professionals, or govern Facility Professional's determination of what care to provide patients, even if those patients are Customers. The decision regarding what care is to be provided remains with Facility Professionals and with Customers, and not with CCO or any Payer.

3.5 Communication with Customers. Nothing in this Agreement is intended to limit Facility's or Facility Professional's right or ability to communicate fully with a Customer regarding the Customer's health condition and treatment options. Facility and Facility Professionals are free to discuss all treatment options without regard to whether or not a given option is a Covered Service. Facility and Facility Professionals are free to discuss with a Customer any financial incentives Facility may have under this Agreement,

including describing at a general level the payment methodologies contained in this Agreement.

Article IV
Duties of Facility

4.1 Provide Covered Services. Facility will provide Covered Services to Customers. Facility must be in compliance with section 2.1(iv) of this Agreement and, to the extent Facility and Facility Professionals are subject to credentialing by CCO, Facility and Facility Professionals must be credentialed by CCO or its delegate prior to furnishing any Covered Services to Customers under this Agreement. Facility and Facility Professionals will participate in and cooperate with CCO's credentialing program, as applicable.

4.2 Nondiscrimination. Facility will not discriminate against any patient, with regard to quality or accessibility of services, on the basis that the patient is a Customer.

Facility will not require a Customer to pay a "membership fee" or other fee in order to access Facility for Covered Services (except for co-payments, coinsurance and/or deductibles provided for under Customer's Benefit Plan) and will not discriminate against any Customer based on the failure to pay such a fee.

4.3 Accessibility. Facility will be open during normal business hours and will provide or arrange for the provision of advice and assistance to Customers in emergency situations 24 hours a day, seven days a week.

4.4 Protocols.

i) Cooperation with Protocols. Facility will cooperate with and be bound by CCO's and Payers' Protocols. The Protocols include but are not limited to all of the following:

a) For non-emergency Covered Services, Facility will assist Customers to maximize their benefits by referring or directing Customers only to other providers that participate in CCO's network, except as otherwise authorized by CCO through CCO's process for approving out-of-network services at in-network benefit levels.

b) If the Customer's Benefit Plan requires the Customer to receive certain Covered Services from or upon referral by a primary care physician, all Facility Professionals must adhere to the following additional protocols:

1) Notify the Customer's primary care physician of referrals to other participating or non-participating providers.

2) Render Covered Services pursuant to the terms and limitations of the referral notification issued by or on behalf of the Customer's primary care physician.

3) Notify the Customer's primary care physician of all admissions.

c) Facility will provide notification for certain Covered Services, accept and return telephone calls from CCO staff, and respond to CCO requests for clinical information as required by CCO or Payer as described in the Protocols.

ii) **Availability of Protocols.** The Protocols will be made available to Facility online or upon request. Some or all Protocols also may be disseminated in the form of an administrative manual or guide or in other communications. Currently, the Protocols may be found at portal.com or as indicated in the Additional Manual Appendix, if applicable. CCO will notify Facility of any changes in the location of the Protocols.

iii) **Changes to Protocols.** CCO may change the Protocols from time to time. CCO will use reasonable commercial efforts to inform Facility at least 30 days in advance of any material changes to the Protocols. CCO may implement changes in the Protocols without Facility's consent if the change is applicable to all or substantially all similarly situated facilities in CCO's network located in the same state as Facility. Otherwise, changes to the Protocols proposed by CCO to be applicable to Facility are subject to the requirements regarding amendments in section 9.2 of this Agreement.

4.5 Employees and Subcontractors. Facility will ensure that its employees, affiliates and any individuals or entities subcontracted by Facility to render services in connection with this Agreement adhere to the requirements of this Agreement. The use of employees, affiliates or Subcontractors to render services in connection with this Agreement will not limit Facility's obligations and accountability under this Agreement with regard to those services. Facility affiliates are those entities that control, are controlled by or are under common control with Facility.

[For laboratory services, Facility must comply with the Clinical Laboratory Improvement Amendments (CLIA) for those laboratory services that are RHC services, as defined by CMS.]

4.6 Licensure. Facility will maintain, without material restriction, such licensure, registration, and permits as are necessary to enable Facility to lawfully perform this Agreement.

4.7 Liability insurance. Facility will ensure that Facility and Facility Professionals are covered by liability insurance. Except to the extent coverage is a state mandated placement, the coverage must be placed with responsible, financially sound insurance carriers authorized or approved to write coverage in the state in which the Covered Services are provided. The liability insurance will be, at a minimum, of the types and in the amounts set forth below. Medical malpractice insurance will be either per occurrence or claims made with an extended period reporting option. Upon CCO's request, Facility will submit to CCO in writing evidence of insurance coverage.

Type of Insurance	Minimum Limits
Medical malpractice and/or professional liability insurance	If Facility insures all Facility Professionals in a single policy: $3,000,000.00 per occurrence and $5,000,000.00 aggregate. OR If Facility insures each Facility Professional separately, $1,000,000.00 per occurrence and $3,000,000.00 aggregate for each Facility Professional.
Commercial general and/or umbrella liability insurance	$1,000,000.00 per occurrence and aggregate.

In lieu of purchasing the insurance coverage required in this section, Facility may self-insure its medical malpractice and/or professional liability, as well as its commercial general liability. Facility will maintain a separate reserve for its self-insurance. If Facility uses the self-insurance option described in this paragraph, Facility will provide to CCO, prior to the Effective Date, a statement, verified by an independent auditor or actuary, that its reserve funding levels and process of funding appears adequate to meet the requirements of this section and fairly represents the financial condition of the fund. Facility will provide a similar statement during the term of this Agreement upon CCO's request, which will be made no more frequently than annually. Facility will assure that its self-insurance fund will comply with applicable laws and regulations.

4.8 Notice by Facility. Facility will give notice to CCO within 10 days after any event that causes Facility to be out of compliance with section 4.6 or 4.7 of this Agreement. Facility will give notice to CCO at least 30 days prior to any change in Facility's name, ownership, control, or Taxpayer Identification Number.

In addition, Facility will give written notice to CCO within 10 days after it learns of any of the following:

i) any suspension, revocation, condition, limitation, qualification or other material restriction on a Facility Professional's licenses, certifications and permits by any government agency under which a Facility Professional is authorized to provide health care services;
ii) any suspension, revocation, condition, limitation, qualification or other material restriction of a Facility Physician's staff privileges at any hospital, nursing home or other facility at which a Facility Physician has staff privileges during the term of this Agreement;
iii) an indictment, arrest or conviction of a Facility Professional for a felony, or for any criminal charge related to the practice of the Facility Professional's profession;
iv) the departure of any Facility Professional from Facility; or
v) any changes to the information contained in Appendix 1.

4.9 Customer consent to release of medical record information. Facility will obtain any Customer consent required in order to authorize Facility to provide access to requested information or records as contemplated in section 4.10 of this Agreement, including copies of the Facility's medical records relating to the care provided to Customer.

4.10 Maintenance of and access to records.

i) **Maintenance.** Facility will maintain medical, financial and administrative records related to Covered Services rendered by Facility under this Agreement, including claims records, for at least 6 years following the end of the calendar year during which the Covered Services are provided, unless a longer retention period is required by applicable law.

ii) **Access.** Facility will provide access to these records as follows:

a) to CCO or its designees, in connection with CCO's utilization management, quality assurance and improvement and for claims payment, health care operations and other administrative obligations, including reviewing Facility's compliance with the terms and provisions of this Agreement and appropriate billing practice. Facility will provide access during ordinary business hours within 14 days after a request is made, except in cases of a CCO billing audit involving an allegation of fraud or abuse or the health and safety of a Customer (in which case, access must be given within 48 hours after the request) or of an expedited Customer appeal or grievance (in which case, access will be given so as to enable CCO to reasonably meet the timelines for determining the appeal or grievance). If records are requested to adjudicate a claim, make a decision regarding a request for correction under section 6.10, or to review an appeal, Facility will provide copies of the requested records within 14 days after the request is made; and

b) to agencies of the government, in accordance with applicable law, to the extent that access is necessary to comply with regulatory requirements applicable to Facility, CCO, or Payers.

Facility will cooperate with CCO on a timely basis in connection with any such record request including, among other things, in the scheduling of and participation in an exit interview to review findings, within 30 days after CCO's request.

Facility will provide copies of records requested by CCO free of charge**.**

4.11 Access to data. Facility represents that in conducting its operations, it collects and reviews certain quality data relating to care rendered by Facility that is reported in a manner which has been validated by a third party as having a clear, evidence-based link to quality or safety (e.g., AHRQ standards) or which has been created by employer coalitions as proxies for quality (e.g., Leapfrog standards)**.**

CCO recognizes that Facility has the sole discretion to select the metrics which it will track from time to time and that Facility's primary goal in tracking quality data is to advance the quality of patient care. If the information that Facility chooses to report on is available in the public domain in a format that includes all data elements required by CCO, CCO will obtain quality information directly from that source. If the Facility does not report metrics in the public domain, on a quarterly basis, Facility will share these metrics with CCO as tracked against a database of all patients (including patients who are not Customers). CCO may publish this data to entities to which CCO renders services or seeks to render services, and to Customers.

4.12 Compliance with law. Facility will comply with applicable regulatory requirements, including but not limited to those relating to confidentiality of Customer medical information.

4.13 Electronic connectivity. When made available by CCO, Facility will do business with CCO electronically using portal.com, or other electronic resources as made available by CCO.

4.14 New Facility Professionals. This section 4.14 applies when CCO credentials the Facility Professionals individually.

Facility will notify CCO at least 30 days before a physician or other health care professional becomes a Facility Professional. In the event that the Facility's agreement with the new Facility Professional provides for a starting date that would make it impossible for Facility to provide 30 days advance notice to CCO, then Facility will give notice to CCO as soon as reasonably possible but no later than five business days after reaching agreement with the new Facility Professional. In either case, the new Facility Professional will submit and complete a credentialing application to CCO or its delegate within 30 days of the new Facility Professional's agreement to join Facility, unless the new Facility Physician already has been credentialed by CCO and is already a participant in CCO's network, or unless CCO's credentialing program does not apply to the new Facility Professional. In addition, Facility will provide to CCO the information described in the Facility Professional Roster to this Agreement with respect to the new Facility Professional.

4.15 Termination of a Facility Professional from CCO's network. CCO may terminate a Facility Professional's participation in CCO's network, without terminating this Agreement, immediately upon becoming aware of any of the following:

i) the material breach of this Agreement by the Facility Professional that is not cured by Facility and/or the Facility Professional within 30 days after CCO provided notice to Facility of the breach;
ii) the suspension, revocation, condition, limitation, qualification or other material restriction on a Facility Professional's license, certification and/or permit by any government agency under which the Facility Professional is authorized to provide health care services;

iii) the suspension, revocation, condition, limitation, qualification or other material restriction of a Facility Professional's staff privileges at any licensed hospital, nursing home or other facility at which the Facility Professional has staff privileges during the term of this Agreement;
iv) any criminal charge related to the practice of Facility Professional's profession, or any indictment, arrest, or conviction for a felony;
v) a sanction imposed by any governmental agency or authority, including Medicare or Medicaid; or
vi) the failure to meet the requirements of CCO's credentialing program to the extent that those requirements apply to the Facility Professional.

CCO will notify Facility of the Facility Professional's termination according to the notice provision set forth in section 9.8 of this Agreement.

4.16 Covered Services by Facility Professionals who are not participating providers. Facility will staff its service locations so that Covered Services can appropriately be rendered to Customers by Facility Professionals who participate in CCO's network. A Facility Professional who does not participate in CCO's network will not render Covered Services to a Customer.

In the event Covered Services are rendered by a Facility Professional who does not participate in CCO's network, neither Facility nor the Facility Professional will submit a claim or other request for payment to CCO or Payer pursuant to this Agreement, and will not seek or accept payment from the Customer.

Article V
Duties of CCO and Payers

5.1 Payment of claims. As described in further detail in Article VI of this Agreement, Payers will pay Facility for rendering Covered Services to Customers. CCO will make its Payment Policies available to Facility online and upon request. CCO may change its Payment Policies from time to time and will make information available describing the change.

5.2 Liability insurance. CCO will procure and maintain professional and general liability insurance and other insurance, as CCO reasonably determines may be necessary, to protect CCO and CCO's employees against claims, liabilities, damages or judgments that arise out of services provided by CCO or CCO's employees under this Agreement.

5.3 Licensure. CCO will maintain, without material restriction, such licensure, registration, and permits as are necessary to enable CCO to lawfully perform this Agreement.

5.4 Notice by CCO. CCO will give written notice to Facility within 10 days after any event that causes CCO to be out of compliance with section 5.2 or 5.3 of this Agreement, or of any change in CCO's name, ownership, control, or Taxpayer Identification Number. This

section does not apply to changes of ownership or control that result in CCO being owned or controlled by an entity with which it was already affiliated prior to the change.

5.5 Compliance with law. CCO will comply with applicable regulatory requirements, including but not limited to those relating to confidentiality of Customer medical information and those relating to prompt payment of claims, to the extent those requirements are applicable.

5.6 Electronic connectivity. CCO will do business with Facility electronically using portal.com, or other electronic resources as made available by CCO.

5.7 Employees and Subcontractors. CCO will assure that its employees, affiliates and any individuals or entities subcontracted by CCO to render services in connection with this Agreement adhere to the requirements of this Agreement. The use of employees, affiliates or Subcontractors to render services in connection with this Agreement will not limit CCO's obligations and accountability under this Agreement with regard to those services.

Article VI
Submission, Processing, and Payment of Claims

6.1 Form and content of claims. Facility must submit claims for Covered Services as described in the Protocols, using current, correct, and applicable coding.

6.2 Electronic filing of claims. Within six months after the Effective Date of this Agreement, Facility will use electronic submission for all of its claims under this Agreement that CCO is able to accept electronically.

6.3 Time to file claims. Unless a longer timeframe is required under applicable law, all information necessary to process a claim must be received by CCO no more than 90 days from the date Covered Services are rendered. If Payer is not the primary payer on a claim, and Facility is pursuing payment from the primary payer, the period in which Facility must submit the claim will begin on the date Facility receives the claim response from the primary payer.

6.4 Payment of claims for Covered Services. Payer will pay claims for Covered Services according to the amount specified in the applicable Payment Appendix(ices) to this Agreement, and in accordance with Payment Policies

Claims for Covered Services subject to coordination of benefits will be paid in accordance with the Customer's Benefit Plan and applicable law.

The obligation for payment under this Agreement is solely that of Payer and not that of CCO unless CCO is the Payer.

Ordinarily, fee amounts listed in the Payment Appendix(ices) are based upon primary fee sources. CCO reserves the right to use gap-fill fee sources where primary fee sources are not available.

CCO routinely updates its payment appendices: (1) to remain current with applicable coding practices; (2) in response to price changes for immunizations and injectable medications; and (3) to remain in compliance with HIPAA requirements. CCO will not attempt to communicate routine updates of this nature. Ordinarily, CCO's fee schedule is updated using similar methodologies for similar services.

CCO will give Facility at least 90 days written or electronic notice of non-routine fee schedule changes which will substantially alter the overall methodology or reimbursement level of the fee schedule. In the event such changes will reduce Facility's overall reimbursement under this Agreement, Facility may terminate this Agreement by giving 60 days written notice to CCO, provided that the notice is given by Facility within 30 days after the notice of the fee schedule change.

6.5 Denial of claims for not following Protocols, for not filing timely, for services not covered under the Customer's Benefit Plan, or for lack of medical necessity.

i) **Non-compliance with Protocol.** Payment may be denied in whole or in part if Facility does not comply with a Protocol or does not file a timely claim as required under section 6.3 of this Agreement. Facility may request reconsideration of the denial and the denial will be reversed if Facility can show one or more of the following:

a) the denial was incorrect because Facility complied with the Protocol.
b) at the time the Protocol required notification or prior authorization, (i) Facility did not know and was unable to reasonably determine that the patient was a Customer, (ii) Facility took reasonable steps to learn that the patient was a Customer, and (iii)Facility promptly submitted a claim after learning the patient was a Customer.

A claim is also subject to denial for other reasons permitted under the Agreement. Reversal of a claim denial under this subsection (i) does not preclude CCO from upholding a denial for one of these other reasons.

ii) **Non-Covered Services.** Services not covered under the applicable Benefit Plan are not subject to the rates or discounts of this Agreement. Facility may seek and collect payment from a Customer for such services (provided that Facility obtained the Customer's prior written consent).

iii) **Denials for lack of medical necessity through the prior authorization process.** If a service would otherwise be a Covered Service, but is not a Covered Service under the applicable Benefit Plan because it is determined through the prior authorization process to not meet the requirement of medical necessity, as defined in the Benefit Plan or applicable law (or not meet a similar concept in the Benefit Plan, such as not being consistent with nationally recognized scientific evidence as available, or not being

consistent with prevailing medical standards and clinical guidelines), Facility may seek or collect payment from the Customer if, prior to receiving the service, the Customer had knowledge of the determination of non-coverage and specifically agreed in writing to be responsible for payment of those charges.

6.6 Retroactive correction of information regarding whether patient is a Customer. Prior to rendering services, Facility will ask the patient to present his or her Customer identification card. In addition, Facility may contact CCO to obtain the most current information available to CCO on the patient's status as a Customer.

However, such information provided by CCO is subject to change retroactively, under any of the following circumstances:

i) if CCO has not yet received information that an individual is no longer a Customer;
ii) if the individual's Benefit Plan is terminated retroactively for any reason including, but not limited to, non-payment of premium;
iii) as a result of the Customer's final decision regarding continuation of coverage pursuant to state and federal laws; or
iv) if eligibility information CCO receives is later proven to be false.

If Facility provides health care services to an individual, and it is determined that the individual was not a Customer at the time the health care services were provided, those services are not payable under this Agreement and any payments made with regard to those services may be recovered as overpayments under the process described in section 6.10 of this Agreement. Facility may then directly bill the individual, or other responsible party, for those services.

6.7 Payment under this Agreement is payment in full. Payment as provided under section 6.4 of this Agreement, together with any co-payment, deductible or coinsurance for which the Customer is responsible under the Benefit Plan, is payment in full for a Covered Service. Facility will not seek to recover, and will not accept, any payment from Customer, CCO, Payer or anyone acting on any of their behalves, in excess of payment in full as provided in this section 6.7, regardless of whether that amount is less than Facility's billed charge or Customary Charge.

6.8 Customer hold harmless. Facility will not bill or collect payment from the Customer, or seek to impose a lien, for the difference between the amount paid under this Agreement and Facility's billed charge or Customary Charge, or for any amounts denied or not paid under this Agreement due to:

i) Facility's failure to comply with the Protocols,
ii) Facility's failure to file a timely claim,
iii) Payer's Payment Policies,
iv) inaccurate or incorrect claim processing,
v) insolvency or other failure by Payer to maintain its obligation to fund claims payments, if Payer is CCO, or is an entity required by applicable law to assure that its Customers not be billed in these circumstances, or

vi) a denial based on lack of medical necessity or consistency with nationally recognized scientific evidence as available, and prevailing medical standards and clinical guidelines, except as provided in section 6.5 of this Agreement.

This obligation to refrain from billing Customers applies even in those cases in which Facility believes that CCO or Payer has made an incorrect determination. In such cases, Facility may pursue remedies under this Agreement against CCO or Payer, as applicable, but must still hold the Customer harmless.

In the event of a default by a Payer other than those Payers covered by the above clause v) of this section 6.8, Facility may seek payment directly from the Payer or from Customers covered by that Payer, if Facility first inquires in writing to CCO as to whether the Payer has defaulted and, if so confirmed, gives CCO 15 days prior written notice of Facility's intent to seek payment from Payer or Customers. For purposes of this paragraph, a default is a systematic failure by a Payer to fund claims payments related to Customers covered through that Payer; a default does not occur in the case of a dispute as to whether certain claims should be paid or the amounts that should be paid for certain claims.

This section 6.8 and section 6.7 will survive the termination of this Agreement, with regard to Covered Services rendered prior to when the termination takes effect.

6.9 Consequences for failure to adhere to Customer protection requirements. If Facility collects payment from, brings a collection action against, or asserts a lien against a Customer for Covered Services rendered (other than for the applicable co-payment, deductible or coinsurance), contrary to section 6.7 or 6.8 of this Agreement, Facility will be in breach of this Agreement. This section 6.9 will apply regardless of whether Customer or anyone purporting to act on Customer's behalf has executed a waiver or other document of any kind purporting to allow Facility to collect such payment from Customer.

In the event of such a breach, Payer may deduct, from any amounts otherwise due Facility, the amount wrongfully collected from Customers, and may also deduct an amount equal to any costs or expenses incurred by the Customer, CCO or Payer in defending the Customer and otherwise enforcing sections 6.7 through 6.9 of this Agreement. Any amounts deducted by Payer in accordance with this provision will be used to reimburse the Customer and to satisfy any costs incurred. The remedy contained in this paragraph does not preclude CCO from invoking any other remedy for breach that may be available under this Agreement.

6.10 Correction of claims payments. If Facility does not seek correction of a given claim payment or denial by giving notice to CCO within 12 months after the claim was initially processed, it will have waived any right to subsequently seek such correction under this section 6.10, or through dispute resolution under Article VII of this Agreement or in any other forum.

Facility will repay overpayments within 30 days of written or electronic notice of the overpayment. Facility will promptly report any credit balance that it maintains with regard

to any claim overpayment under this Agreement, and will return the overpayment to CCO within 30 days after posting it as a credit balance.

Recovery of overpayments may be accomplished by offsets against future payments.

6.11 Claims payment issues arising from departure of Facility Professionals from Facility. In the event a Facility Professional departs from Facility and uncertainty arises as to whether Facility or some other entity is entitled to receive payment for certain services rendered by such former Facility Professional, the parties will cooperate with each other in good faith in an attempt to resolve the situation appropriately.

In the event that Facility's failure to give timely notice under section 4.8(iv) of this Agreement results in claims payments being made incorrectly to Facility, Facility will promptly notify CCO and return such payments to CCO. In the event Facility fails to do so, CCO may hold Facility liable for any attorneys' fees, costs, or administrative expenses incurred by CCO as a result.

In the event that both Facility and some other entity assert a right to payment for the same service rendered by the former Facility Professional, CCO may refrain from paying either entity until the entity to which payment is owed is determined. Provided that CCO acts in good faith, Facility will waive any right to receive interest or penalties under any applicable law relating to the prompt payment of claims.

Article VII
Dispute Resolution

The parties will work together in good faith to resolve any and all disputes between them ("Disputes") including, but not limited to the existence, validity, scope or termination of this Agreement or any term thereof, and all questions of arbitrability, with the exception of any question regarding the availability of class arbitration or consolidated arbitration, which is expressly waived below. Disputes also include any dispute in which Facility is acting as the assignee of one or more Customer. In such cases, Facility agrees that the provisions of this Article VII will apply, including without limitation the requirement for arbitration.

If the Dispute pertains to a matter which is generally administered by certain CCO procedures, such as a credentialing or quality improvement plan, the policies and procedures set forth in that plan must be fully exhausted by Facility before Facility may invoke any right to arbitration under this Article VII.

For Disputes regarding payment of claims, a party must have timely initiated and completed the claim reconsideration and appeal process as set forth in the Administrative Guide in order to initiate the Dispute process.

If the parties are unable to resolve any such Dispute within 60 days following the date one party sent written notice of the Dispute to the other party, and if either party wishes to pursue the Dispute,

it may do so only by submitting the Dispute to binding arbitration conducted by the American Arbitration Association ("AAA") in accordance with the AAA Healthcare Payor Provider Arbitration Rules, as they may be amended from time to time (see http://www.adr.org), except that, in any case involving a Dispute in which a party seeks an award of $1,000,000 or greater, or seeks termination of this Agreement, a panel of three arbitrators will be used; a single arbitrator cannot award $1,000,000 or more, or order that this Agreement is terminated. The arbitrator(s) will be selected from the AAA National Healthcare Roster (as described in the AAA Healthcare Payor Provider Arbitration Rules) or the AAA's National Roster of Arbitrators. Unless otherwise agreed to in writing by the parties, if the party wishing to pursue the Dispute does not initiate the arbitration within one year after the date on which written notice of the Dispute was given, or, for Disputes subject to the procedures or processes described in the previous paragraph, within one year after the completion of the applicable procedure or process, it will have waived its right to pursue the Dispute in any forum.

Any arbitration proceeding under this Agreement will be conducted in [name of county] County, [state]. The arbitrator(s) may construe or interpret but must not vary or ignore the terms of this Agreement and will be bound by controlling law. The arbitrator(s) have no authority to award punitive, exemplary, indirect or special damages, except in connection with a statutory claim that explicitly provides for that relief.

Except as may be required by law, neither a party (including without limitation, the parties' representatives, consultants and counsel of record in the arbitration), nor an arbitrator may disclose the existence, content, or results of any arbitration hereunder, or any Confidential Arbitration Information, without the prior written consent of all parties. "Confidential Arbitration Information" means any written submissions in an arbitration by either party, discovery exchanged, evidence submitted, transcriptions or other records of hearings in the matter and any orders and awards issued, and any reference to whether either party won, lost, prevailed, or did not prevail against the other party in any arbitration proceeding, as well as any settlement agreement related to an arbitration. However, judgment on the award may be entered under seal in any court having jurisdiction thereof, by either party.

The parties expressly intend that any arbitration be conducted on an individual basis, so that no third parties may be consolidated, joined or allowed to proceed with class arbitration. The parties agree that any arbitration ruling allowing class arbitration, or requiring consolidated arbitration involving any third party(ies), would be contrary to the terms of this Agreement and require immediate judicial review. Notwithstanding anything in this Agreement to the contrary, this paragraph may not be severed from Article VII of the Agreement under any circumstances, including but not limited to unlawfulness, invalidity or unenforceability.

The decision of the arbitrator(s) on the points in dispute will be binding. The parties acknowledge that because this Agreement affects interstate commerce, the Federal Arbitration Act applies.

In the event any court determines that this arbitration procedure is not binding or otherwise allows litigation involving a Dispute to proceed, the parties hereby waive any and all right to trial by jury

in, or with respect to, the litigation. The litigation would instead proceed with the judge as the finder of fact.

In the event a party wishes to terminate this Agreement based on an assertion of uncured material breach, and the other party disputes whether grounds for the termination exist, the matter will be resolved through arbitration under this Article VII. While the arbitration remains pending, the termination for breach will not take effect.

This Article VII will survive any termination of this Agreement.

Article VIII
Term and Termination

8.1 **Term.** This Agreement will take effect on the Effective Date. This Agreement has an initial term of [three years] and renews automatically for renewal terms of one year, until terminated pursuant to section 8.2 of this Agreement.

8.2 **Termination.** This Agreement may be terminated under any of the following circumstances:

i) by mutual written agreement of the parties;
ii) by either party, upon at least 180 days' prior written notice, effective at the end of the initial term or effective at the end of any renewal term;
iii) by either party, upon 60 days' prior written notice, in the event of a material breach of this Agreement by the other party, which notice will include a specific description of the alleged breach; however, the termination will not take effect if the breach is cured within 60 days after notice of the termination, or if the termination is deferred under Article VII of this Agreement;
iv) by either party, upon 10 days' prior written notice, in the event the other party loses licensure or other governmental authorization necessary to perform this Agreement, or fails to have insurance as required under section 4.7 or section 5.2 of this Agreement;
v) by CCO, upon 10 days' prior written notice, in the event Facility loses accreditation; or
vi) by CCO, immediately upon written notice, in the event:
    a) Facility loses approval for participation under CCO's credentialing plan, or
    b) Facility does not successfully complete the CCO's re-credentialing process as required by the credentialing plan.

8.3 **Ongoing services to certain Customers after termination takes effect.** In the event a Customer is receiving any of the Covered Services listed below, as of the effective date of the termination of this Agreement, or the effective date that a Benefit Plan is added to the list in Appendix 2 of Benefit Plans excluded from this Agreement, Facility will continue to render those Covered Services to that Customer, and this Agreement will continue to apply to those Covered Services, after the termination/exclusion takes effect, for the length of time indicated below:

Covered Service	Continuity of Care Period
Inpatient Covered Services	30 days or until discharge, whichever comes first
Pregnancy, Third Trimester – Low Risk	Through postpartum follow up visit
Pregnancy, First, Second or Third Trimester – Moderate Risk and High Risk	Through postpartum follow up visit
Non-Surgical Cancer Treatment	30 days or a complete cycle of radiation or chemotherapy, whichever is greater
End Stage Kidney Disease and Dialysis	30 days
Symptomatic AIDS undergoing active treatment	30 days
Any circumstance where Payer is required by applicable law to provide transition coverage of services rendered by Facility after Facility leaves the provider network accessed by Payer.	As required by applicable law

Article IX
Miscellaneous Provisions

9.1 **Entire Agreement.** In order for this Agreement to be binding, it must be executed by all parties through written or electronic signature. This Agreement is the entire agreement between the parties with regard to its subject matter, and supersedes any prior written or unwritten agreements between the parties or their affiliates with regard to the same subject matter.

9.2 **Amendment.** In order for an amendment to this Agreement to be binding, it must be executed by all parties through written or electronic signature, except as otherwise provided in this section 9.2.

CCO may amend this Agreement upon written notice to Facility in order to comply with applicable regulatory requirements, but only if that amendment is imposed on a similar basis to all or substantially all of the facilities in CCO's network that would be similarly impacted by the regulation in question. CCO will provide at least 30 days' notice of any such regulatory amendment, unless a shorter notice period is necessary in order to comply with regulatory requirements.

9.3 **Non-waiver.** The waiver by either party of any breach of any provision of this Agreement will not operate as a waiver of any subsequent breach of the same or any other provision.

9.4 **Assignment.** This Agreement may not be assigned by either party without the written consent of the other party, except that this Agreement may be assigned by CCO to any CCO Affiliate.

Additionally, if CCO transfers to a third party all of its business described in a given line item in Appendix 2, section 1, or other line of business, CCO may assign this Agreement, only as it relates to that transferred business, to that third party. Such an assignment will not impact the relationship of the parties under this Agreement with regard to the remainder of CCO's business.

9.5 Relationship of the parties. The sole relationship between the parties to this Agreement is that of independent contractors. This Agreement does not create a joint venture, partnership, agency, employment or other relationship between the parties.

9.6 No third-party beneficiaries. CCO and Facility are the only entities with rights and remedies under this Agreement.

9.7 Calendar days. Unless this Agreement specifically provides otherwise, all references in this Agreement to a period of days refers to calendar days.

9.8 Notice procedures. Any notice required to be given under this Agreement must be in writing, except in cases in which this Agreement specifically permits electronic notice, or as otherwise permitted or required in the Protocols. Acceptable forms of written notice include facsimile, first class mail, certified mail, or overnight delivery by a national, recognized delivery service. All notices of termination of this Agreement by either party must be sent by certified mail, return receipt requested, addressed to the appropriate party at the address set forth on the signature portion of this Agreement. Each party will provide the other with proper addresses, facsimile numbers and electronic mail addresses. All notices will be deemed received upon receipt by the party to which notice is given or on the 5th business day following mailing, whichever occurs first.

9.9 Confidentiality. Neither party may disclose to a Customer, other health care provider, or other third party any of the following information (except as required by an agency of the government):

i) any proprietary business information, not available to the general public, obtained by the party from the other party;

ii) the specific reimbursement amounts provided for under this Agreement, except for purposes of administration of benefits, including informing Customers, Benefit Plan sponsors and/or referring providers about the cost of a particular Covered Service or set of Covered Services; or

iii) any customer list of the other party regardless of how such customer list was generated.

This section 9.9 does not preclude the disclosure of information by CCO to a third party as part of the process by which the third party is considering whether to purchase services from CCO.

At least 48 hours before either party issues a press release, advertisement, or other media statement about the business relationship between the parties, that party will give the other party a copy of the material the party intends to issue.

9.10 Governing law. This Agreement will be governed by and construed in accordance with the laws of the state in which Facility renders Covered Services, and any other applicable law.

9.11 Regulatory appendices. One or more regulatory appendices may be attached to this Agreement, setting forth additional provisions included in this Agreement in order to satisfy regulatory requirements under applicable law. These regulatory appendices, and any attachments to them, are expressly incorporated into this Agreement and are binding on the parties to this Agreement. In the event of any inconsistent or contrary language between a regulatory appendix and any other part of this Agreement, including but not limited to appendices, amendments and exhibits, the regulatory appendix will control, to the extent it is applicable.

9.12 Severability. Except as otherwise set forth in this Agreement, any provision of this Agreement that is unlawful, invalid or unenforceable in any situation in any jurisdiction will not affect the validity or enforceability of the remaining provisions of this Agreement or the lawfulness, validity or enforceability of the offending provision in any other situation or jurisdiction.

9.13 Survival. Notwithstanding the termination of this Agreement, this Agreement will continue to apply to Covered Services rendered while this Agreement was in effect. Additionally, section 9.9 of this Agreement, (except for the last paragraph) will survive the termination of this Agreement.

THIS AGREEMENT CONTAINS A BINDING ARBITRATION PROVISION THAT MAY BE ENFORCED BY THE PARTIES.

[Facility], as signed by its authorized representative		***Address to be used to give notice to Facility under this Agreement:***	
Signature:	_____	Street:	_____
Print Name and Title:	_____	City:	_____
		State:	_____Zip Code:_____
D/B/A:	_____	Phone:	_____Fax:_____
Date:_____		E-mail:	_____

CCO, on behalf of itself, HMO and the other entities that are CCO Affiliates, as signed by its authorized representative:

Signature:	_____
Print Name:	_____
Title:	_____
Date:	_____

Address to be used for giving notice to CCO under this Agreement:

Street:_____
City:_____
State: _____ Zip Code:_____
Fax:_____
Email:_____

For office use only: [_____]
Contract number: [_____]
Month, day and year in which Agreement is first effective: [_____]

Appendix 1
Facility Service Locations

Facility attests that this Appendix identifies all services and locations covered under this Agreement.

IMPORTANT NOTE: Facility acknowledges its obligation under Section 4.8 to promptly report any change in Facility's name or Taxpayer Identification Number. Failure to do so may result in denial of claims or incorrect payment.

Facility Name_____
Street Address_____
City_____ State_____ Zip_____
Taxpayer Identification Number(s) (TIN)
_____
National Provider ID (NPI) _____

FACILITY LOCATION - List BOTH the Service Location and the Billing Address for the Service Location	
Service Location	**Billing Address for the Service Location**
Facility Name	**Facility Name**
Street Address	**Street Address**
City	**City**
State and Zip Code	**State and Zip Code**
Phone Number	**Phone Number**
TIN (*if different from above*)	
National Provider ID (NPI)	
ADDITIONAL FACILITY LOCATIONS - List BOTH the Service Location and the Billing Address for the Service Location	
Service Location	**Billing Address for the Service Location**
Facility Name	**Facility Name**
Street Address	**Street Address**
City	**City**
State and Zip Code	**State and Zip Code**

Phone Number	**Phone Number**
TIN (*if different from above*)	
National Provider ID (NPI)	
Facility Name	**Facility Name**
Street Address	**Street Address**
City	**City**
State and Zip Code	**State and Zip Code**
Phone Number	**Phone Number**
TIN (*if different from above*)	
National Provider ID (NPI)	
Facility Name	**Facility Name**
Street Address	**Street Address**
City	**City**
State and Zip Code	**State and Zip Code**
Phone Number	**Phone Number**
TIN (*if different from above*)	
National Provider ID (NPI)	

Appendix 2
Benefit Plan Descriptions

Section 1. CCO may allow Payers to access Facility's services under this Agreement for the Benefit Plan types described in each line item below, unless otherwise specified in section 2 of this Appendix 2:

- [Mississippi Medicaid Benefit Plans.]

- [Mississippi CHIP Benefit Plans.]

Section 2. Notwithstanding the above section 1 of this Appendix 2, this Agreement will not apply to the Benefit Plan types described in the following line items:

- [Mississippi Medicaid Benefit Plans.]
- [Mississippi CHIP Benefit Plans.]
- Medicaid and CHIP Benefit Plans other than those separately addressed in this Appendix 2.

Page Intentionally left Blank.

Note: Excluding certain Benefit Plans or programs from this Agreement does not preclude the parties or their affiliates from having or entering into a separate agreement providing for Facility's participation in a network for such Benefit Plans or programs.

Section 3. Definitions:

Note: CCO may adopt a different name for a particular Benefit Plan, and/or may modify information referenced in the definitions in this Appendix 2 regarding Customer identification cards. If that happens, section 1 or section 2 of this Appendix 2 will continue to apply to those Benefit Plans as it did previously, and CCO will provide Facility with the updated information. Additionally, CCO may revise the definitions in this Appendix 2 to reflect changes in the names or roles of CCO's business units, provided that doing so does not change Facility's participation status in Benefit Plans impacted by that change, and further provided that CCO provides Facility with the updated information.

MEDICAID, CHIP AND OTHER STATE PROGRAMS:

- **Medicaid Benefit Plans** means Benefit Plans that offer coverage to beneficiaries of a program that is authorized by Title XIX of the federal Social Security Act, and jointly financed by the federal and state governments and administered by the state.

- **Mississippi Medicaid Benefit Plans** means Medicaid Benefit Plans issued in Mississippi that have a reference to "CCO" on the valid identification card of any Customer eligible for and enrolled in that Benefit Plan.

- **Children's Health Insurance Program ("CHIP") Benefit Plans** means Benefit Plans under the program authorized by Title XXI of the federal Social Security Act that is jointly financed by the federal and state governments and administered by the state.

- **Mississippi CHIP Benefit Plans** means CHIP Benefit Plans issued in Mississippi that include a reference to "CCO" and "MSCHIP" on the face of the valid identification card of any Customer eligible for and enrolled in that Benefit Plan.

- **Other Governmental Benefit Plans** means Benefit Plans that are funded wholly or substantially by a state or district government or a subdivision of a state (such as a city or county), but do not include Benefit Plans for:
  i) employees of a state government or a subdivision of a state and their dependents;
  ii) students at a public university, college or school;
  iii) employer-based coverage of private sector employees, even if the employer receives a government subsidy to help fund the coverage;
  iv) Medicaid beneficiaries;
  v) Children's Health Insurance Program (CHIP) beneficiaries; and
  vi) Medicare and Medicaid Enrollees (MME).

Additional Manuals Appendix

For some of the Benefit Plans for which Facility may provide Covered Services under this Agreement, Facility is subject to additional requirements of one or more additional provider manuals ("Additional Manuals"). When this Agreement refers to Protocols or Payment Policies, it is also referring to the Additional Manuals. An Additional Manual may be a separate document or it may be a supplement to the CCO Care Provider Administrative Guide ("CCO Administrative Guide").

For Benefit Plans subject to an Additional Manual, the Additional Manual controls if it conflicts with any of the following: (1) a provision of this Agreement or of the CCO Administrative Guide; or (2) a CCO Protocol or Payment Policy. However, the Additional Manual does not control where it conflicts with applicable statutes or regulations.

The Additional Manuals will be made available to Facility on a designated website and upon request. The names of the Additional Manuals, the websites to view and download them, and the Benefit Plans to which they apply, are listed in Table 1 below. CCO may change the location of a website or the Customer identification card identifier used to identify Customers subject to a given Additional Manual; if CCO does so, CCO will inform Facility.

CCO may make changes to the Additional Manuals subject to this Appendix in accordance with the provisions of this Agreement relating to Protocol and Payment Policy changes.

Table 1

Benefit Plan(s)	**Description of Applicable Additional Manual**	**Website**
[No Additional Manuals Apply]		
[Mississippi CHIP Benefit Plans	CCO Administrative Guide for Mississippi Children's Health Insurance Program (CHIP)	portal.com]
[Mississippi Medicaid Benefit Plans	CCO Administrative Guide for Mississippi Medicaid	portal.com]

Facility Professional Roster

IMPORTANT NOTE: Facility acknowledges its obligation to notify CCO of any change in Facility Professionals in accordance with Article IV and Section 4.8. Failure to do so may result in denial of claims or incorrect payment.

Facility represents that it has provided CCO with a Facility Professional Roster that includes all of the following data elements for each Facility Professional:

- Name of Professional (first name, middle initial, last name)
- Degree (MD, DO, NP, PA, other)
- Gender (M/F)
- Provider Specialty(ies) (primary, secondary, additional specialties)
- Operates as and willing to be listed/assigned as a Primary Care Professional "PCP" (Y/N)
- State License Number
- Medicaid ID Number
- NPI Number
- Foreign Language(s)
- Admitting Hospital(s)

If any data element is not applicable to a specific Facility Professional, Facility will indicate "not applicable" in the appropriate field. Acceptable formats include in writing, electronically in Excel, ANSI, or text (comma delineated) formats.

Payment Appendix – [Mississippi CHIP] [and] [MississippiMedicaid]

This Appendix applies to Covered Services rendered by Facility to Customers covered under the following type(s) of Benefit Plans as described in this Agreement:

- [Mississippi CHIP Benefit Plans.]
- [Mississippi Medicaid Benefit Plans.]

Section 1
Definitions

Any capitalized terms used herein, but not otherwise defined, will have the meanings ascribed to them in the Agreement.

Fee Schedule: The Mississippi Medicaid fee schedule published by Mississippi Division of Medicaid (the "Mississippi Medicaid Program").

FQHC [RHC] Covered Services: Services which the Mississippi Medicaid Program defines as Covered Services when provided by an FQHC [RHC].

Per Visit: The flat rate payment made to Facility for all Covered Services rendered to a Customer, during a one calendar day period, for each outpatient service category. Unless otherwise specified in this Appendix, the Per Visit, together with any co-payment, deductible or coinsurance for which the Customer is responsible under the Benefit Plan, will be considered payment in full for all Covered Services rendered to the Customer including, but not limited to, physician and other professional fees billed by the Facility on a claim, (including services rendered by non-physician personnel, regardless of whether those personnel are employed by Facility and regardless of whether those services are characterized as professional services), nursing care, diagnostic and therapeutic services, durable medical equipment, supplies (including, but not limited to anesthesia supplies), medications, Facility and ancillary services, and, if applicable, room and board. Facility is required to identify each date of service when submitting claims spanning multiple dates of service.

Section 2
Contracted Rate for Covered Services

2.1 Contract Rate. For Covered Services rendered by Facility to a Customer, CCO will pay the lesser of the contract rates as determined in accordance with Section 2.2 of this Appendix or Facility's Customary Charges. Payment under this Appendix will be less any applicable co-payments, deductibles and coinsurance and is subject to the requirements set forth in the Agreement, such as Payment Policies.

2.2 Covered Services. For FQHC [RHC] Covered Services rendered by Facility to a Customer, the contract rates will be the rates set forth in FQHC [RHC] Covered Services Table.

FQHC [RHC] Covered Services Table

Service Category	Payment Method	Contract Rate
FQHC [RHC] Covered Services	Per Visit	100% of the Facility Specific Mississippi Medicaid Program Rate for FQHC [RHC] Covered Services

For FQHC [RHC] Covered Services rendered by Facility to a Mississippi Medicaid Benefit Plan Customer that are not payable under FQHC [RHC] Covered Services Table, the contract rates will be 100% of the Mississippi Medicaid Fee Schedule rate.

For FQHC [RHC] Covered Services rendered by Facility to a Mississippi CHIP Benefit Plan Customer that are not payable under FQHC [RHC] Covered Services Table, .the contract rates will be based off of the Services other than FQHC [RHC] Covered Services Payment Appendix.

If an applicable state or federal program is available to provide items or payment directly to Facility for specific Covered Services for Customers subject to this Appendix that would otherwise be payable under this Appendix, the applicable program will apply and not this Appendix. (For example, the Vaccines For Children program currently provides vaccines free of charge, and therefore no amount will be payable under this Appendix for vaccines within the Vaccines For Children program. However, the administration of such vaccine may be payable under this Appendix if payment is not provided under the Vaccines For Children program for vaccine administration.)

2.3 Billing and Filing of Claims. Facility will submit a single claim for all Covered Services performed during one calendar day for a Customer. Facility will immediately notify CCO if Facility files more than one claim for services provided to a Customer on one calendar day. Facility will bill using a CMS 1500 or successor form or its electronic equivalent. All claims submitted under this Appendix must use CPT Codes, HCPCS Codes, ICD-10 Codes or its successor and other codes in compliance with HIPPA standard data set requirements. Claims submitted without HIPPA standard data set requirements may be denied.

Section 3
Miscellaneous Provisions

3.1 Inclusive Rates. The contract rate established by this Appendix for the service category listed in Table 1 is all-inclusive and represents the entire payment including but not limited to any applicable tax, for the provision to the Customer of all Covered Services that are in the given service category, including but not limited to those Covered Services that are generally provided as a part of the service in the given service category. No additional payments will be made for any Covered services billed for separately by Facility.

Covered Services billed for separately by Facility that are not generally provided as a part of the service category listed in Table 1 are not subject to reimbursement under this Appendix, but may be payable under another appendix to this Agreement or under another agreement.

3.2 Payment Code Updates. CCO will have the right to update any codes, such as Revenue Codes, ICD-10-CM Codes or successor, HCPCS Codes and/or CPT Codes, from time to time according to changes in the industry, including among other things (a) the latest edition of the Current Procedural Terminology (CPT) manual which is revised by the American Medical Association, (b) the latest edition of the HCPCS manual which is revised by the Centers for Medicare and Medicaid Services (CMS), (c) the latest edition of the ICD-10-CM or successor which is issued by the U.S. Department of Health and Human Services, and (d) the latest guidelines from the National Uniform Billing Committee. CCO will not generally notify Facility of these code updates.

3.3 Changes to Medicaid State Agency FQHC/RHC Services Rate and Reimbursement Methodology. With regard to all Covered Services that are reimbursed under this Appendix and based on the Mississippi Division of Medicaid (Medicaid State Agency ") Rate (including a contract rate that is a fixed percentage of the Medicaid State Agency Rate) and reimbursement methodology, the contract rate and reimbursement methodology under this Appendix will be adjusted consistent with changes made by the Medicaid State Agency , as finalized and published, and as further described in this Section 3.3 and Sections 3.3(i) and 3.3(ii). In the case of a contract rate that is a fixed percentage of the Medicaid State Agency Rate, the new contract rate after a change to the Medicaid State Agency Rate, will be the same fixed percentage of the new Medicaid State Agency Rate; the timetable for implementing the change is described in Section 3.3(i).

i) Medicaid State Agency Rates. In the event that the Medicaid State Agency changes the Medicaid State Agency Rate, published as described in Section 3.3, provided that the state does not change its methodology, the contract rate change will automatically apply to this Appendix within 45 days from the date the change is published in the Medicaid agency's official correspondence to CCO or is otherwise formally communicated by the Medicaid agency to CCO. CCO will make the changes effective in its system on the effective date of the change by the primary fee source. Claims for dates of service on or after the effective date of the Medicaid State Agency Rate change that were adjudicated before CCO implemented the change will not be adjusted to the new contract rate unless otherwise required by law.

ii) Medicaid State Agency Reimbursement Methodologies. If the Medicaid State Agency changes the manner in which it reimburses or changes the Medicaid primary fee source such that CCO is required to make significant programming or platform changes in order to implement the Medicaid agency changes, CCO will implement the new state methodologies, effective on the date that is published in the Medicaid agency's official correspondence to CCO or as otherwise formally communicated by the Medicaid agency to CCO. Facility agrees that, in such case, it will accept the current payment as set forth in this Payment Appendix until such a time as CCO can implement the Medicaid agency change. At such time CCO is able to implement the change, CCO will communicate the change via a copy of a new payment appendix. The changes will be incorporated into this Payment Appendix for all dates of service on or after those changes are effective in the Medicaid program.

In the event that CCO is unable to incorporate the state methodology changes, in their entirety, through commercially reasonable efforts, CCO will contact Facility within 90 days from the date the change is finalized and published. In this case, the parties will negotiate in good faith for a period of up to 60 days to agree upon an amendment to this Appendix which will amend the Agreement to replace this Appendix with a new Appendix and stated effective date for the new rates. At any time after expiration of the 60 day required negotiation period, if the parties have not reached an agreement upon such an amendment, either party may initiate Dispute Resolution according to the Agreement.

3.4 Services Not Payable Under This Appendix But May Be Payable Under Another Appendix To The Agreement Or Under Another Agreement. The following [FQHC] [RHC] Covered Services are not subject to payment under this Appendix: Dental Services, Vision Services, Mental Health Services, and Central Nervous System Assessments. Facility should refer to the Mississippi Medicaid Program provider manual as coding for the aforementioned services may change from time to time. In the event Facility is a party to another agreement with CCO or an affiliate of CCO that is applicable to those services rendered to a Customer, or another appendix to the Agreement applies to these services rendered to a Customer the services below may be payable under that agreement or appendix.
]

[Payment Appendix – Mississippi CHIP
Services other than FQHC [RHC] Covered Services

The provisions of this Payment Appendix apply to Covered Services that are not FQHC [RHC] Covered Services and that are rendered by Facility to Customers covered by Mississippi CHIP Benefit Plans as described in this Agreement.

Facility will submit claims using current CMS 1500 or successor forms for paper claims and HIPAA standard professional format for electronic claims, as applicable, with applicable coding including, but not limited to, ICD, CPT, and HCPCS coding.

]

Mississippi Medicaid Program
Regulatory Requirements Appendix

MISSISSIPPI MEDICAID PROGRAM

REGULATORY REQUIREMENTS APPENDIX

PROVIDER

THIS MISSISSIPPI MEDICAID PROGRAM REGULATORY REQUIREMENTS APPENDIX (this "Appendix") supplements and is made part of the provider agreement (the "Agreement") between HMO ("HMO") or one of its Affiliates and the party named in the Agreement ("Provider").

SECTION 1
APPLICABILITY

The requirements of this Appendix apply to Medicaid benefit plans sponsored, issued or administered by HMO under the Mississippi Coordinated Access Network Program (the "MississippiCAN Program") governed by the State's designated regulatory agencies. In the event of a conflict between this Appendix and other appendices or any provision of the Agreement, the provisions of this Appendix shall control except with regard to benefit plans outside the scope of this Appendix or unless otherwise required by law. In the event HMO is required to amend or supplement this Appendix as required or requested by the State to comply with federal or State regulations, HMO will unilaterally initiate such additions, deletions or modifications. All provider agreements must be in writing and must include all specific activities and report responsibilities delegated to the Provider by HMO.

SECTION 2
DEFINITIONS

Unless otherwise defined in this Appendix, all capitalized terms shall be as defined in the Agreement. For purposes of this Appendix, the following terms shall have the meanings set forth below; provided, however, in the event any definition set forth in this Appendix or the Agreement is inconsistent with any definitions under the MississippiCAN Program, the definitions shall have the meaning set forth under the MississippiCAN Program.

2.1 **Adverse Benefit Determination:** The denial or limited authorization of a requested service, including determinations on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit; the reduction, suspension, or termination of previously authorized services; the denial, in whole or in part, of payment for a service; HMO's failure to provide services in a timely manner; HMO's failure to resolve Complaints, Grievances, or Appeals within the specified time frames; for residents in a rural area with only one MCO, the denial of a Covered Person's request to exercise his or her right, under 42 C.F.R. §438.52(b)(2)(ii); the denial of a Covered Person's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other enrollee financial liabilities; and determinations by skilled nursing facilities and nursing facilities to transfer or discharge residents and adverse determinations made by a State with regard to the preadmission screening and annual resident review requirements of Section 1919(e)(7) of the Act, if applicable.

2.2 **Affiliate:** Those entities controlling, controlled by, or under common control with HMO.

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

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

2.5 **CMS:** Center for Medicare and Medicaid Services is an agency within the U.S. Department of Health & Human Services responsible for administration of several key federal health care programs.

2.6 **Complaint:** An expression of dissatisfaction received orally or in writing that is of a less serious or formal nature that is resolved within one (1) business day of receipt.

2.7 **Covered Person:** An individual who meets all of the eligibility requirements for Mississippi Medicaid and is currently enrolled with HMO for the provision of services under a MississippiCAN Program. A Covered Person may also be referred to as an Enrollee, Member or Customer under the Agreement.

2.8 **Covered Services:** Health care services or products for which a Covered Person is enrolled with HMO to receive coverage under the State Contract, including all services required by the State Contract and State and federal law.

2.9 **DOM:** Division of Medicaid, Office of the Governor, State of Mississippi.

2.10 **Early, Periodic, Screening, Diagnosis, and Treatment (EPSDT) Services:** Defined by DOM to include:

i) Age appropriate, comprehensive health and development history that includes physician and mental health assessments along with counseling and anticipatory guidance and risk factor reduction interventions;
ii) Calculation of Body Mass Index;
iii) Growth measurements and head circumference;
iv) Nutritional counseling;
v) Developmental surveillance and Developmental and autism Spectrum Disorders Screenings as appropriate;
vi) Comprehensive unclothed exam;
vii) Appropriate laboratory tests (including blood level assessment appropriate to age and risk);

viii) Appropriate immunizations in accordance with Recommended Childhood and Adolescent Immunization Schedule adopted by DOM;
ix) A vision assessment;
x) A hearing assessment;
xi) A dental screening and/or referral to dental care;
xii) Health education; and
xiii) Referrals for identified abnormalities.

2.11 Fraud and Abuse: Fraud is any type of intentional deception or misrepresentation made by an entity or person with the knowledge that the deception could result in some unauthorized benefit to the entity, him or herself, or some other person. The Fraud can be committed by many entities, including a vendor, a subcontractor, a provider, a State employee, or a Covered Person, among others. Abuse is any practice that is inconsistent with sound fiscal, business, or medical practices, and results in an unnecessary cost to the Medicaid program, a vendor, a subcontractor or Provider or in reimbursement for services that are not Medically Necessary or that fail to meet professionally recognized standards for health care.

2.12 Grievance: An expression of dissatisfaction about any matter or aspect of HMO or its operation, other than an Adverse Benefit Determination as defined herein. Grievances may include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the Covered Person's rights regardless of whether remedial action is requested. Grievance includes a Covered Person's right to dispute an extension of time proposed by HMO to make an authorization decision.

2.13 Marketing: The activities that promote visibility and awareness for the MississippiCAN Program and HMO's participation in the program. All marketing activities are subject to prior review and approval by DOM and may not contain misleading information.

2.14 Medical Record: A single complete record, which documents the entire treatment plan developed for, and medical services received by, the Covered Person including inpatient, outpatient, referral services and emergency medical services whether provided by contracted Providers or non-contracted providers.

2.15 Mississippi Coordinated Access Network (MississippiCAN) Program: Mississippi Medicaid's coordinated care program for select Medicaid Beneficiaries.

2.16 Primary Care Provider (PCP): Any physician or health care practitioner or group operating within the scope of his or her licensure who is responsible for supervising, prescribing and providing primary care and primary case management services in the MississippiCAN Program, whose practice is limited to the general practice of medicine or who is an Internist, Pediatrician, Obstetrician, Gynecologist, Family Practitioner, General Practitioner, Certified Nurse Practitioners whose specialty is pediatrics, adult, family, certified nurse midwife, obstetrics/gynecology, or a physician assistant.

2.17 Prior Authorization: A determination to approve a Provider's request, pursuant to services covered in the MississippiCAN Program, to provide a service or course of

treatment of a specific duration and scope to a Member prior to the initiation or continuation of the service.

2.18 Provider Network: The Panel of health service Providers with which HMO contracts for the provision of covered services to Covered Persons and Non-Contracted Providers administering services to Covered Persons.

2.19 State: The State of Mississippi or its designated regulatory agencies.

2.20 State Contract: HMO's contract with the State for the purpose of providing and paying for Covered Services to Covered Persons enrolled in the MississippiCAN Program.

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

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

SECTION 3
PROVIDER REQUIREMENTS

The MississippiCAN Program, through the State Contract and federal and State statutes and regulations, requires the Agreement to contain certain conditions that HMO and Provider agree to undertake, which include the following:

3.1 Definitions Related to the Provision of Covered Services. Provider shall follow the applicable State Contract's requirements for the provision of Covered Services. Provider's decisions affecting the delivery of acute or chronic care services to Covered Persons shall be made on an individualized basis and in accordance with the following definitions:

i) Emergency Medical Condition: A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in any of the following: (a) 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; (b) serious impairment to body functions; or (c) serious dysfunction of any body organ or part.

ii) Emergency Services: Covered inpatient and outpatient services, inclusive of dialysis services, furnished by a provider who is qualified to furnish those health

services and that are needed to evaluate or stabilize an Emergency Medical Condition in accordance with 42 CFR 438.114.

iii) Medically Necessary Services: As set forth in the Social Security Act, Section 1905 (42 USC 1396d(a)), Medically Necessary Services are defined as services, supplies, or equipment provided by a licensed health care professional that are:

a) Appropriate and consistent with the diagnosis or treatment of the Covered Person's condition, illness, or injury;

b) In accordance with the standards of good medical practice consistent with the individual Covered Person's condition(s);

c) Not primarily for the personal comfort or convenience of the Member, family, or Provider;

d) The most appropriate services, supplies, equipment, or levels of care that can be safely and efficiently provided to the Covered Person;

e) Furnished in a setting appropriate to the Covered Person's medical need and condition and, when applied to the care of an inpatient, further mean that the Covered Person's medical symptoms or conditions require that the services cannot be safely provided to the Covered Person as an outpatient;

f) Not experimental or investigational or for research or education;

g) Provided by an appropriately licensed practitioner; and

h) Documented in the patient's record in a reasonable manner, including the relationship of the diagnosis to the service.

Medically Necessary Services may also be those services for children that are necessary to correct or ameliorate defects and physical and mental illnesses and conditions discovered during an interperiodic or periodic EPSDT screen, whether such services are covered or exceed the benefit limits in the Medicaid State Plan and Title 23 of Mississippi Administrative Code.

iv) Urgent Care: Urgent care services are utilized because the Covered Person's primary care physician is not available. An urgent condition is not life threatening but may need prompt attention. Urgent care services are for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe it requires emergency room care.

3.2 Provider Eligibility. Provider must be enrolled in the Mississippi Medicaid program and must use the same National Provider Identifier (NPI) number to participate in HMO's Network. Upon notification from the State that Provider's enrollment has been denied or terminated, HMO must terminate Provider immediately and will notify affected Covered Persons that Provider is no longer participating in the network. HMO will exclude from its

network any provider who has been terminated or suspended from the Medicare or Medicaid program in any state.

3.3 Accessibility Standards. Provider shall provide for timely access for Covered Person appointments in accordance with the appointment availability requirements established under the State Contract, as further described in the applicable provider manual.

Type	Appointment Scheduling Time Frames
PCP (well care visit)	Not to exceed thirty (30) calendar days
PCP (routine sick visit)	Not to exceed seven (7) calendar days
PCP (urgent care visit)	Not to exceed twenty-four (24) hours
Specialists	Not to exceed forty-five (45) calendar days
Dental Providers (routine visits)	Not to exceed forty-five (45) calendar days
Dental Providers (urgent Care)	Not to exceed forty-eight (48) hours
Behavioral Health Providers (routine visit)	Not to exceed fourteen (14) calendar days
Behavioral Health Providers (urgent visit)	Not to exceed twenty-four (24) hours
Behavioral Health Providers (post-discharge from an acute psychiatric hospital when the Contractor is aware of the Member's discharge)	Not to exceed seven (7) calendar days
Urgent Care Providers	Not to exceed twenty-four (24) hours
Emergency Providers	Immediately (twenty-four (24) hours a day, seven (7) days a week) and without Prior Authorization

3.4 Hours of Operation; Appointments. Provider shall offer hours of operation that are no less than the hours of operation offered to commercial beneficiaries or comparable to Medicaid fee-for-service if Provider serves only Medicaid beneficiaries. As applicable, Provider will make Covered Services available 24 hours a day, 7 days a week when medically necessary.

3.5 Hold Harmless. Except for any applicable cost-sharing requirements under the State Contract, Provider shall look solely to HMO for payment of Covered Services provided to Covered Persons pursuant to the Agreement and the State Contract and hold the State, DOM, the U.S. Department of Health and Human Services and Covered Persons harmless in the event that HMO cannot or will not pay for such Covered Services. In accordance with 42 CFR 447.15, as may be amended from time to time, the Covered Person is not liable to Provider for any services for which HMO is liable and as specified under the State's relevant health insurance or managed care statutes, rules or administrative agency guidance. Provider shall not require any copayment or cost sharing for Covered Services provided under the Agreement unless expressly permitted under the State Contract.

Provider shall also be prohibited from charging Covered Persons for missed appointments if such practice is prohibited under the State Contract or applicable law. Neither the State, DOM nor Covered Persons shall be in any manner liable for the debts and obligations of HMO and under no circumstances shall HMO, or any providers used to deliver services covered under the terms of the State Contract, charge Covered Persons for Covered Services.

Covered Person may be responsible for non-covered item(s) and/or service(s), only if the Provider ensures that written documentation in compliance with the Advance Beneficiary Notification (ABN) is received from the Covered Person that an item(s) or service(s) rendered is a non-covered item and/or service(s) and that the Covered Person will be financially responsible for the item(s) and/or service(s). If HMO determines a Covered Person was charged for Covered Services inappropriately, such payment may be recovered, as applicable.

This provision shall survive any termination of the Agreement, including breach of the Agreement due to insolvency.

3.6 **Indemnification.** To the extent applicable to Provider in performance of the Agreement, Provider shall indemnify, defend, protect, save and hold DOM and its employees and Covered Persons harmless from and against all injuries, deaths, losses, damages, claims, suits, liabilities, judgments, costs and expenses, including, without limitation, court costs, investigative fees and expenses and attorney fees, to the extent proximately caused by any negligent act or other intentional misconduct or omission of Provider, its agents, officers, employees or contractors arising from the Agreement. DOM may waive this requirement for public entities if Provider is a state agency or sub-unit as defined by the State or a public health entity with statutory immunity. This clause shall survive the termination of the Agreement for any reason, including breach due to insolvency.

3.7 **Provider Selection.** To the extent applicable to Provider in performance of the Agreement, Provider shall comply with 42 CFR 438.214, as may be amended from time to time, which includes, but is not limited to the selection and retention of providers, credentialing and recredentialing requirements and nondiscrimination. If HMO delegates credentialing to Provider, HMO will provide monitoring and oversight and Provider shall ensure that all licensed medical professionals are credentialed in accordance with HMO's and the State Contract's credentialing requirements.

3.8 **Restrictions on Referrals.** Provider shall not make inappropriate referrals for designated health services to health care entities with which Provider or a member of Provider's family has a financial relationship, pursuant to federal anti-kickback and physician self-referral laws that prohibit such referrals.

3.9 **Records Retention.** As required under State or federal law or the State Contract, Provider shall maintain an adequate record keeping system for recording services, charges, dates and all other commonly accepted information elements sufficient to disclose the quality, quantity, appropriateness and timeliness of services rendered to Covered Persons. All financial records shall follow generally accepted accounting principles. Medical records and supporting management systems shall include all pertinent information related to the

medical management of each Covered Person. Other records shall be maintained as necessary to clearly reflect all actions taken by Provider related to services provided under the State Contract. Such records, including, as applicable, grievance and appeal records shall be maintained for a period of not less than ten (10) years from the close of the Agreement, or such other period as required by law. If records are under review or audit, they must be retained for a minimum of ten (10) years following resolution of such action. Prior approval for the disposal of records must be requested and approved by HMO if the Agreement is continuous.

3.10 Records Access. Provider agrees to cooperate with HMO to maintain and share a health record of all services provided to a Covered Person, as appropriate and in accordance with applicable laws, regulations and professional standards. Provider acknowledges and agrees that the State, DOM, the U.S. Department of Health and Human Services and other authorized federal and state personnel shall have complete access to all records pertaining to services provided to Covered Persons. Provider shall provide immediate access to facilities, records and supportive materials pertinent to the State Contract for State or Federal fraud investigators. Copies of requested documents shall be provided to the State, DOM, the U.S. Department of Health and Human Services and other authorized federal and state personnel or their designees free of charge.

3.11 Government Audit; Investigations. Provider acknowledges and agrees that the State and the U.S. Department of Health and Human Services, the Centers for Medicare & Medicaid Services, the Office of Inspector General, the General Accounting Office, or any other auditing agency and their designees or their authorized representatives, with prior approval by DOM, shall, at all reasonable time, with or without notice, have the right to inspect, audit or otherwise evaluate the quality, appropriateness, and timeliness of services provided under the terms of the State Contract and any other applicable rules, including the right to inspect and audit any records or documents of Provider and its subcontractors, and the right to inspect the premises, physical facilities, and equipment where Medicaid-related activities or work is conducted. The right to audit under this section exists for 10 years from the end date of the State Contract or from the date of completion of any audit, whichever is later. There shall be no restrictions on the right of the State or federal government to conduct whatever inspections and audits are necessary to assure quality, appropriateness or timeliness of services provided pursuant to the State Contract and the reasonableness of their costs.

3.12 Privacy; HIPAA. Provider shall comply with all applicable privacy rule and security rule provisions of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), and associated implementing regulations, as may be amended from time to time, and shall safeguard information about Covered Persons in accordance with applicable federal and State privacy laws and rules including 42 CFR 438.224 and 42 CFR Part 431, Subpart F, as may be amended from time to time. HMO agrees and shall require Provider to agree that confidential information, including but not limited to medical and other pertinent information relative to Covered Persons, shall not be disclosed to any person or organization for any purpose without the expressed, written authority of DOM or as otherwise required by law and that all such disclosures shall fully comply with HIPAA privacy and security standards.

3.13 Compliance with Law. Provider shall comply with all applicable federal and State laws and regulations, and all provisions of the State Contract, that pertain to a Covered Person's rights, including but not limited to the following to the extent applicable to Provider in performance of the Agreement:

i) Title VI of the Civil Rights Act of 1964; Title XIX of the Social Security Act; 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 Genetic Information Non-Discrimination Act of 2008 (GINA); the Americans with Disabilities Act; section 1557 of the Patient Protection and Affordable Care Act, and their implementing regulations, as may be amended from time to time.

ii) All relevant federal and State statutes, regulations and orders related to equal opportunity in employment, including but not limited to compliance with E.O. 11246, "Equal Employment Opportunity," as amended by E.O. 11375, "Amending Executive Order 11246 Relating to Equal Employment Opportunity," and as supplemented by regulations at 41 CFR part 60, "Office of Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor."

iii) All federal and State professional and facility licensing and accreditation requirements/standards that apply to the services HMO and Provider perform pursuant to the Agreement, including but not limited to:

a) All applicable standards, orders or requirements issued under Section 306 of the Clean Air Act (42 USC 1857 (h)). Section 508 of the Clean Water Act (33 USC 1368), Executive Order 11738, and Environmental Protection Agency (EPA) regulations (40) CFR Part 15), which prohibit the use of facilities included on the EPA list of violating facilities. Any violations must be reported to DSHS, DHHS, and the EPA;

b) Any applicable mandatory standards and policies relating to energy efficiency that are contained in the State Energy Conservation Plan, including the Energy Policy & conservation Act (Pub. L. 94-165), and issued in compliance with the Federal Energy Policy & Conservation Act.

c) Those specified for laboratory services in the Clinical Laboratory Improvement Amendments (CLIA). All laboratory service sites must have a CLIA certificate of registration or waiver, and a CLIA identification number.

d) Section 1128B(d)(1) of the Balanced Budget Act of 1997; and,

e) Any other requirements associated with the receipt of federal funds.

iv) All Medicaid laws, regulations and program instructions to the extent applicable to Provider in Provider's performance of the Agreement. Provider understands that payment of a claim by HMO or the State is conditioned upon the claim and the underlying transaction complying with such laws, regulations, and program

instructions (including, but not limited to, federal requirements on fraud, waste and abuse, disclosure, debarment, termination and exclusion screening), and is conditioned on the Provider's compliance with all applicable conditions of participation in Medicaid. Provider understands and agrees that each claim the Provider submits to HMO constitutes a certification that the Provider has complied with all applicable Medicaid laws, regulations and program instructions in connection with such claims and the services provided therein. Provider's payment of a claim will be denied if Provider is terminated or excluded from participation in federal healthcare programs. Provider's payment of a claim may be temporarily suspended if the State or HMO provides notice that a credible allegation of fraud exists and there is a pending investigation. Provider's payment of a claim may also be temporarily suspended or adjusted if the Provider bills a claim with a code that does not match the service provided. HMO performs coding edit procedures based primarily on National Correct Coding Initiative (NCCI) policies and other nationally recognized and validated policies. Provider agrees that it will provide medical records to HMO upon its request in order to determine appropriateness of coding. Provider may dispute any temporarily suspended or adjusted payment consistent with the terms of the Agreement.

3.14 Physician Incentive Plans. In the event Provider participates in a physician incentive plan ("PIP") under the Agreement, Provider agrees that such PIPs must comply with 42 CFR 417.479, 42 CFR 438.3(i), 42 CFR 422.208, and 42 CFR 422.210, as may be amended from time to time. Neither HMO nor Provider may make a specific payment directly or indirectly under a PIP to a physician or physician group as an inducement to reduce or limit Medically Necessary services furnished to an individual Covered Person. PIPs must not contain provisions that provide incentives, monetary or otherwise, for the withholding of services that meet the definition of Medical Necessity.

3.15 Lobbying. Provider agrees to comply with the following requirements related to lobbying:

i) Prohibition on Use of Federal Funds for Lobbying: By signing the Agreement, Provider certifies to the best of Provider's knowledge and belief, pursuant to 31 U.S.C. Section 1352 and 45 CFR Part 93, as may be amended from time to time, that no federally appropriated funds have been paid or will be paid to any person by or on Provider's behalf for the purpose of influencing or attempting to influence an officer or employee of any agency, a member of Congress, an officer or employee of Congress, or an employee of a member of Congress in connection with the award of any federal contract, the making of any federal grant, the making of any federal loan, the entering into of any cooperative agreement, or the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan, or cooperative agreement.

ii) Disclosure Form to Report Lobbying: If any funds other than federally appropriated funds have been paid or will be paid to any person for the purpose of influencing or attempting to influence an officer or employee of any agency, a member of Congress, an officer or employee of Congress, or an employee of a member of Congress in connection with the award of any federal contract, the making of any federal grant, the

making of any federal loan, the entering into of any cooperative agreement, or the extension, continuation, renewal, amendment or modification of any federal contract, grant, loan, or cooperative agreement and the value of the Agreement exceeds $100,000, Provider shall complete and submit Standard Form-LLL, "Disclosure Form to Report Lobbying," in accordance with its instructions.

3.16 Excluded Individuals and Entities. Provider certifies that neither it nor any of its employees, principals, nor any providers, subcontractors or consultants or persons with an ownership or controlling interest in the Provider (an owner including the Provider himself or herself), or an agent or managing employee of the Provider, with whom Provider contracts and who are providing items or services that are significant and material to Provider's obligations under the Agreement is:

i) excluded from participation in federal health care programs under either Section 1128 or section 1128A of the Social Security Act; or

ii) debarred, suspended or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in nonprocurement activities under regulations issued under Executive Order no. 12549 or under guidelines implementing Executive Order No. 12549; or an affiliate, as defined in the Federal Acquisition Regulation, of such a person.

Provider acknowledges and agrees that payment will not be made for any items or Covered Services provided by an excluded individual pursuant to 42 CFR 1001.1901(b) and is obligated to screen all employees, contractors, and subcontractors for exclusion as required under applicable State and Federal laws. Additionally, Provider acknowledges that pursuant to 42 CFR 1003.102(a)(2) civil monetary penalties may be imposed against Provider if he or she employs or enters into contracts with excluded individuals or entities to provide items or Covered Services to Covered Persons under this Agreement. Provider agrees not to employ or subcontract with individuals or entities whose owner, those with a controlling interest, or managing employees are on a State or Federal exclusion list to provide items or Covered Services under this Agreement. Provider shall immediately report to HMO any exclusion information discovered. Provider can search the HHS-OIG website, at no cost, by the names of any individuals or entities. The database is called LEIE and can be accessed at http://www.oig.hhs.gov/fraud/exclusions.asp. The GSA EPLS/SAM database can be accessed at https://www.sam.gov. Federal and State exclusion databases must be reviewed monthly to ensure that no employee or contractor has been excluded. Applicable state exclusion databases can be accessed through the State's Medicaid website. HMO will terminate the Agreement immediately and exclude from its network any provider who has been excluded from federal health care programs or terminated from the Medicare or the Medicaid program in any state. HMO may also terminate the Agreement if Provider or Provider's owners, agents, or managing employees are found to be excluded on a State or Federal exclusion list.

3.17 Disclosure. Provider must be screened and enrolled in the State's Medicaid program and submit disclosures to the DOM related to ownership and control, significant business transactions, and persons convicted of crimes in accordance with 42 CFR Part 455 .Provider must submit information related to ownership and control of subcontractors or

wholly owned suppliers within thirty-five (35) calendar days of a request for such information in accordance with 42 CFR 455.105. Additionally, Provider must cooperate with DOM for submission of fingerprints upon a request from DOM or CMS in accordance with 42 CFR 455.434.

By executing this Agreement, Provider certifies that neither Provider nor any of its principals is presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in any State or federal health care program or from participating in transactions by any State or federal department or agency. HMO will terminate the Agreement upon becoming aware or receiving notice from DOM, whichever is earlier, that Provider is or has been excluded from participation in any State or federal health care program or by any State or federal agency.

3.18 Cultural Competency and Access. Provider shall participate in HMO's and the State's efforts to promote the delivery of services in a culturally competent manner to all Covered Persons, including those with limited English proficiency, physical or mental disabilities, diverse cultural and ethnic backgrounds and regardless of gender, sexual orientation or gender identity, and shall provide interpreter services in a Covered Person's primary language and for the hearing impaired for all appointments and emergency services. Provider shall provide information to Covered Persons regarding treatment options and alternatives, as well as information on complaints and appeals, in a manner appropriate to the Covered Person's condition and ability to understand. Provider shall provide physical access, reasonable accommodations, and accessible equipment for Covered Persons with physical or mental disabilities.

3.19 Marketing. As required under State or federal law or the applicable State Contract, any marketing materials developed and distributed by Provider as related to the performance of the Agreement must be submitted to HMO at least sixty (60) days prior to planned distribution for timely submission to DOM for prior approval. Provider agrees it will not proceed with the statement or communication until the required approval is obtained.

3.20 Fraud, Waste and Abuse Prevention. Provider shall cooperate fully with HMO's policies and procedures designed to protect program integrity and prevent and detect potential or suspected fraud, waste, and abuse in the administration and delivery of services under the State Contract and shall cooperate and assist DOM and any other State or federal agency charged with the duty of preventing, identifying, investigating, sanctioning or prosecuting suspected fraud, waste, and abuse in state and/or federal health care programs.

In accordance with HMO's policies and the Deficit Reduction Act of 2005 (DRA), Provider shall have written policies for its employees, contractors or agents that: (a) provide detailed information about the federal False Claims Act (established under sections 3729 through 3733 of title 31, United States Code), including if any entity makes or receives annual payments under the State Program of at least $5,000,000, such entity must establish certain minimum written policies and information communicated through an employee handbook relating to the Federal False Claims Act in accordance with 42 CFR 438.600; (b) cite administrative remedies for false claims and statements (established under chapter 38 of title 31, United States Code) and whistleblower protections under federal and state laws; (c) reference state laws pertaining to civil or criminal penalties for false claims

and statements; and (d) with respect to the role of such laws in preventing and detecting fraud, waste, and abuse in federal health care programs (as defined in section 1128B(f)), include as part of such written policies, detailed provisions regarding Provider's policies and procedures for detecting and preventing fraud, waste, and abuse. Provider agrees to train its staff on the aforesaid policies and procedures.

3.21 Data; Reports. Provider shall cooperate with and release to HMO any information necessary for HMO to perform its obligations under the State Contract to the extent applicable to Provider in performance of the Agreement, including the timely submission of reports and information required by HMO, in the format specified by HMO and the State. Such reports shall include child health check-up reporting, if applicable, as well as complete and accurate encounter data in accordance with the requirements of HMO and the State. Data must be provided at the frequency and level of detail specified by HMO or the State. By submitting data to HMO, Provider represents and attests to HMO and the State that the data is accurate, complete and truthful, and upon HMO's request Provider shall certify in writing, that the data is accurate, complete, and truthful, based on Provider's best knowledge, information and belief.

Provider shall be able to receive, maintain and utilize applicable data extracts from HMO or DOM and systematically update its database within five (5) calendar days of receipt of the files. Data extract files include but are not limited to the following, as applicable: 1. Daily Active Provider Extract; 2. Weekly Provider Affiliation Details Extract; 3. 834 Enrollment Files; 4. 835 Claims Payment Remittance Advice Transaction; 5. 277 Claims Acknowledgement; 6. NCPDP Formulary; 7. NCPDP Response File; 8. TPL Resource/Policy Information File, etc.; 9. Claims History Extracts; and 10. Prior Authorization Extracts.

3.22 Encounter Data. Provider agrees to cooperate with HMO to comply with HMO's obligation to prepare encounter data submissions, reports, and clinical information including, without limitation, child and adolescent health check-up reporting, EPSDT encounters, and cancer screening encounters, as applicable, and such other reporting regarding Covered Services as may be required under the State Contract. Encounter data must be accurate and include all services furnished to a Covered Person, including capitated provider's data and rendering provider information. Encounter data must be provided within the timeframes specified and in a form that meets HMO and State requirements. By submitting encounter data to HMO, Provider represents to HMO that the data is accurate, complete and truthful, and upon HMO's request Provider shall certify in writing, that the data is accurate, complete, and truthful, based on Provider's best knowledge, information and belief.

3.23 Claims Information. Provider shall promptly submit to HMO the information needed to make payment and shall identify third party liability coverage, including Medicare and other insurance, and if applicable seek such third party liability payment before submitting claims to HMO. Provider understands and agrees that each claim Provider submits to HMO constitutes a certification that the claim is true and accurate to the best of Provider's knowledge and belief and that the Covered Services are 1) Medically Necessary and 2) have been provided to the Covered Person prior to submitting the claim.

Effective July 1, 2014, Provider must submit claims within six (6) months from the date of service. Claims filed within the appropriate time frame but denied may be resubmitted to the Contractor within ninety (90) calendar days from the date of denial

3.24. Electronic Visit Verification. Provider shall cooperate with State requirements for electronic visit verification for personal care services and home health services, as applicable.

3.25 Licensure. Provider represents that it is currently licensed and/or certified under applicable State and federal statutes and regulations and by the appropriate State licensing body or standard-setting agency, as applicable. Provider represents that it is in compliance with all applicable State and federal statutory and regulatory requirements of the Medicaid program and that it is eligible to participate in the Medicaid program. Provider represents that it does not have a Medicaid provider agreement with DOM that is terminated, suspended, denied, or not renewed as a result of any action of DOM, CMS, HHS, or the Medicaid Fraud Control Unit of the State's Attorney General. Provider shall maintain at all times throughout the term of the Agreement all necessary licenses, certifications, registrations and permits as are required to provide the health care services and/or other related activities delegated to Provider by HMO under the Agreement. If at any time during the term of the Agreement, Provider is not properly licensed as described in this Section, Provider shall discontinue providing services to Covered Persons. As applicable, if Provider performs any laboratory tests on human specimens for the purpose of diagnosis and/or treatment, Provider agrees to acquire and maintain the appropriate CLIA certification or waiver for the type of laboratory testing performed. Provider further agrees to provide a copy of the certification if requested by HMO. A State authorized license or permit that meets the CLIA requirements may be substituted for the CLIA certificate pursuant to State law. Medicare and Medicaid programs require the applicable CLIA certification or waiver for the type of services performed as a condition of payment. Provider must include the appropriate CLIA certificate or waiver number on claims submitted for payment for laboratory services.

3.26 Quality; Utilization Management. Pursuant to any applicable provider manuals and related protocols, or as elsewhere specified under the Agreement, Provider agrees to cooperate with HMO's quality improvement and utilization review and management activities. This shall include, but not be limited to, participation in any internal and external quality assurance, utilization review, peer review, and grievance procedures established by HMO or as required under the State Contract to ensure that Covered Persons have due process for their complaints, grievances, appeals, fair hearings or requests for external review of adverse decisions made by HMO or Provider. Provider shall adhere to the quality assurance and utilization review standards of the MississippiCAN Program and shall monitor quality and initiate corrective action to improve quality consistent with the generally accepted level of care.

3.27 Non-Discrimination. Provider will not discriminate against, nor use any policy or practice that has the effect of discriminating against, Covered Persons on the basis of race, color, creed, sex, religion, age, national origin, ancestry, marital status, sexual orientation, gender identity, language, health status, disease or pre-existing condition (including genetic

information), anticipated need for health care or physical or mental handicap, except where medically indicated. Examples of prohibited practices include, but are not limited to, the following:

i) Denying or not providing a Covered Person any Medicaid Covered Service. Health care and treatment necessary to preserve life must be provided to all Covered Persons who are not terminally ill or permanently unconscious, except where a competent Covered Person objects to such care on his/her own behalf.

ii) Subjecting a Covered Person to segregated, separate, or different treatment, including a different place or time from that provided to other Covered Persons or public or private patients, in any manner related to the receipt of any Medicaid Covered Service, except where Medically Necessary.

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

3.28 Advance Directives. Provider shall comply with the advance directives requirements set forth in the Uniform Health-Care Decisions Act, Section 41-41-215 of the Mississippi Code. When applicable, Provider shall comply with the advance directives requirements for hospitals, nursing facilities, providers of home and health care and personal care services, hospices, and HMOs as specified in 42 CFR Part 49, subpart I, 42 CFR § 417.436(d), 42 CFR § 422.128, and 42 CFR 438.3(i).

3.29 National Provider ID (NPI). Provider shall obtain a National Provider Identification Number (NPI) and when filing claims with HMO, the NPI used is the same NPI used when filing claims with DOM.

3.30 Termination. In the event of termination of the Agreement, Provider shall promptly supply to HMO all information necessary for the reimbursement of any outstanding Medicaid claims.

3.31 Complaints; Grievances and Appeals. Information on how Provider or Provider's authorized representative can submit complaints and file grievances and appeals, and the resolution process, is contained in the applicable provider manual.

3.32 Health Care Acquired/Preventable Conditions. Provider agrees that no payment shall be made for the provision of medical assistance for health care acquired conditions and other provider preventable conditions as may be identified by the State. As a condition of payment, Provider shall identify and report to HMO any provider preventable conditions in accordance with 42 CFR §§ 434.6(a)(12), 438 including but not limited to 438.3(g), and 447.26.

3.33 Quality and Utilization Management Program. Provider shall cooperate with HMO in meeting the Quality Management and Utilization Management Program standards outlined

in the State Contract including, without limitation, any external evaluations and assessments of HMO's performance authorized by DOM under the State Contract and conducted by DOM's contracted External Quality Review Organization (EQRO) or other designee.

3.34 Referrals. Provider shall make referrals for social, vocational, education or human services when a need for such service is identified.

3.35 Insolvency. In the event HMO becomes insolvent or unable to pay Provider, Provider shall not seek compensation for services rendered from the State, DOM, their officers, Agents, or employees, or the Covered Persons or their eligible dependents.

3.36 Third Party Resources. Provider will report all third party resources to HMO identified through the provision of medical services.

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

3.38 Capitated Providers. If Provider is capitated and terminates its agreement with HMO, for any reason, Provider will provide services to Covered Persons assigned to Provider up to the end of the month in which the effective date of termination falls.

3.39 Certification on Relationship to State, DOM and CMS. Provider certifies that no officer, director, employee, subcontractor or agent of Provider, or person with an ownership or control interest in Provider, is also employed by, or is a public official of, the State of Mississippi or any of its agencies, DOM or CMS.

3.40 Funding. Provider recognizes that the obligation of DOM to proceed under its Contract with HMO is conditioned upon the appropriation of funds by the Mississippi State

Legislature and the receipt of State and/or Federal funds. If the funds anticipated for the continuing fulfillment of the agreement are, at any time, not forthcoming or insufficient, either through the failure of the Federal government to provide or the State of Mississippi to appropriate funds, or the discontinuance, or material alteration of the program under which the funds were provided or if funds are not otherwise available to DOM, DOM has the right upon ten (10) working days written notice to HMO to terminate the Contract.

3.41 Gratuities. Provider represents that it has not violated, is not violating, and promises that it will not violate the prohibitions against gratuities set forth in Section 6-204 (Gratuities) of the Mississippi Personal Service Contract Procurement Regulations.

3.42 Assignment/Delegation. Provider shall not assign or delegate the Agreement without the express written consent of HMO or DOM. If Provider subcontracts or delegates any functions of the Agreement, in accordance with the terms of the Agreement and with the express written consent of HMO or DOM, the subcontract or delegation must be in writing and include all of the requirements of this Appendix, and applicable requirements of the State Contract, and applicable laws and regulations. The transfer of five percent (5%) or more of the beneficial ownership in Provider at any time during the term of this Agreement shall be deemed an assignment under this Agreement.

3.43 Notice of Legal Action. Immediately upon obtaining knowledge or receiving notice of any legal action or notice listed below, Provider shall provide to HMO written notice of such legal action or notice and, upon request by HMO, a complete copy of all filings and other documents generated in connection with any such legal action:

i. Any action, suit or counterclaim filed against Provider;

ii. Any regulatory action, or proposed action, respecting Provider's business or operations;

iii. Any notice received by Provider from the Department of Insurance or the State Health Officer;

iv. The filing of a petition in bankruptcy by or against Provider, or the insolvency of Provider;

v. The conviction of any person who has an ownership or control interest in Provider, or who is an agent or managing employee of Provider, of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or Title XX of the Social Security Act; or

vi. A malpractice action against any Provider delivering service under an agreement.

3.44 Federal and State Funds Liability. Providers acknowledges and agrees that payments made to Provider for services provided under the Agreement are derived from federal and State funds and that any false claim or statement in documents or any concealment of material fact related to such services may be a cause for sanctions and prosecution under applicable federal and State laws. Provider shall be subject to all laws applicable to

individuals and entities receiving State and federal funds and may be held civilly or criminally liable to both HMO and DOM in the event of nonperformance, misrepresentation, fraud, or abuse related to services provided pursuant to the State Contract. Provider recognizes that payments made to the Provider are derived from federal and State funds, and are contingent upon and subject to availability and receipt of funds.

3.45 Insurance Requirements. As applicable, Provider shall secure and maintain during the term of the Agreement insurance appropriate to the services to be performed under the Agreement. Provider shall require that its providers secure and maintain during the term of the Agreement general liability insurance, professional liability insurance, and workers' compensation insurance for all employees connected with the provision of services under the Agreement. Such workers compensation insurance shall comply with Mississippi Workers' Compensation Laws. Such comprehensive general liability insurance and professional liability insurance shall provide coverage in an amount established by HMO pursuant to the Agreement or as required under the State Contract.

3.46 Overpayment. Provider shall to report to HMO when it has received an overpayment and will return the overpayment to HMO within 60 calendar days after the date on which the overpayment was identified. Provider will notify HMO in writing of the reason for the overpayment.

SECTION 4
ADDITIONAL PROVIDER REQUIREMENTS FOR SPECIFIC ACTIVITIES

4.1 Behavioral Health Providers. Behavioral Health Providers shall ensure that all Covered Persons receiving inpatient psychiatric services are scheduled for outpatient follow-up and/or continuing treatment prior to discharge from the inpatient psychiatric hospital if the Provider is aware of the Covered Person's inpatient hospitalization status. Behavioral Health Providers will be provided daily reports identifying Covered Persons known to be admitted to an inpatient facility. Behavioral Health Services will be delivered in compliance with the requirements of 42 CFR 438 subpart K insofar as those requirements are applicable.

4.2 PCP Responsibilities. Providers acting as PCPs shall meet the following requirements:

i) PCPs who serve Covered Persons under the age of twenty-one (21) are responsible for conducting all EPSDT screens for individuals on their Panel under the age of twenty-one (21). Should the PCP be unable to conduct the necessary EPSDT screens, the PCP is responsible for arranging to have the necessary EPSDT screens conducted by another network Provider and ensure that all relevant medical information, including the results of the EPSDT screens, are incorporated into the Covered Person's PCP Medical Record.

ii) PCPs who serve Members under the age of twenty-one (21) report encounter data associated with EPSDT screens, using a format approved by DOM, to the Contractor within ninety (90) calendar days from the date of service.

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

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

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

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

4.3 Specialists as PCPs. Covered Persons with disabling conditions, chronic illnesses, or child(ren) with special health care needs may request that their PCP be a specialist. The designation of a specialist as a PCP must be pursuant to a treatment plan approved by HMO, in consultation with the PCP to which the Covered Person is currently assigned, the Covered Person and, as appropriate, the specialist.

The specialist as a PCP shall provide or arrange for all primary care, including routine preventive care, and to provide those specialty medical services consistent with the Covered Person's disabling condition, chronic illness, or special health care need in accordance with HMO's standards and within the scope of the specialty training and clinical expertise.

The specialist as a PCP shall have admitting privileges at a hospital in HMO's network.

4.4 Long-Term Services and Supports (LTSS) Providers. Any LTSS Covered Services under the State Contract that could be authorized through a waiver under section 1915(c) of the Social Security Act (the "Act") or a State Program amendment authorized through sections 1915(i) or 1915(k) of the Act must be delivered in settings consistent with 42 CFR 441.301(c)(4).

SECTION 5
HMO REQUIREMENTS

5.1 Prompt Payment. HMO shall pay Provider pursuant to the State Contract and applicable State and federal law and regulations, including but not limited to Mississippi Code Section 83-9-5, 42 CFR 447.46, 42 CFR 447.45(d)(2), 42 CFR 447.45(d)(3), 42 CFR 447.45(d)(5) and 42 CFR 447.45(d)(6), as applicable and as may be amended from time to time. If a third party liability exists, payment of claims shall be determined in accordance with federal and/or State third party liability law and the terms of the State Contract. Unless HMO otherwise requests assistance from Provider, HMO will be responsible for third party collections in accordance with the terms of the State Contract.

5.2 No Incentives to Limit Medically Necessary Services. HMO shall not structure compensation provided to individuals or entities that conduct utilization management and concurrent review activities so as to provide incentives for the individual or entity to deny, limit, or discontinue Medically Necessary services to any Covered Person.

5.3 Provider Discrimination Prohibition. HMO shall not discriminate with respect to participation, reimbursement, or indemnification of a provider who is acting within the scope of the provider's license or certification under applicable State law, solely on the basis of such license or certification. HMO shall not discriminate against Provider for serving high-risk Covered Persons or if Provider specializes in conditions requiring costly treatments. This provision shall not be construed as prohibiting HMO from limiting a provider's participation to the extent necessary to meet the needs of Covered Persons. This provision also is not intended and shall not interfere with measures established by HMO that are designed to maintain quality of care practice standards and control costs.

5.4 Communications with Covered Persons. Covered Persons are entitled to the full range of their Providers' opinions and counsel about the availability of Medically Necessary Services under the provisions of the State Contract. Any contractual provisions, including gag clauses or rules, that restrict a Provider's ability to advise Covered Persons about Medically Necessary treatment options violate federal law and regulations.

HMO shall not prohibit or otherwise restrict Provider, when acting within the lawful scope of practice, from advising or advocating on behalf of a Covered Person for the following:

i) The Covered Person's health status, medical care, or treatment options, including any alternative treatment that may be self-administered;

ii) Any information the Covered Person needs in order to decide among all relevant treatment options;

iii) The risks, benefits, and consequences of treatment or non-treatment;

iv) The Covered Person's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions; or

v) Information regarding the nature of treatment options including those that may not reflect HMO's position or may not be covered by HMO.

HMO also shall not prohibit a Provider from advocating on behalf of a Covered Person in any grievance system, utilization review process, or individual authorization process to obtain necessary health care services.

5.5 Termination, Revocation and Sanctions. In addition to its termination rights under the Agreement, HMO shall have the right to revoke any functions or activities HMO delegates to Provider under the Agreement or impose other sanctions consistent with the State Contract if in HMO's reasonable judgment Provider's performance under the Agreement is inadequate. HMO shall also have the right to suspend, deny, refuse to renew or terminate

Provider in accordance with the terms of the State Contract and applicable law and regulation. However, HMO shall not exclude or terminate a Provider from participation in HMO's Provider Network due to the fact that the Provider has a practice that includes a substantial number of patients with expensive medical conditions, and shall not terminate a Provider for filing a Complaint, Grievance, or Appeal on a Covered Person's behalf.

5.6 Rights of DOM. DOM shall have the right to invoke against Provider any remedy set forth in the State Contract, including the right to require the termination of the Agreement, for each and every reason for which it may invoke such a remedy against HMO or require termination of the State Contract. Suspected Fraud and Abuse by Provider will be investigated by DOM.

SECTION 6
OTHER REQUIREMENTS

6.1 Compliance with State Contract. All tasks performed under the Agreement shall be performed in accordance with the requirements of the applicable State Contract, as set forth in this Appendix, applicable provider manuals, and protocols, policies and procedures that HMO has provided or delivered to Provider. The applicable provisions of the State Contract are incorporated into the Agreement by reference. Nothing in the Agreement relieves HMO of its responsibility under the State Contract. If any provision of the Agreement is in conflict with provisions of the State Contract, the terms of the State Contract shall control and the terms of the Agreement in conflict with those of the State Contract will be considered waived.

6.2 Monitoring. HMO shall perform ongoing monitoring (announced or unannounced) of services rendered by Provider under the Agreement and shall perform periodic formal reviews of Provider according to a schedule established by the State, consistent with industry standards or State managed care organization laws and regulations or requirements under the State Contract. As a result of such monitoring activities, HMO shall identify to Provider any deficiencies or areas for improvement mandated under the State Contract and Provider and HMO shall take appropriate corrective action. Provider shall comply with any corrective action plan initiated by HMO and/or required by the MississippiCAN Program. In addition, Provider shall monitor and report the quality of services delivered under the Agreement and initiate a plan of correction where necessary to improve quality of care, in accordance with that level of care which is recognized as acceptable professional practice in the respective community in which HMO and Provider practice and/or the performance standards established under the State Contract.

6.3 Enrollment. The parties acknowledge and agree that DOM is responsible for enrollment, reenrollment and disenrollment of Covered Persons.

6.4 No Exclusivity. Nothing in the Agreement or this Appendix shall be construed as prohibiting or penalizing Provider for contracting with a managed care organization other than HMO or as prohibiting or penalizing HMO for contracting with other providers. HMO may not require Providers who agree to participate in the MississippiCAN Program to contract with HMO's other lines of business.

6.5 **Delegation.** The parties agree that, prior to execution of the Agreement, HMO evaluated Provider's ability to perform any duties delegated to Provider under the Agreement. Any delegated duties and reporting responsibilities shall be set forth in the Agreement or other written delegation agreement or addendum between the parties. HMO shall have the right to revoke any functions or activities HMO delegates to Provider under the Agreement if in HMO's reasonable judgment Provider's performance under the Agreement is inadequate.

MississippiCHIP
Regulatory Requirements Appendix

MississipiCHIP

REGULATORY REQUIREMENTS APPENDIX

PROVIDER

THIS MISSISSIPPICHIP PROGRAM REGULATORY REQUIREMENTS APPENDIX (this "Appendix") supplements and is made part of the provider agreement (the "Agreement") between HMO contracting on behalf of itself and the other entities that are its affiliates (collectively, "CCO") and the party named in the Agreement ("Provider").

SECTION 1
APPLICABILITY

This Appendix applies with respect to the provision of direct or health care related services provided by Provider under the Mississippi Children's Health Insurance Program (the "MississippiCHIP Program") as governed by the State's designated regulatory agencies. In the event of a conflict between this Appendix and other appendices or any provision of the Agreement, the provisions of this Appendix shall control except with regard to benefit plans outside the scope of this Appendix or unless otherwise required by law. In the event CCO is required to amend or supplement this Appendix as required or requested by the State to comply with federal or State regulations, CCO will unilaterally initiate such additions, deletions or modifications. All provider agreements must be in writing and must include all specific activities and report responsibilities delegated to the Provider by CCO.

SECTION 2
DEFINITIONS

Unless otherwise defined in this Appendix, all capitalized terms shall be as defined in the Agreement. For purposes of this Appendix, the following terms shall have the meanings set forth below; provided, however, in the event any definition set forth in this Appendix or the Agreement is inconsistent with any definition under the MississippiCHIP Program Contract, the definition shall have the meaning set forth under the MississippiCHIP Program Contract.

2.1 **Abuse:** Any practice that is inconsistent with sound fiscal, business, or medical practices, and results in an unnecessary cost to CHIP, CCO, a subcontractor, or a provider or in reimbursement for services that are not Medically Necessary or that fail to meet professionally recognized standards for healthcare.

2.2 **Adverse Benefit Determination:** The denial or limited authorization of a requested service, including determinations on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit; the reduction, suspension, or termination of previously authorized services; the denial, in whole or in part, of payment for a service; CCO's failure to provide services in a timely manner; CCO's failure to resolve Complaints, Grievances, or Appeals within the specified time frames; for residents in a rural area with only one MCO, the denial of a Covered Person's request to exercise his or her right, under 42 C.F.R. §438.52(b)(2)(ii); the denial of a Covered Person's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other enrollee financial liabilities; and determinations by skilled nursing facilities and nursing facilities to transfer or discharge residents and adverse determinations made by a State with regard to the preadmission

screening and annual resident review requirements of Section 1919(e)(7) of the Act, if applicable.

2.3 **Agreement:** An agreement between the CCO and an individual, business, university, government entity, affiliate, or nonprofit organization to perform part or all of CCO's responsibilities under the MississippiCHIP Program Contract. Agreements must be approved in writing by DOM prior to the start date of the Agreement.

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

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

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

2.7 **Benchmark Plan:** The State School Employee's Health Insurance Plan.

2.8 **Child:** An individual who is under nineteen (19) years of age who is not eligible for Medicaid benefits and is not covered by other health insurance. Child is also referred to as Member.

2.9 **CHIP:** The Children's Health Insurance Program as defined in Title XXI of the Social Security Act.

2.10 **Complaint:** An expression of dissatisfaction received orally or in writing that is of a less serious or formal nature that is resolved within one (1) business day of receipt.

2.11 **Coordinated Care Organization (CCO):** An organization that meets the requirements for participation as a Contractor in CHIP and manages the purchase and provision of health care services under CHIP. For purposes of this Appendix, CCO is a CCO.

2.12 **Co-Payment:** The fixed amount certain CHIP Members pay for a covered health care service. The amount may vary based on healthcare service being provided.

2.13 **Cost Sharing:** In accordance with 42 C.F.R. §457.10, premium charges, enrollment fees, deductibles, coinsurance, Co-Payments, or other similar fees that the Member has responsibility for paying.

2.14 **Covered Services:** Health care services or products for which a Member is enrolled with CCO to receive coverage under the MississippiCHIP Program Contract, including all services required by the State Contract and State and federal law.

2.15 Disenrollment: Action taken by DOM, or its Agent, to remove a Member's name from the monthly Member Listing Report following DOM's receipt and approval of a request for Disenrollment or a determination that the Member is no longer eligible for Enrollment in Contractor.

2.16 DOM: The Division of Medicaid, Office of the Governor, State of Mississippi.

2.17 Fraud: Fraud is any type of intentional deception or misrepresentation made by an entity or person with the knowledge that the deception could result in some unauthorized benefit to the entity, him or herself, or some other person. The Fraud can be committed by many entities, including a vendor, a subcontractor, a provider, a State employee, or a Member among others.

2.18 Grievance: An expression of dissatisfaction about any matter or aspect of CCO or its operation, other than an Adverse Benefit Determination as defined herein. Grievances may include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the Covered Person's rights regardless of whether remedial action is requested. Grievance includes a Covered Person's right to dispute an extension of time proposed by CCO to make an authorization decision.

2.19 Marketing: The activities that promote visibility and awareness for the MississippiCHIP Program and the CCOs participating in the program. All marketing activities are subject to prior review and approval by DOM and may not contain misleading information.

2.20 Medical Record: A single complete record, which documents the entire treatment plan developed for, and medical services received by, the Member including inpatient, outpatient, referral services and emergency medical services whether provided by Contracted Providers or Non-Contracted Providers.

2.21 Member: An individual who meets all of the eligibility requirements for CHIP, enrolls in a CCO under CHIP, and receives health benefits coverage through CHIP.

2.22 MississippiCHIP Program: The Mississippi Medicaid child health program for select individuals under the age of nineteen (19) years of age who are not eligible for Medicaid benefits and are not covered by other health insurances.

2.23 MississippiCHIP Program Contract: The DOM contract with CCO, for the purpose of providing and paying for Covered Services to Members enrolled in the MississippiCHIP Program.

2.24 Primary Care Provider (PCP): Any physician or health care practitioner or group operating within the scope of his or her licensure who is responsible for supervising, prescribing and providing primary care and primary case management services in the MississippiCHIP Program, whose practice is limited to the general practice of medicine or who is an Internist, Pediatrician, Obstetrician/Gynecologist, Family and General Practitioner, Nurse Practitioners (who meet requirements of Section 4.B, Choice of a Health Care Professional), Physician Assistants, specialists who perform primary care functions upon request, and other providers approved by DOM.

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

2.26 Provider Network: The Panel of health service Providers with which the CCO contracts for the provision of covered services to Members and Non-Contracted Providers administering services to Member.

2.27 State: The State of Mississippi or its designated regulatory agencies.

2.28 State Child Health Plan: The State of Mississippi's plan submitted to HHS for the administration of CHIP.

2.29 Third Party Liability/Resource: Any resource available to a Member for the payment of medical expenses associated with the provision of covered services, including but not limited to, insurers and workers' compensation plan.

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

2.31 Well-Baby and Well-Child Care Services: Regular or preventive diagnostic and treatment services necessary to ensure the health of babies, children, and adolescents as defined by DOM in the State Child Health Plan. For the purposes of Cost Sharing, the term has the meaning assigned at 42 C.F.R. § 457.520.

SECTION 3
PROVIDER REQUIREMENTS

The MississippiCHIP Program, through contractual requirements and federal and State statutes and regulations, requires that providers who provide services to Members enrolled in the MississippiCHIP Program comply with certain requirements as set forth below and elsewhere in this Appendix.

3.1 Definitions Related to the Provision of Covered Services. Provider shall follow the applicable MississippiCHIP Program Contract's requirements for the provision of Covered Services. Provider's decisions affecting the delivery of acute or chronic care services to Members shall be made on an individualized basis and in accordance with the following definitions:

i) Emergency Medical Condition: In accordance with Section 1932(b) of the Act and 42 CFR §457.10, a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in any of the following: (1) 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; (2) serious impairment to body functions; or (3) serious dysfunction of any body organ or part.

ii) Emergency Services: Covered inpatient and outpatient services, inclusive of dialysis services, furnished by a provider who is qualified to furnish those health services and that

are needed to evaluate or stabilize an Emergency Medical Condition in accordance with 42 CFR 438.114.

iii) Medically Necessary Services: As set forth in the Social Security Act, Section 1905 (42 U.S.C. 1396d(a)), Medically Necessary Services are defined as services, supplies, or equipment provided by a licensed health care professional that are:

a) Appropriate and consistent with the diagnosis or treatment of the patient's condition, illness, or injury;

b) In accordance with the standards of good medical practice consistent with the individual patient's condition(s);

c) Not primarily for the personal comfort or convenience of the Member, family, or Provider;

d) The most appropriate services, supplies, equipment, or levels of care that can be safely and efficiently provided to the Member;

e) Furnished in a setting appropriate to the patient's medical need and condition and, when applied to the care of an inpatient, further mean that the Member's medical symptoms or conditions require that the services cannot be safely provided to the Member as an outpatient;

f) Not experimental or investigational or for research or education;

g) Provided by an appropriatelylicensed practitioner; and

h) Documented in the patient's record in a reasonable manner, including the relationship of the diagnosis to the service.

Medically Necessary Services may also be those services for children that are necessary to correct or ameliorate defects and physical and mental illnesses and conditions discovered during an interperiodic or Well-Baby and Well-Child Care Services, whether such services are covered or exceed the benefit limits in the Medicaid State Plan and Title 23 of Mississippi Administrative Code.

3.2 Accessibility Standards. Provider shall provide for timely access for Member appointments in accordance with the appointment availability requirements established under the MississippiCHIP Program Contract, as further described in the applicable provider manual.

Type	Appointment Scheduling Time Frames
PCP (well care visit)	Not to exceed thirty (30) calendar days
PCP (routine sick visit)	Not to exceed seven (7) calendar days
PCP (urgent care visit)	Not to exceed twenty-four (24) hours
Specialists	Not to exceed forty-five (45) calendar days

Dental Providers (routine visits)	Not to exceed forty-five (45) calendar days
Dental Providers (urgent Care)	Not to exceed forty-eight (48) hours
Behavioral Health Providers (routine visit)	Not to exceed fourteen (14) calendar days
Behavioral Health Providers (urgent visit)	Not to exceed twenty-four (24) hours
Behavioral Health Providers (post-discharge from an acute psychiatric hospital when the Contractor is aware of the	Not to exceed seven (7) calendar days
Urgent Care Providers	Not to exceed twenty-four (24) hours
Emergency Providers	Immediately (twenty-four (24) hours a day, seven (7) days a week) and without Prior

3.3 Hours of Operation; Appointments. Provider shall offer hours of operation that are no less than the hours of operation offered to commercial beneficiaries. As applicable, Provider will make Covered Services available 24 hours a day, 7 days a week when medically necessary.

3.4 PCP Responsibilities. If applicable, and Provider is a PCP, Provider shall comply with the following:

i) PCPs who serve Members under the age of nineteen (19) are responsible for conducting all Well-Baby and Well-Child Care services. Should the PCP be unable to conduct the necessary Well-Baby and Well-Child Care services screens, the PCP is responsible for arranging to have the necessary Well-Baby and Well-Child Care services screens conducted by another network provider and ensure that all relevant medical information, including the results of the Well-Baby and Well-Child Care services screens, are incorporated into the Member's PCP Medical Record.

ii) PCPs who serve Members under the age of nineteen (19) report encounter data associated with Well-Baby and Well-Child Care services, using a format approved by DOM, to Contractor within one hundred and eighty (180) calendar days from the date of service.

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

a) Contact Members identified in the quarterly Encounter lists as not complying with Well-Baby, Well-Child Care, and immunization schedules for Children;

b) Identify to Contractor any such Members who have not come into compliance with Well-Baby, Well-Child Care, and immunization schedules within one (1) month of such notification to the site by Contractor; and

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

iv) PCP shall provide Well-Baby and Well-Child Care Services, including vision screening, laboratory

tests and hearing screenings, according to recommendations of the U.S. Preventive Services Task Force. Vision and hearing screenings shall be included as part of periodic Well-Child assessments. PCP shall have written policies and procedures related to the provision of the full-range of Well-Baby Care, Well-Child Care, and childhood and adolescent immunization services as defined in, and in accordance with, the State Child Health Plan, 42 C.F.R. §457.495, and this provisions of the MississippiCHIP Program Contract. Services shall include, without limitation, 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). PCP shall make all reasonable efforts to identify all Members whose Medical Records do not indicate up-to-date immunizations and shall ensure that these Members receive necessary immunizations. Immunizations are purchased and distributed through the Mississippi State Department of Health. CCO shall reimburse PCP for the administration of the immunizations.

CCO requires that PCP cooperate to the maximum extent possible with the efforts to improve the health status of Mississippi citizens, and to actively work to improve the percentage of Members receiving appropriate screenings, and meet or exceed DOM's targets.

a) The following minimum elements must be included in the periodic health screening assessment of children:

i. Comprehensive health and development history (including assessment of both physical and mental development);

ii. Measurements (e.g. head circumference for infants, height, weight, body mass index);

iii. Comprehensive unclothed physical examination;

iv. Immunizations appropriate to age and health history;

v. Assessment of nutritional status;

vi. Laboratory tests (including tuberculosis screening and Federally required blood lead screenings);

vii. Vision screening;

viii. Hearing screening;

ix. Dental and oral health assessment; and

x. Developmental and behavioral assessment.

v) If a suspected problem is detected by a screening examination, the child must be evaluated as necessary for further diagnosis. This diagnosis is used to determine treatment needs. PCP must establish a tracking system that provides information on compliance with Well-Baby and Well-Child Care services and immunization services provision requirements in the following areas:

a) Initial visit for newborns;

b) Well-Baby and Well-Child Care services and reporting of all assessment results; and

c) Diagnosis and/or treatment for Children.

vi) PCP must have an established process for reminders, follow-ups and outreach to Members that includes:

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

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

c) Protocols for conducting outreach with non-compliant Members, including home visits, as appropriate; and

d) A process for outreach and follow-up to Members with special health care needs.

vii) PCP may develop an alternate process for follow-up and outreach subject to prior written approval from CCO and DOM.

viii) **Specialists as PCPs**. Members with disabling conditions, chronic conditions, or with special health care needs may request that their PCP be a specialist. The designation of a specialist as a PCP must be pursuant to a treatment plan approved by Contractor; in consultation with the PCP to which the Member is currently assigned, the Member and, as appropriate, the specialist. When possible, the specialist must be a provider participating in Contractor's network. The specialist as a PCP must agree to provide or arrange for all primary care, including routine preventive care, and to provide those specialty medical services consistent with the Member's disabling condition, chronic illness, or special health care need in accordance with Contractor's standards and within the scope of the specialty training and clinical expertise. To accommodate the full spectrum of care, the specialist as a PCP must also have admitting privileges at a hospital in Contractor's network.

3.5 Provider Selection. To the extent applicable to Provider in performance under the Agreement, Provider shall comply with 42 CFR §438.214, as may be amended from time to time, which includes, but is not limited to the selection and retention of providers, credentialing and re-credentialing requirements and nondiscrimination. If CCO delegates credentialing to Provider, CCO will provide monitoring and oversight and Provider shall ensure that all licensed medical professionals are credentialed in accordance with CCO's and the MississippiCHIP Program Contract's credentialing requirements.

3.6 Records Retention. As required under State or federal law or the MississippiCHIP Program Contract, Provider shall maintain a record keeping system of current, detailed, and organized records for recording services, charges, dates and all other commonly accepted information elements sufficient to disclose the quality, quantity, appropriateness and timeliness of services rendered to Members. All financial records shall follow generally accepted accounting principles. Medical records and supporting management systems shall include all pertinent information related to the medical management of each Member. Other records shall be maintained as necessary to clearly reflect all actions taken by Provider related to services provided under the MississippiCHIP Program Contract. Such records, including, as applicable, grievance and appeals records shall be maintained for a period of not less than ten (10) years from the close of the Agreement, or such other period as required by law. If records are under review or audit or are the subject of litigation they must be retained for a minimum of ten (10) years following resolution of such action. Prior approval for the disposal of records must be requested and approved by CCO if the Agreement is continuous. Provider shall have written records retention policies and procedures and will make such policies and procedures available to CCO or DOM upon request. DOM requires ready access to any and all documents and records of transactions pertaining to the provisions of services provided by Provider and those copies of requested documents/records will be provided to DOM or its designee free of charge.

3.7 Records Access. Provider agrees to cooperate with CCO to maintain and share a health record of all services provided to a Covered Person, as appropriate and in accordance with applicable laws, regulations and professional standards. Provider acknowledges and agrees and shall require Provider to acknowledge and agree that DOM, the U.S. Department of Health and Human Services and other authorized federal and state personnel shall have complete access to all records pertaining to services provided to Members. Provider shall provide immediate access to facilities, records and supportive materials pertinent to the MississippiCHIP Program Contract for State or Federal fraud investigators.

3.8 Government Audit; Investigations. Provider acknowledges and agrees and shall require Provider to acknowledge and agree that the State or any of its duly authorized representatives, DOM, the U.S. Department of Health and Human Services, the Centers for Medicare & Medicaid Services, the Office of Inspector General, the General Accounting Office, or any other auditing agency or their authorized representatives and their designees, with prior approval by DOM, at any time during the term of the Agreement, shall, at all reasonable time and within regular business hours, with or without notice, have the right to inspect, audit or otherwise evaluate the quality, appropriateness, and timeliness of services provided under the terms of the MississippiCHIP Program Contract and any other applicable federal and State law and regulation.

This shall include, but not be limited to, the right to enter onto Provider's premises, access to and the right to audit, inspect, monitor, and examine any pertinent books, documents, papers, medical records, financial records, surveys and computer databases and/or to otherwise evaluate the performance of Provider related to Provider's performance under the Agreement. Such monitoring activities may also include, without limitation, on-site inspections of all service locations and facilities; auditing and/or review of all records developed under the MississippiCHIP Program Contract or the Agreement; reviewing management systems and procedures developed under the MississippiCHIP Program Contract or the Agreement; and review of any other areas of materials relevant or pertaining to the MississippiCHIP Program Contract or the Agreement. All reviews and audits shall be performed in such a manner as will not unduly delay the work of Provider. There will be no restrictions on the right of the State or federal authorities to conduct inspections and audits as necessary.

The Provider must fully cooperate with any and all reviews and/or audits by state or federal agencies, such as the Department of Audit, Department of Health and Human Services, Centers for Medicare and Medicaid Services, Office of Inspector General, General Accounting Office, or any other auditing agency approved by DOM, by assuring that appropriate employees and involved parties are available for interviews relating to the reviews or audits.

All records shall be maintained and available for review by authorized federal and state agencies during the entire term of the MississippiCHIP Program Contract and for a period of ten (10) years thereafter, unless an audit, litigation, or other legal action is in progress. When an audit or litigation is in progress or audit findings are unresolved, records shall be kept for a period of ten (10) years or until all issues are finally resolved, whichever is later. The Provider must have written policies and procedures for storing this information. Records must be kept in an original paper state or preserved on micro media or electronic format.

3.9 Data; Reports. Provider shall and shall require that Provider cooperate with and release to CCO any information necessary for CCO to perform its obligations under the MississippiCHIP Program Contract to the extent applicable to Provider in performance of the Agreement, including the timely submission of reports and information required by CCO, in the format specified by CCO and the State. Such reports shall include well-baby/well-child reporting, as well as complete and accurate encounter and utilization management data in accordance with the requirements of CCO and DOM. Data must be provided at the frequency and level of detail specified by CCO or the State. By submitting data to CCO, Provider represents and attests to CCO and the State that the data is accurate, complete and truthful, and upon

CCO's request Provider shall certify in writing, that the data is accurate, complete, and truthful, based on Provider's best knowledge, information and belief.

Provider shall be able to receive, maintain and utilize applicable data extracts from CCO or DOM and systematically update its database within five (5) calendar days of receipt of the files. Data extract files include but are not limited to the following, as applicable: 1. Daily Active Provider Extract; 2. Weekly Provider Affiliation Details Extract; 3. 834 Enrollment Files; 4. 835 Claims Payment Remittance Advice Transaction; 5. 277 Claims Acknowledgement; 6. NCPDP Formulary; 7. NCPDP Response File; 8. TPL Resource/Policy Information File, etc.; 9. Claims History Extracts; and 10. Prior Authorization Extracts.

3.10 Encounter Data. Provider shall agree to cooperate with CCO to comply with CCO's obligation to prepare encounter data submissions, reports, and clinical information including, without limitation, and well-baby/well-child reporting and encounters, as applicable, and such other reporting regarding Covered Services as may be required under the MississippiCHIP Program Contract. Encounter data must be accurate and include all services furnished to a Covered Person, including capitated provider's data and rendering provider information. Encounter data must be provided within the timeframes specified and in a form that meets CCO and State requirements. By submitting encounter data to CCO, Provider represents to CCO that the data is accurate, complete and truthful, and upon CCO's request Provider shall certify in writing, that the data is accurate, complete, and truthful, based on Provider's best knowledge, information and belief.

3.11 Claims Information. Provider shall promptly submit to CCO the information needed to make payment and shall identify third party liability coverage, including Medicare and other insurance, and if applicable seek such third party liability payment before submitting claims to CCO. Provider understands and agrees that each claim Provider submits to CCO constitutes a certification that the claim is true and accurate to the best of Provider's knowledge and belief and that the Covered Services are 1) Medically Necessary and 2) have been provided to the Member prior to submitting the claim.

Provider must submit claims within six (6) months from the date of service. Claims filed within the appropriate time frame but denied may be resubmitted to CCO within ninety (90) calendar days from the date of denial.

3.12 Third Party Resources. Provider shall report all Third Party Resources to CCO identified through the provision of medical services.

3.13 Privacy; HIPAA. Provider shall comply with all applicable privacy rule and security rule provisions of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), and associated implementing regulations, as may be amended from time to time, and shall safeguard information about Members in accordance with applicable federal and State privacy laws and rules including 42 CFR §438.224 and 42 CFR Part 431, Subpart F, as may be amended from time to time. Provider agrees that confidential information, including but not limited to, medical and other pertinent information relative to Members, shall not be disclosed to any person or organization for any purpose without the expressed, written authority of DOM or as otherwise required by law and that all such disclosures shall fully comply with HIPAA privacy and security standards.

3.14 Cultural Competency and Access. Provider shall participate in CCO's and DOM's efforts to

promote the delivery of services in a culturally competent manner to all Members, including those with limited English proficiency, physical or mental disabilities, diverse cultural and ethnic backgrounds and regardless of gender, sexual orientation or gender identity, and shall provide interpreter services in a Member's primary language and for the hearing impaired for all appointments and emergency services. Provider shall provide information to Members regarding treatment options and alternatives, as well as information on complaints and appeals, in a manner appropriate to the Member's condition and ability to understand. Provider shall provide physical access, reasonable accommodations, and accessible equipment for Covered Persons with physical or mental disabilities.

3.15 Approval of Marketing Materials. As required under State or federal law or the applicable MississippiCHIP Program Contract, any marketing materials developed and distributed by Provider as related to the performance of the Agreement must be submitted to CCO at least sixty (60) days prior to planned distribution for timely submission to DOM for prior approval. Provider agrees it will not proceed with the statement or communication until the required approval is obtained.

3.16 Independent Contractor Relationship. Provider expressly agrees that Provider is acting in an independent capacity in the performance of the Agreement and not as an officer, agent or employee of DOM, CMS or the State. Provider further expressly agrees that the Agreement shall not be construed as a partnership or joint venture between Provider and DOM, CMS or the State. Nothing in the Agreement shall be construed, nor shall it be deemed to create, any right or remedy in any third party.

3.17 Certification on Relationship to State, DOM and CMS. Provider certifies that no officer, director, employee, subcontractor or agent of Provider, or person with an ownership or control interest in Provider, is also employed by, or is a public official of, the State of Mississippi or any of its agencies, DOM or CMS.

3.18 Ownership and Control Information. If applicable, Provider shall cooperate with CCO in obtaining and providing information to DOM related to ownership and control, significant business transactions, and persons convicted of a criminal offense in compliance with§1128 of the Social Security Act, 42 USC §1320a-7 and 42 CFR Part 455, as amended and shall provide information upon request. Provider shall submit information related to ownership and control of subcontractors or wholly owned supplier within thirty-five (35) calendar days of a request for such information.

By executing the Agreement, Provider certifies that neither Provider nor any of its principals is presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in any State or federal health care program or from participating in transactions by any State or federal department or agency. CCO will terminate the Agreement upon becoming aware or receiving notice from DOM, whichever is earlier, that Provider is or has been excluded from participation in any State or federal health care program or by any State or federal agency.

3.19 Excluded Individuals and Entities. Provider certifies that neither it nor any of its employees, principals, nor any providers, subcontractors or consultants or persons with an ownership or controlling interest in the Provider (an owner including the Provider himself or herself), or an agent or managing employee of the Provider, with whom Provider contracts and who are providing items or services that are significant and material to Provider's obligations under the

Agreement is:

i) excluded from participation in federal health care programs under either Section 1128 or section 1128A of the Social Security Act; or

ii) debarred, suspended, proposed for debarment, declared ineligible, or otherwise voluntarily excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549; or an affiliate, as defined in the Federal Acquisition Regulation, of such a person.

Provider acknowledges and agrees and shall require that Provider acknowledge and agree that payment will not be made for any items or Covered Services provided by an excluded individual pursuant to 42 CFR §1001.1901(b) and is obligated to screen all employees, contractors, and subcontractors for exclusion as required under applicable State and Federal laws. Additionally, Provider acknowledges that pursuant to 42 CFR §1003.102(a)(2) civil monetary penalties may be imposed against Provider if he or she employs or enters into contracts with excluded individuals or entities to provide items or Covered Services to Member under the Agreement. Provider agrees not to employ or subcontract with individuals or entities whose owner, those with a controlling interest, or managing employees are on a State or Federal exclusion list to provide items or Covered Services under the Agreement. Provider shall immediately report to CCO any exclusion information discovered. Provider can search the HHS-OIG website, at no cost, by the names of any individuals or entities. The database is called LEIE and can be accessed at http://www.oig.hhs.gov/fraud/exclusions.asp. The GSA EPLS/SAM database can be accessed at https://www.sam.gov. Federal and State exclusion databases must be reviewed monthly to ensure that no employee or contractor has been excluded. Applicable state exclusion databases can be accessed through the State's Medicaid website. CCO will terminate the Agreement immediately upon becoming aware or receiving notice from DOM, whichever is earlier, that Provider's owners, agents, managing employees, or any provider is or has been excluded from federal health care programs or terminated from the Medicare or the Medicaid program in any state.

3.20 Licensure. Provider represents that it is currently licensed and/or certified under applicable State and federal statutes and regulations and by the appropriate State licensing body or standard-setting agency, as applicable. Provider represents that it does not have a Medicaid provider agreement with DOM that is terminated, suspended, denied, or not renewed as a result of any action of DOM, CMS, HHS, or the Medicaid Fraud Control Unit of the State's Attorney General. Provider shall maintain at all times throughout the term of the Agreement all necessary licenses, certifications, registrations and permits as are required to provide the health care services and/or other related activities delegated to Provider by CCO under the Agreement. If at any time during the term of the Agreement, Provider is not properly licensed as described in this Section, Provider shall discontinue providing services to Members.

3.21 National Provider ID (NPI). If applicable, Provider shall and shall require that Providers obtain a National Provider Identification Number (NPI) and when filing claims with Provider, the NPI number used is the same NPI number used when filing claims with DOM.

3.22 Funding. Provider recognizes that the obligation of DOM to proceed under its MississippiCHIP Program Contract with CCO is conditioned upon the appropriation of funds by the Mississippi

State Legislature and the receipt of State and/or Federal funds. If the funds anticipated for the continuing fulfillment of the agreement are, at any time, not forthcoming or insufficient, either through the failure of the Federal government to provide or the State of Mississippi to appropriate funds, or the discontinuance, or material alteration of the program under which the funds were provided or if funds are not otherwise available to DOM, DOM has the right upon ten (10) working days written notice to CCO to terminate the MississippiCHIP Program Contract.

3.23 Federal and State Funds Liability. Providers acknowledges and agrees that payments made to Provider for services provided under the Agreement are derived from federal and State funds and that any false claim or statement in documents or any concealment of material fact related to such services may be a cause for sanctions and prosecution under applicable federal and State laws. Provider shall be subject to all laws applicable to individuals and entities receiving State and federal funds and may be held civilly or criminally liable to both CCO and DOM in the event of nonperformance, misrepresentation, fraud, or abuse related to services provided pursuant to the MississippiCHIP Program Contract. Provider recognizes that payments made to the Provider are derived from federal and State funds, and are contingent upon and subject to availability and receipt of funds.

3.24 Insolvency. In the event CCO becomes insolvent or unable to pay Provider, Provider shall not seek compensation for services rendered from DOM, its officers, Agents, or employees, or the Members or their eligible dependents.

3.25 Termination. In the event of termination of the Agreement, Provider shall promptly supply to CCO all information necessary for the reimbursement of any outstanding MississippiCHIP Program claims.

3.26 Capitated Providers. If a Provider that is capitated terminates its agreement with CCO, for any reason, Provider will provide services to Members assigned to Provider up to the end of the month in which the effective date of termination falls.

3.27 Fraud, Waste, and Abuse Prevention. Provider shall cooperate fully with the CCO's policies and procedures designed to protect program integrity and prevent and detect potential or suspected fraud, waste, and abuse in the administration and delivery of services under the MississippiCHIP Program Contract and shall cooperate and assist DOM and any other State or federal agency charged with the duty of preventing, identifying, investigating, sanctioning or prosecuting suspected fraud, waste, and abuse in state and/or federal health care programs. Provider and CCO are responsible for reporting suspected fraud and abuse by participating and non-participating providers, as well as Members, when detected.

In accordance with CCO's policies and the Deficit Reduction Act of 2005 (DRA), Provider shall have written policies for its employees, contractors or agents that: (a) provide detailed information about the federal False Claims Act (established under sections 3729 through 3733 of title 31, United States Code), including if any entity makes or receives annual payments under the State Program of at least $5,000,000, such entity must establish certain minimum written policies and information communicated through an employee handbook relating to the Federal False Claims Act in accordance with 42 CFR 438.600; (b) cite administrative remedies for false claims and statements (established under chapter 38 of title 31, United States Code) and whistleblower protections under federal and state laws; (c) reference state laws pertaining to civil or criminal penalties for false

claims and statements; and (d) with respect to the role of such laws in preventing and detecting fraud, waste, and abuse in federal health care programs (as defined in section 1128B(f)), include as part of such written policies, detailed provisions regarding Provider's policies and procedures for detecting and preventing fraud, waste, and abuse. Provider agrees to train its staff on the aforesaid policies and procedures.

3.28 Quality Utilization Management. Pursuant to any applicable provider manuals and related protocols, or as elsewhere specified under the Agreement, Provider agrees to cooperate with CCO's quality improvement and utilization review and management activities. This shall include, but not be limited to, participation in any internal and external quality assurance, utilization review, peer review, and grievance procedures established by CCO or as required under the MississippiCHIP Program Contract to ensure that Members have due process for their complaints, grievances, appeals, fair hearings or requests for external review of adverse decisions made by CCO or Provider. Provider shall adhere to the quality assurance and utilization review standards of the MississippiCHIP Program and shall monitor quality and initiate corrective action to improve quality consistent with the generally accepted level of care.

3.29 Quality and Utilization Management Program. Provider shall cooperate with CCO in meeting the Quality Management and Utilization Management Program standards outlined in the MississippiCHIP Program Contract.

3.30 Referrals. Provider shall make referrals for social, vocational, education or human services when a need for such service is identified.

3.31 Restrictions on Referrals. Provider shall not make inappropriate referrals for designated health services to health care entities with which Provider or a member of Provider's family has a financial relationship, pursuant to federal anti-kickback and physician self-referral laws that prohibit such referrals.

3.32 Complaints, Grievances and Appeals. Information on how Provider or Provider's authorized representative shall submit complaints and file grievances and appeals, and the resolution process, is contained in the CCO MississippiCHIP Provider Manual.

3.33 Health Care Acquired/Preventable Conditions. Provider agrees that no payment shall be made for the provision of medical assistance for health care acquired conditions and other provider preventable conditions as may be identified by the State. As a condition of payment, Provider shall identify and report to CCO any provider preventable conditions in accordance with 42 CFR §§ 434.6(a)(12), 438 including but not limited to 438.3(g), and 447.26.

3.34 Compliance with Laws. Provider shall comply with all applicable federal and State laws and regulations and all provisions of the MississippiCHIP Program Contract that pertain to a Member's rights, including but not limited to the following, to the extent applicable to Provider in performance of the Agreement:

i) Title VI of the Civil Rights Act of 1964; (b) Title XIX of the Social Security Act; Title IX of the Education Amendments of1972 (regarding education programs and activities); the Age Discrimination Act of 1975; the Rehabilitation Act of 1973; and The Genetic Information Non-Discrimination Act of 2008 (GINA); the Americans with Disabilities Act;

section 1557 of the Patient Protection and Affordable Care Act, and their implementing regulations, as may be amended from time to time.

ii) All federal and State professional and facility licensing and accreditation requirements/standards that apply to the services Provider perform pursuant to the Agreement, including but not limited to:

a) All applicable standards, orders or requirements issued under Section 306 of the Clean Air Act (42 USC 1857 (h)). Section 508 of the Clean Water Act (33 USC 1368), Executive Order 11738, and Environmental Protection Agency (EPA) regulations (40) CFR Part 15), which prohibit the use of facilities included on the EPA list of violating facilities. Any violations must be reported to DSHS, DHHS, and the EPA;

b) Any applicable mandatory standards and policies relating to energy efficiency that are contained in the State Energy Conservation Plan, including the Energy Policy & conservation Act (Pub. L. 94-165), and issued in compliance with the Federal Energy Policy & Conservation Act.

iii) All relevant federal and State statutes, regulations and orders related to equal opportunity in employment, including but not limited to compliance with E.O. 11246, "Equal Employment Opportunity," as amended by E.O. 11375, "Amending Executive Order 11246 Relating to Equal Employment Opportunity," and as supplemented by regulations at 41 CFR Part 60, "Office of Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor."

iv) If the Agreement is for an amount in excess of $100,000, Provider shall comply with all applicable standards, orders or regulations issued pursuant to the Clean Air Act, 42 U.S.C. 7401 et seq., and the Federal Water Pollution Control Act, as amended, 33 U.S.C. 1251 et seq. Any violations shall be reported to DHHS and the appropriate Regional Office of the Environmental Protection Agency.

v) Those specified for laboratory services in the Clinical Laboratory Improvement Amendments (CLIA). All laboratory service sites must have a CLIA certificate of registration or waiver, and a CLIA identification number.

vi) The American with Disabilities Act (ADA). Provider shall make reasonable accommodation for Members with disabilities in accord with the ADA for all Covered Services and shall assure physical and communication barriers do not inhibit Members with disabilities from obtaining Covered Services;

vii) Section 1128B(d)(1) of the Balanced Budget Act of 1997; and,

viii) Any other requirements associated with the receipt of federal funds.

ix) All Medicaid laws, regulations and program instructions to the extent applicable to Provider in Provider's performance of the Agreement. Provider understands that payment of a claim by CCO or the State is conditioned upon the claim and the underlying transaction complying with such laws, regulations, and program instructions (including, but not limited

to, federal requirements on fraud, waste and abuse, disclosure, debarment, termination and exclusion screening), and is conditioned on the Provider's compliance with all applicable conditions of participation in Medicaid. Provider understands and agrees that each claim the Provider submits to CCO constitutes a certification that the Provider has complied with all applicable Medicaid laws, regulations and program instructions in connection with such claims and the services provided therein. Provider's payment of a claim will be denied if Provider is terminated or excluded from participation in federal healthcare programs. Provider's payment of a claim may be temporarily suspended if the State or CCO provides notice that a credible allegation of fraud exists and there is a pending investigation. Provider's payment of a claim may also be temporarily suspended or adjusted if the Provider bills a claim with a code that does not match the service provided. CCO performs coding edit procedures based primarily on National Correct Coding Initiative (NCCI) policies and other nationally recognized and validated policies. Provider agrees that it will provide medical records to CCO upon its request in order to determine appropriateness of coding. Provider may dispute any temporarily suspended or adjusted payment consistent with the terms of the Agreement.

3.35 Non-Discrimination. Provider will not discriminate against, nor use any policy or practice that has the effect of discriminating against, Covered Persons on the basis of race, color, creed, sex, religion, age, national origin, ancestry, marital status, sexual orientation, gender identity, language, health status, disease or pre-existing condition (including genetic information), anticipated need for health care or physical or mental handicap, except where medically indicated. Examples of prohibited practices include, but are not limited to, the following:

i) Denying or not providing a Member any MississippiCHIP Covered Service. Health care and treatment necessary to preserve life must be provided to all Members who are not terminally ill or permanently unconscious, except where a competent Member objects to such care on his/her own behalf.

ii) Subjecting a Member to segregated, separate, or different treatment, including a different place or time from that provided to other Members or public or private patients, in any manner related to the receipt of any MississippiCHIP Covered Service, except where Medically Necessary.

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

3.36 Advance Directives. Provider shall comply with the advance directives requirements with 42 C.F.R §422.128 and with the Uniform Health-Care Decisions Act (Miss. Code Ann. § 41-41-201, *et. seq*.). When applicable, Provider shall comply with the advance directives requirements for hospitals, nursing facilities, providers of home and health care and personal care services, hospices, and HMOs as specified in 42 CFR Part 49, subpart I, 42 CFR § 417.436(d), 42 CFR § 422.128, and 42 CFR 438.3(i).

3.37 Physician Incentive Plans. In the event Provider participates in a physician incentive plan

("PIP") under the Agreement, Provider agrees that such PIPs must comply with 42 CFR § 417.479, 42 CFR § 438.3, 42 CFR § 422.208, and 42 CFR § 422.210, as may be amended from time to time. CCO or Provider may not make a specific payment directly or indirectly under a PIP to a physician or physician group as an inducement to reduce or limit Medically Necessary services furnished to an individual Member. PIPs must not contain provisions that provide incentives, monetary or otherwise, for the withholding of services that meet the definition of Medical Necessity. Provider shall disclose annually to CCO any PIP arrangement Provider may have with any physicians even if there is not substantial financial risk between CCO and such physicians.

3.38 Lobbying. Provider agrees to comply with the following requirements related to lobbying:

i) Prohibition on Use of Federal Funds for Lobbying: By signing the Agreement, Provider certifies to the best of Provider's knowledge and belief, pursuant to 31 U.S.C. § 1352 and 45 CFR Part 93, as may be amended from time to time, that no federally appropriated funds have been paid or will be paid to any person by or on Provider's behalf for the purpose of influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the award of any federal contract, the making of any federal grant, the making of any federal loan, the entering into of any cooperative agreement, or the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan, or cooperative agreement.

ii) Disclosure Form to Report Lobbying: If any funds other than federally appropriated funds have been paid or will be paid to any person for the purpose of influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the award of any federal contract, the making of any federal grant, the making of any federal loan, the entering into of any cooperative agreement, or the extension, continuation, renewal, amendment or modification of any federal contract, grant, loan, or cooperative agreement and the value of the Agreement exceeds $100,000, Provider shall complete and submit Standard Form-LLL, "Disclosure Form to Report Lobbying," in accordance with its instructions.

iii) Contractor shall abide by lobbying laws of the State of Mississippi.

3.39 Gratuities. Provider represents that it has not violated, is not violating, and promises that it will not violate the prohibitions against gratuities set forth in Section 6-204 (Gratuities) of the Mississippi Personal Service Contract Procurement Regulations.

3.40 Compliance with Mississippi Employment Protection Act (MEPA). Represents and warrants and shall require that Provider represent and warrant that it will ensure its compliance with the Mississippi Employment Protection Act, Section 71-11-1 et set of the Mississippi Code Annotated (Supp. 2008), and will register and participate in the status verification system for all newly hired employees. The term "employee" as used herein means any person that is hired to perform work within the State of Mississippi. As used herein, "status verification system" means the Illegal Immigration Reform and Immigration Responsibility Act of 1996 that is operated by the United States Department of Homeland Security, also known as the E-Verify Program, or any other

successor electronic verification system replacing the E-Verify Program. Provider agrees and shall require that Provider agree to maintain records of such compliance and, upon request of the State and approval of the Social Security Administration or Department of Homeland Security, where required, to provide a copy of each such verification to the State. Provider represents and warrants that any person assigned to perform services hereunder meets the employment eligibility requirements of all immigration laws of the State of Mississippi. Provider acknowledges and agrees that any breach of these warranties may subject Provider to the following: (a) termination of the Agreement and ineligibility for any state or public contract in Mississippi for up to three (3) years, with notice of such cancellation/termination being made public, or (b) the loss of any license, permit, certification or other document granted to Provider by an agency, department or governmental entity for the right to do business in Mississippi for up to one (1) year, or (c) both.

3.41 Insurance Requirements. As applicable, Provider shall and shall require that Provider secure and maintain during the term of the Agreement general liability insurance, professional liability insurance, and workers' compensation insurance for all employees connected with the provision of services under the Agreement. Such workers compensation insurance shall comply with Mississippi Workers' Compensation Laws. Such comprehensive general liability insurance and professional liability insurance shall provide coverage in an amount established by CCO pursuant to the Agreement or as required under the MississippiCHIP Program Contract.

3.42 Indemnification. To the extent applicable to Provider in performance under the Agreement, Provider shall indemnify, defend, protect, save and hold DOM and its employees and Members harmless from and against all injuries, deaths, losses, damages, claims, suits, demands, actions, recovery, liabilities, judgments, costs and expenses, including without limitation, court costs, investigative fees and expenses, and attorney fees, to the extent proximately caused by any negligent act or other intentional misconduct or omission of Provider, its agents, officers, employees or contractors arising from the Agreement. DOM may waive this requirement for public entities if Provider is a state agency or sub-unit as defined by the State or a public health entity with statutory immunity. This clause shall survive the termination of the Agreement for any reason, including breach due to insolvency.

3.43 Notice of Legal Action. Immediately upon obtaining knowledge or receiving notice of any legal action or notice listed below, Provider shall provide to CCO written notice of such legal action or notice and, upon request by CCO, a complete copy of all filings and other documents generated in connection with any such legal action:

i) Any action, suit or counterclaim filed against Provider;

ii) Any regulatory action, or proposed action, respecting Provider's business or operations;

iii) Any notice received by Provider from the Department of Insurance or the State Health Officer;

iv) The filing of a petition in bankruptcy by or against Provider, or the insolvency of Provider;

v) The conviction of any person who has an ownership or control interest in Provider, or who is an agent or managing employee of Provider, of a criminal offense related to that person's

involvement in any program under Medicare, Medicaid, or Title XX of the Social Security Act; or

vi) A malpractice action against any Provider delivering service under an agreement.

3.44 Hold Harmless. Except for any applicable cost-sharing requirements under the MississippiCHIP Program Contract, Provider shall look solely to CCO for payment of Covered Services provided to Members pursuant to the Agreement and the MississippiCHIP Program Contract and hold DOM, the State, the U.S. Department of Health and Human Services and Members harmless in the event that CCO cannot or will not pay for such Covered Services. In accordance with 42 CFR § 447.15, as may be amended from time to time, the Member is not liable to Provider for any services for which CCO is liable and as specified under the State's relevant health insurance or managed care statutes, rules or administrative agency guidance. Provider shall not require any copayment or cost sharing for Covered Services provided under the Agreement unless expressly permitted under the MississippiCHIP Program Contract. Provider shall also be prohibited from charging Members for missed appointments if such practice is prohibited under the MississippiCHIP Program Contract or applicable law. Neither the State, DOM, nor Member shall be in any manner liable for the debts and obligations of CCO and under no circumstances shall CCO, or any providers used to deliver services covered under the terms of the MississippiCHIP Program Contract, charge Members for Covered Services.

3.45 Assignment/Delegation. Provider shall not assign or delegate the Agreement without the express written consent of CCO or DOM. If Provider subcontracts or delegates any functions of the Agreement, in accordance with the terms of the Agreement and with the express written consent of CCO or DOM, the subcontract or delegation must be in writing and include all of the requirements of this Appendix, and applicable requirements of the State Contract, and applicable laws and regulations. The transfer of five percent (5%) or more of the beneficial ownership in Provider at any time during the term of this Agreement shall be deemed an assignment under this Agreement.

3.46 Behavioral Health Providers. Behavioral Health Providers shall ensure that all Covered Persons receiving inpatient psychiatric services are scheduled for outpatient follow-up and/or continuing treatment prior to discharge from the inpatient psychiatric hospital if the Provider is aware of the Covered Person's inpatient hospitalization status. Behavioral Health Providers will be provided daily reports identifying Covered Persons known to be admitted to an inpatient facility. Behavioral Health Services will be delivered in compliance with the requirements of 42 CFR 438 subpart K insofar as those requirements are applicable.

3.47 Provider Eligibility. Provider must be enrolled in the Mississippi CHIP program and must use the same National Provider Identifier (NPI) number to participate in CCO's Network. Upon notification from the State that Provider's enrollment has been denied or terminated, CCO must terminate Provider immediately and will notify affected Covered Persons that Provider is no longer participating in the network. CCO will exclude from its network any provider who has been terminated or suspended from the Medicare, Medicaid or CHIP program in any state.

3.48 Disclosure. Provider must be screened and enrolled in the State's CHIP program and submit disclosures to the DOM related to ownership and control, significant business transactions, and persons convicted of crimes in accordance with 42 CFR Part 455 .Provider must submit information related to ownership and control of subcontractors or wholly owned suppliers within thirty-five (35)

calendar days of a request for such information in accordance with 42 CFR 455.105. Additionally, Provider must cooperate with DOM for submission of fingerprints upon a request from DOM or CMS in accordance with 42 CFR 455.434.

3.49 Electronic Visit Verification. Provider shall cooperate with State requirements for electronic visit verification for personal care services and home health services, as applicable.

3.50 Clinical Laboratory Improvements Act (CLIA) Certification or Waiver. As applicable, if Provider performs any laboratory tests on human specimens for the purpose of diagnosis and/or treatment, Provider agrees to acquire and maintain the appropriate CLIA certification or waiver for the type of laboratory testing performed. Provider further agrees to provide a copy of the certification if requested by CCO. A State authorized license or permit that meets the CLIA requirements may be substituted for the CLIA certificate pursuant to State law. Medicare and Medicaid programs require the applicable CLIA certification or waiver for the type of services performed as a condition of payment. Provider must include the appropriate CLIA certificate or waiver number on claims submitted for payment for laboratory services.

3.51 Overpayment. Provider shall to report to CCO when it has received an overpayment and will return the overpayment to CCO within 60 calendar days after the date on which the overpayment was identified. Provider will notify CCO in writing of the reason for the overpayment.

SECTION 4
CCO REQUIREMENTS

4.1 Communications with Members. Members are entitled to the full range of their Providers' opinions and counsel about the availability of Medically Necessary Services under the provisions of the MississippiCHIP Program Contract. Any contractual provisions, including gag clauses or rules, that restrict a Provider's ability to advise Members about Medically Necessary treatment options violate federal law and regulations. CCO shall not prohibit or otherwise restrict Provider, when acting within the lawful scope of practice, from advising or advocating on behalf of a Member for the following:

i) The Member’s health status, medical care, or treatment options, including any alternative treatment that may be self-administered;

ii) Any information the Member needs in order to decide among all relevant treatment options;

iii) The risks, benefits, and consequences of treatment or non-treatment;

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

v) Information regarding the nature of treatment options including those that may not reflect CCO’s position or may not be covered by CCO.

CCO shall not prohibit a Provider from advocating on behalf of a Member in any grievance system,

utilization review process, or individual authorization process to obtain necessary health care services.

4.2 Prompt Payment. CCO shall pay Provider pursuant to the MississippiCHIP Program Contract and applicable State and federal law and regulations, including but not limited to Miss. Code Ann. §83-9-5, 42 CFR §447.46, 42 CFR §447.45(d)(2), 42 CFR §447.45(d)(3), 42 CFR §447.45(d)(5) and 42 CFR §447.45(d)(6), as applicable and as may be amended from time to time. If a third party liability exists, payment of claims shall be determined in accordance with federal and/or State third party liability law and the terms of the MississippiCHIP Program Contract. Unless CCO otherwise requests assistance from Provider, CCO will be responsible for third party collections in accordance with the terms of the MississippiCHIP Program Contract.

4.3 No Incentives to Limit Medically Necessary Services. CCO shall not structure compensation provided to individuals or entities that conduct utilization management and concurrent review activities so as to provide incentives for the individual or entity to deny, limit, or discontinue Medically Necessary services to any Member.

4.4 Provider Discrimination Prohibition. CCO shall not discriminate with respect to participation, reimbursement, or indemnification of a provider who is acting within the scope of the provider's license or certification under applicable State law, solely on the basis of such license or certification. CCO shall not discriminate against Provider for serving high-risk Members or if Provider specializes in conditions requiring costly treatments. This provision shall not be construed as prohibiting CCO from limiting a provider's participation to the extent necessary to meet the needs of Members. This provision also is not intended and shall not interfere with measures established by CCO that are designed to maintain quality of care practice standards and control costs. CCO shall not provide false or misleading information to any person or entity in an attempt to recruit Providers for CCO's network.

4.5 Termination, Revocation and Sanctions. In addition to its termination rights under the Agreement, CCO shall have the right to revoke any functions or activities CCO delegates to Provider under the Agreement or impose other sanctions consistent with the MississippiCHIP Program Contract if in CCO's reasonable judgment Provider's performance under the Agreement is inadequate. CCO shall also have the right to suspend, deny, refuse to renew or terminate the subcontract in accordance with the terms of the MississippiCHIP Program Contract and applicable law and regulation. However, CCO shall not exclude or terminate a Provider from participation in CCO's Provider Network due to the fact that the Provider has a practice that includes a substantial number of patients with expensive medical conditions, and shall not terminate a Provider for filing a Complaint, Grievance, or Appeal on a Member's behalf.

SECTION 5
OTHER REQUIREMENTS

5.1 Compliance with MississippiCHIP Program Contract. All tasks performed under the Agreement shall be performed in accordance with the requirements of the MississippiCHIP Program Contract, as applicable, as set forth in this Appendix, applicable provider manuals, and protocols, policies and procedures that CCO has provided or delivered to Provider. The applicable provisions of the MississippiCHIP Program Contract are incorporated into the Agreement by reference. Nothing in the Agreement or this Appendix relieves CCO of its responsibility under the

MississippiCHIP Program Contract. If any provision of the Agreement is in conflict with provisions of the MississippiCHIP Program Contract, the terms of the MississippiCHIP Program Contract shall control and the terms of the Agreement in conflict with those of the MississippiCHIP Program Contract will be considered waived.

5.2 Monitoring. In accordance with 42CFR § 457.950, CCO shall perform ongoing monitoring (announced or unannounced) of services rendered by Provider under the Agreement and shall perform periodic formal reviews of Provider according to a schedule established by the State, consistent with industry standards or State managed care organization laws and regulations or requirements under the MississippiCHIP Program Contract. As a result of such monitoring activities, and/or as a result of the inspecting, auditing and monitoring activities of DOM or other authorities pursuant to section 4.4 above, CCO shall identify to Provider any deficiencies or areas for improvement mandated under the MississippiCHIP Program Contract and Provider and CCO shall take appropriate corrective action within the relevant timeframe permitted, as applicable. Provider shall comply with any corrective action plan initiated by CCO and/or required by the MississippiCHIP Program. In addition, Provider shall monitor and report the quality of services delivered under the Agreement and initiate a plan of correction where necessary to improve quality of care, in accordance with that level of care which is recognized as acceptable professional practice in the respective community in which CCO and Provider practice and/or the performance standards established under the MississippiCHIP Program Contract.

5.3 Enrollment. The parties acknowledge and agree that DOM is responsible for enrollment, reenrollment and disenrollment of Members.

5.4 No Exclusivity. Nothing in the Agreement or this Appendix shall be construed as prohibiting or penalizing Provider for contracting with a managed care organization other than CCO or as prohibiting or penalizing CCO for contracting with other providers. The CCO may not require Providers who agree to participate in the MississippiCHIP Program to contract with the Contractor's other lines of business.

5.5 Revoking Delegation. The parties agree that, prior to execution of the Agreement, CCO evaluated Provider's ability to perform any duties delegated to Provider under the Agreement. Any delegated duties and reporting responsibilities shall be set forth in the Agreement or other written delegation agreement or addendum between the parties. In addition to its termination rights under the Agreement, CCO shall have the right to revoke any functions, assignment authority, or activities CCO delegates to Provider under the Agreement or impose other sanctions if in CCO's reasonable judgment Provider's performance under the Agreement is inadequate or untimely.

5.6 Rights of DOM. DOM shall have the right to invoke against Provider any remedy set forth in the MississippiCHIP Program Contract, including the right to require the termination of the Agreement, for each and every reason for which it may invoke such a remedy against CCO or require termination of the MississippiCHIP Program Contract. Suspected Fraud and Abuse by Provider will be investigated by DOM.

Mississippi
Regulatory Requirements Appendix

Mississippi Regulatory Requirements Appendix

This Mississippi Regulatory Requirements Appendix (the "Appendix") is made part of the agreement ("Agreement") entered into between **CCO,** contracting on behalf of itself, **HMO**, and the other entities that are CCO's Affiliates (collectively referred to as "CCO") and the health care professional or entity named in the Agreement ("Provider").

This Appendix applies to all products or benefit plans sponsored, issued or administered by or accessed through CCO to the extent such products are regulated under Mississippi laws; provided, however, that the requirements in this Appendix will not apply to the extent they are preempted by the Medicare Modernization Act or other applicable law.

CCO and Provider each agree to be bound by the terms and conditions contained in this Appendix. In the event of a conflict or inconsistency between this Appendix and any term or condition contained in the Agreement, this Appendix shall control, except with regard to Benefit Plans outside the scope of this Appendix.

If any of the capitalized terms in this Appendix are used or defined (or the equivalent terms are used or defined) in the Agreement, then the terms used in this Appendix will have the same meaning as the terms (or equivalent terms) used or defined in the Agreement. For example, "Benefit Plans," as used in this Appendix, will have the same meaning as "benefit contracts"; "Customer," as used in this Appendix, will have the same meaning as "member," "enrollee," or "covered person"; "Payer," as used in this Appendix, will have the same meaning as "participating entity"; "Provider," as used in this Appendix, will have the same meaning as "Facility," "Medical Group," "Ancillary Provider," "Physician," or "Practitioner." Additionally, if the Agreement uses pronouns to refer to the contracted entities, then "CCO" will have the same meaning as "we" or "us," and "Provider" will have the same meaning as "you" or "your."

This Appendix will be deemed to be updated to incorporate any changes to the laws and regulations referenced herein, including any changes to definitions referenced herein, effective as of the date of such changes.

1. Customer Hold Harmless and Continuation of Services. Provider agrees that in no event, including but not limited to nonpayment by CCO, Payer or intermediary, insolvency of CCO, Payer or intermediary, or breach of this Agreement, shall Provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against a Customer or a person (other than CCO, Payer or intermediary) acting on behalf of the Customer for services provided pursuant to this Agreement. This Agreement does not prohibit Provider from collecting coinsurance, deductibles or copayments, as specifically provided in the evidence of coverage, or fees for uncovered services delivered on a fee-for-service basis to Customers. Nor does this Agreement prohibit Provider (except for a health care professional who is employed full-time on the staff of CCO and has agreed to provide services exclusively to CCO's Customers and no others) and a Customer from agreeing to continue services solely at the expense of the Customer, as long as the provider has clearly informed the Customer that CCO or Payer

may not cover or continue to cover a specific service or services. Except as provided herein, this Agreement does not prohibit Provider from pursuing any available legal remedy.

In the event of CCO, Payer or intermediary insolvency or other cessation of operations, Covered Services to Customers will continue through the period for which a premium has been paid to CCO or Payer on behalf of the Customer or until the Customer's discharge from an inpatient facility, whichever time is greater. Covered Services to Customers confined in an inpatient facility on the date of insolvency or other cessation of operations will continue until their continued confinement in an inpatient facility is no longer medically necessary.

The provisions in this section 1 shall be construed in favor of the Customer, shall survive the termination of the Agreement regardless of the reason for termination, including the insolvency of CCO or Payer, and shall supersede any oral or written contrary agreement between Provider and a Customer or the representative of a Customer if the contrary agreement is inconsistent with the hold harmless and continuation of Covered Services provisions required by this section 1.

In no event shall Provider collect or attempt to collect from a Customer any money owed to Provider by CCO or Payer.

2. CCO Programs. As applicable, Provider shall comply with CCO's administrative policies and programs, including but not limited to terms, including payment, utilization review, quality assessment and improvement programs, credentialing, grievance procedures, data reporting requirements, confidentiality requirements and any applicable federal or state programs.

3. Treatment Options. CCO shall not prohibit Provider from discussing treatment options with Customers irrespective of CCO's position on the treatment options, or from advocating on behalf of Customers within the utilization review or grievance processes established by CCO or a person contracting with CCO.

4. Records. Provider shall make health records available to appropriate state and federal authorities involved in assessing the quality of care or investigating the grievances or complaints of Customers, and to comply with the applicable state and federal laws related to the confidentiality of medical or health records.

5. Termination. CCO and Provider shall provide advance written notice to each other in the form and for the length of time as provided in the Agreement but in no case less than sixty (60) before terminating the Agreement without cause. CCO shall make a good faith effort to provide written notice of a termination within thirty (30) days of receipt or issuance of a notice of termination to all Customers who are patients seen on a regular basis by Provider whose Agreement is terminating, irrespective of whether the termination was for cause or without cause. Where a contract termination involves a primary care professional, all Customers who are patients of that primary care professional shall also be notified. Within five (5) working days of the date that Provider either gives or receives notice of termination, Provider shall supply CCO with a list of those patients of Provider that are covered by a Benefit Plan subject to this Appendix.

6. Assignment. The rights and responsibilities under this Agreement shall not be assigned or delegated by Provider without the prior written consent of CCO.

7. Provision of Covered Services. Provider shall furnish Covered Services to all Customers without regard to the Customer's enrollment in the plan as a private purchaser of the plan or as a participant in publicly financed programs of health care services. This requirement does not apply to circumstances when Provider should not render services due to limitations arising from lack of training, experience, skill or licensing restrictions.

8. Coinsurance, Copayments and Deductibles. Provider shall collect applicable coinsurance, copayments or deductibles from Customers pursuant to the Benefit Plan and, as applicable, Provider shall notify Customers of their personal financial obligations for non-covered services.

9. No Penalty for Reporting to Authorities. CCO shall not penalize Provider because Provider, in good faith, reports to state or federal authorities any act or practice by CCO that jeopardizes patient health or welfare.

10. Definitions. To the extent a definition or other provision in the Agreement conflicts with the Benefit Plan or the Managed Care Plan Network Adequacy Regulation (the "Regulation"), the Benefit Plan or the Regulation will control.

11. Prompt Pay. Provider and CCO shall comply with the prompt payment requirements set forth in the Mississippi Code Section 83-9-5(1)(h). Claims will be paid within twenty-five (25) days after receipt where claims are submitted electronically, and within thirty-five (35) days after receipt where claims are submitted in paper format.

12. Reciprocal Time Limitations. If the Agreement includes a time limit in which Provider is required to submit a claim for payment, CCO or Payer shall have the same time limit following payment of the claim to perform any review or audit for reconsidering the validity of the claim and requesting reimbursement for payment of an invalid claim or overpayment of a claim. If CCO or Payer does not limit the time in which Provider is required to submit a claim for payment, CCO may not request reimbursement or offset another claim payment for reimbursement of an invalid claim or overpayment of a claim more than twelve (12) months after the payment of an invalid or overpaid claim. This provision does not apply to claims submitted in the context of misrepresentation, omission, concealment, or fraud by Provider.

13. Intermediaries. The following provisions apply to intermediaries as defined in the Regulation.

a) Intermediaries and participating providers with whom they contract shall comply with all the applicable requirements of sections 1-10 of this Appendix (section 14.06 of the Regulation).
b) CCO's statutory responsibility to monitor the offering of Covered Services to Customers shall not be delegated or assigned to the intermediary.

c) CCO shall have the right to approve or disapprove participation status of a subcontracted provider in its own or a contracted network for the purpose of delivering Covered Services to the carrier's Customers.
d) CCO shall maintain copies of all intermediary health care subcontracts at its principal place of business in the state, or ensure that it has access to all intermediary subcontracts, including the right to make copies to facilitate regulatory review, upon twenty (20) days prior written notice from CCO.
e) If applicable, an intermediary shall transmit utilization documentation and claims paid documentation to CCO. CCO shall monitor the timeliness and appropriateness of payments made to providers and health care services received by Customers.
f) If applicable, an intermediary shall maintain the books, records, financial information and documentation of services provided to Customers at its principal place of business in the state and preserve them in a manner that facilitates regulatory review.
g) An intermediary shall allow the commissioner access to the intermediary's books, records, financial information and any documentation of services provided to Customers, as necessary to determine compliance with the Regulation.
h) CCO shall have the right, in the event of the intermediary's insolvency, to require the assignment to CCO of the provisions of a provider's contract addressing the provider's obligation to furnish covered services.

Facility Participation Agreement

Facility Participation Agreement

This Agreement is entered into by and between CCO, contracting on behalf of itself, HMO, and the other entities that are CCO Affiliates (collectively referred to as "CCO") and _____ ("Facility").

This Agreement is effective on the later of the following dates (the "Effective Date"):

i) _____, ___ or

ii) the first day of the first calendar month that begins at least 30 days after the date when this Agreement has been executed by all parties.

Through contracts with physicians and other providers of health care services, CCO maintains one or more networks of providers that are available to Customers. Facility is a provider of health care services.

CCO wishes to arrange to make Facility's services available to Customers. Facility wishes to provide those services, under the terms and conditions set forth in this Agreement.

The parties therefore enter into this Agreement.

Article I
Definitions

The following capitalized terms in this Agreement have the meanings set forth below:

1.1 **Benefit Plan** means a certificate of coverage, summary plan description, or other document or agreement, whether delivered in paper or electronic format, under which a Payer is obligated to provide coverage of Covered Services for a Customer.

1.2 **Covered Service** is a health care service or product for which a Customer is entitled to receive coverage from a Payer, pursuant to the terms of the Customer's Benefit Plan with that Payer.

1.3 **Customary Charge** is the fee for health care services charged by Facility that does not exceed the fee Facility would ordinarily charge another person regardless of whether the person is a Customer.

1.4 **Customer** is a person eligible and enrolled to receive coverage from a Payer for Covered Services.

1.5 **Facility Records** are Facility's medical, financial and administrative records related to Covered Services rendered by Facility under this Agreement, including claims records.

1.6 **Payment Policies** are the guidelines adopted by CCO for calculating payment of claims to providers of health care services. The Payment Policies operate in conjunction with the specific reimbursement rates and terms set forth in this Agreement. The Payment Policies may change from time to time as described in section 5.1 of this Agreement.

1.7 **Payer** is an entity obligated to a Customer to provide reimbursement for Covered Services under the Customer's Benefit Plan, and authorized by CCO to access Facility's services under this Agreement.

1.8 **Protocols** are the programs and administrative procedures adopted by CCO or a Payer to be followed by Facility in providing services and doing business with CCO and Payers under this Agreement. Protocols may include, among other things, credentialing and recredentialing processes, utilization management and care management processes, quality improvement, peer review, Customer grievance, or concurrent review. Protocols may change from time to time as described in section 4.4 of this Agreement.

1.9 **Subcontractor** is an individual or entity contracted or otherwise engaged by a party to this Agreement.

1.10 **CCO Affiliates** are those entities controlling, controlled by, or under common control with CCO.

Article II
Representations and Warranties

2.1 **Representations and warranties of Facility**. Facility, by virtue of its execution and delivery of this Agreement, represents and warrants as follows:

i) Facility is a duly organized and validly existing legal entity in good standing under the laws of its jurisdiction of organization.

ii) Facility has all requisite corporate power and authority to conduct its business as presently conducted, and to execute, deliver and perform its obligations under this Agreement. The execution, delivery and performance of this Agreement by Facility have been duly and validly authorized by all action necessary under its organizational documents and applicable corporate law. This Agreement has been duly and validly executed and delivered by Facility and (assuming the due authorization, execution and delivery of this Agreement by CCO) constitutes a valid and binding obligation of Facility, enforceable against Facility in accordance with its terms, except as enforceability may be limited by the availability of equitable remedies or defenses and by applicable bankruptcy, insolvency, reorganization, moratorium or similar laws affecting the enforcement of creditors' rights generally.

iii) The execution, delivery and performance of this Agreement by Facility do not and will not violate or conflict with (a) the organizational documents of Facility, (b) any material agreement or instrument to which Facility is a party or by which Facility or any material part of its property is bound, or (c) applicable law.

iv) Facility has obtained and holds all registrations, permits, licenses, and other approvals and consents, and has made all filings, that it is required to obtain from or make with all governmental entities under applicable law in order to conduct its business as presently conducted and to enter into and perform its obligations under this Agreement.

v) Facility has been given an opportunity to review the Protocols and Payment Policies. See the Additional Manuals Appendix for additional information regarding the Protocols and Payment Policies applicable to Customers enrolled in certain Benefit Plans.

vi) Each submission of a claim by Facility pursuant to this Agreement will be deemed to constitute the representation and warranty by Facility to CCO that (a) the representations and warranties of Facility set forth in this section 2.1 and elsewhere in this Agreement are true and correct as of the date the claim is submitted, (b) Facility has complied with the requirements of this Agreement with respect to the Covered Services involved and the submission of the claim, (c) the charge amount set forth on the claim is the Customary Charge and (d) the claim is a valid claim.

2.2 Representations and warranties of CCO. CCO, by virtue of its execution and delivery of this Agreement, represents and warrants as follows:

i) CCO is a duly organized and validly existing legal entity in good standing under the laws of its jurisdiction of organization.

ii) CCO has all requisite corporate power and authority to conduct its business as presently conducted, and to execute, deliver and perform its obligations under this Agreement. The execution, delivery and performance of this Agreement by CCO have been duly and validly authorized by all action necessary under its organizational documents and applicable corporate law. This Agreement has been duly and validly executed and delivered by CCO and (assuming the due authorization, execution and delivery of this Agreement by Facility) constitutes a valid and binding obligation of CCO, enforceable against CCO in accordance with its terms, except as enforceability may be limited by the availability of equitable remedies or defenses and by applicable bankruptcy, insolvency, reorganization, moratorium or similar laws affecting the enforcement of creditors' rights generally.

iii) The execution, delivery and performance of this Agreement by CCO do not and will not violate or conflict with (a) the organizational documents of CCO, (b) any material agreement or instrument to which CCO is a party or by which CCO or any material part of its property is bound, or (c) applicable law.

iv) CCO has obtained and holds all registrations, permits, licenses, and other approvals and consents, and has made all filings, that it is required to obtain from or make with all governmental entities under applicable law in order to conduct its business as presently conducted and to enter into and perform its obligations under this Agreement.

Article III
Applicability of this Agreement

3.1 Facility's services.

i) This Agreement applies to Covered Services provided at Facility's service locations set forth in Appendix 1. If a service location is not listed in Appendix 1, this section 3.1 and this Agreement should nevertheless be understood as applying to Facility's actual service locations that existed when this Agreement was executed, rather than to a billing address, post office box, or any other address set forth in Appendix 1.

In the event Facility intends to begin providing services at other service locations or under other Taxpayer Identification Number(s), Facility will provide [60] days' advance notice to CCO. Those additional service locations or Taxpayer Identification Numbers will become subject to this Agreement only upon the written agreement of the parties. This subsection 3.1(i) applies to cases when Facility adds the location itself (such as through new construction or through conversion of a free-standing location to provider-based), and when Facility acquires, merges with or otherwise becomes affiliated with an existing provider that was not already under contract with CCO or a CCO Affiliate to participate in a network of health care providers.

ii) Facility will provide [60] days' advance notice to CCO in the event Facility intends to acquire or be acquired by, merge with, or otherwise become affiliated with another provider of health care services that is already under contract with CCO or a CCO Affiliate to participate in a network of health care providers. If one of these events occurs, this Agreement and the other agreement will each remain in effect and will continue to apply as they did prior to the acquisition, merger or affiliation, unless otherwise agreed to in writing by all parties to such agreements.

Similarly, Facility will provide [60] days' advance notice to CCO if Facility intends to buy assets of, or lease space from, a facility under contract directly with CCO or a CCO Affiliate to participate in a network of health care providers. If that occurs, and Facility provides services at that location, but does not assume the CCO contract held by the prior operator, Covered Services rendered at that location will be subject to the same rates and other key terms (including term and termination) as applied under the prior operator's contract.

iii) Facility will provide [60] days' advance notice to CCO in the event Facility intends to transfer all or some of its assets to another entity, with the result that all or some of the Covered Services subject to this Agreement will be rendered by the other entity rather than by Facility. In addition, Facility will request that CCO approve the assignment of this Agreement as it relates to those Covered Services, and if approved by CCO, Facility will ensure the other entity agrees to assume this Agreement. This subsection 3.1(iii) does not limit CCO's right under section 9.4 of this Agreement to elect whether to approve the assignment of this Agreement. This subsection 3.1(iii) applies to arrangements under which another provider intends to lease space from Facility, or intends to enter into a subcontract with Facility to perform services, after the Effective Date of this Agreement, so that Covered Services that were subject to this Agreement as of the Effective Date of this Agreement are rendered and billed instead by the other provider rather than by Facility after the lease or subcontract takes place.

3.2 Payers and Benefit Plans. CCO may allow Payers to access Facility's services under this Agreement for certain Benefit Plans, as described in Appendix 2. CCO may modify Appendix 2 without amendment to include or exclude Benefit Plans in Appendix 2 by providing 30 days prior written or electronic notice to Facility.

In addition to changes allowed above, CCO may make additional changes to Appendix 2 as described in section 3 of that appendix.

Section 8.3 of this Agreement will apply to Covered Services provided to Customers covered by Benefit Plans that are added to the list in Appendix 2 of Benefit Plans excluded from this Agreement as described above.

3.3 Patients who are not Customers. This Agreement does not apply to services rendered to patients who are not Customers at the time the services were rendered. Section 6.6 of this Agreement addresses circumstances in which claims for services rendered to those patients are inadvertently paid.

3.4 Health care. This Agreement and Benefit Plans do not dictate the health care provided by Facility, or govern Facility's determination of what care to provide patients, even if those patients are Customers. The decision regarding what care is to be provided remains with Facility and with Customers and their physicians, and not with CCO or any Payer.

3.5 Communication with Customers. Nothing in this Agreement is intended to limit Facility's right or ability to communicate fully with a Customer and the Customer's physician regarding the Customer's health condition and treatment options. Facility is free to discuss all treatment options without regard to whether or not a given option is a Covered Service. Facility is free to discuss with a Customer any financial incentives Facility may have under this Agreement, including describing at a general level the payment methodologies contained in this Agreement. Facility may also assist a Customer in estimating the cost of a given Covered Service.

Article IV
Duties of Facility

4.1 Provide Covered Services. Facility will provide Covered Services to Customers. Facility must be in compliance with section 2.1(iv) of this Agreement and, to the extent Facility is subject to credentialing by CCO, Facility must be credentialed by CCO or its delegate prior to furnishing any Covered Services to Customers under this Agreement.

4.2 Nondiscrimination. Facility will not discriminate against any patient, with regard to quality or accessibility of services, on the basis that the patient is a Customer.

4.3 Accessibility. Facility will be open 24 hours a day, seven days a week.

4.4 Protocols.

i) Facility will cooperate with and be bound by CCO's and Payers' Protocols. The Protocols include but are not limited to all of the following:

a) For non-emergency Covered Services, Facility will assist Customers to maximize their benefits by referring or directing Customers only to other providers that participate in CCO's network, except as otherwise authorized by CCO through CCO's process for approving out-of-network services at in-network benefit levels.

b) Facility will make reasonable commercial efforts to ensure that all Facility-based providers participate in CCO's network as long as this Agreement is in effect.

In the event that a Facility-based provider is not a participating provider with CCO, Facility's Chief Financial Officer or equivalent senior level officer ("Facility Representative") will assist CCO in its efforts to negotiate an agreement with that group. Upon request by CCO, Facility Representative will:

1) meet with Facility-based provider to encourage participation and require exchange of proposals. Facility Representative will provide CCO with meeting minutes within 15 days after the meeting. Meeting minutes will include a summary of the key discussion points and an outline of any actionable resolution options deemed by Facility Representative.

2) write letter(s) to Facility-based provider encouraging the group to negotiate in good faith with CCO. The letter will also outline any contractual requirements in the agreement between Facility and Facility-based provider that requires Facility-based provider to negotiate in good faith with third party payers, or participate in third

party payer networks, and any other provisions related to Facility-based provider's participation with third party payers.

3) invoke any applicable penalties or other contractual terms in its agreement with Facility-based provider related to its non-participating status with a third party payer.

4) allow independent legal counsel (mutually agreeable to all relevant parties) to review Facility's agreement with the Facility-based provider to ensure Facility is fully invoking all the relevant terms and conditions of that agreement to require or promote Facility-based provider's participation status with CCO.

CCO will negotiate with Facility-based providers in good faith. CCO has no responsibility for the credentialing of any employed or sub-contracted Facility-based provider.

c) As further described in the Protocols, Facility will provide notification and participate in utilization management programs regarding certain Covered Services, accept and return telephone calls from CCO staff, and respond to CCO requests for clinical information as required by CCO or Payer.

ii) **Availability of Protocols.** The Protocols will be made available to Facility online or upon request. Some or all Protocols also may be disseminated in the form of an administrative manual or guide or in other communications. Currently, the Protocols may be found at portal.com, or as indicated in the Additional Manuals Appendix, if applicable. CCO will notify Facility of any changes in the location of the Protocols.

i) **Changes to Protocols.** CCO may change the Protocols from time to time. CCO will use reasonable commercial efforts to inform Facility at least 30 days in advance of any material changes to the Protocols. CCO may implement changes in the Protocols without Facility's consent if the change is applicable to all or substantially all facilities of the same type offering similar services in CCO's network, and are located in the same state as Facility. Otherwise, changes to the Protocols proposed by CCO to be applicable to Facility are subject to the requirements regarding amendments in section 9.2 of this Agreement.

4.5 Employees and Subcontractors. Facility will ensure that its employees, affiliates and any individuals or entities subcontracted by Facility to render services in connection with this Agreement adhere to the requirements of this Agreement. The use of employees, affiliates or Subcontractors to render services in connection with this Agreement will not limit Facility's obligations and accountability under this Agreement with regard to those services. Facility affiliates are those entities that control, are controlled by or are under common control with Facility.

4.6 Licensure. Facility will maintain, without material restriction, such licensure, registration, and permits as are necessary to enable Facility to lawfully perform under this Agreement.

4.7 Liability insurance. Facility will procure and maintain liability insurance. Except to the extent coverage is a state mandated placement, Facility's coverage must be placed with insurance carriers that have an A.M. Best Rating of A-VII or better, and that are authorized or approved to write coverage in the state in which the Covered Services are provided. Facility's liability insurance must be, at a minimum, of the types and in the amounts set forth below. Facility's medical malpractice insurance must be either occurrence or claims made with an extended period reporting option of at least three years. Prior to the Effective Date of this Agreement and within 10 days of each policy renewal thereafter, Facility will submit to CCO in writing evidence of insurance coverage.

TYPE OF INSURANCE	MINIMUM LIMITS
Medical malpractice and/or professional liability insurance	$5,000,000.00 per occurrence/claim and aggregate
Commercial general and/or umbrella liability insurance	$5,000,000.00 per occurrence/claim and aggregate
[Automobile Liability	$5,000,000.00 - combined single limit]

[Substitute for high-risk providers:

TYPE OF INSURANCE	MINIMUM LIMITS
Medical malpractice and/or professional liability insurance	$10,000,000.00 per occurrence/claim and aggregate
Commercial general and/or umbrella liability insurance	$5,000,000.00 per occurrence/claim and aggregate
[Automobile Liability	$5,000,000.00 - combined single limit]

]

In lieu of purchasing the insurance coverage required in this section, Facility may self-insure any of the required insurance. Facility will maintain a separate reserve for its self-insurance. Prior to the Effective Date, Facility will provide a statement, verified by an independent auditor or actuary, that its reserve funding levels and process of funding appears adequate to meet the requirements of this section and fairly represents the financial condition of the fund. Facility will provide a similar statement during the term of this Agreement upon CCO's request, which will be made no more frequently than annually. Facility will assure that its self-insurance fund will comply with applicable laws and regulations.

4.8 Notice by Facility. Facility will give notice to CCO within 10 days after any event that causes Facility to be out of compliance with section 4.6 or 4.7 of this Agreement. Facility will give notice to CCO at least 30 days prior to any change in Facility's name, ownership, control, NPI, or Taxpayer Identification Number.

4.9 Customer consent to release of Facility Record information. Facility will obtain any Customer consent required in order to authorize Facility to provide access to requested Facility Records as contemplated in section 4.10 of this Agreement, including copies of the Facility's medical records relating to the care provided to Customer.

4.10 Maintenance of and access to records.

i) **Maintenance.** Facility will maintain Facility Records for at least [10] years following the end of the calendar year during which the Covered Services are provided, unless a longer retention period is required by applicable law.

ii) **Access to Agencies**. Facility will provide access to Facility Records to agencies of the government, in accordance with applicable law, to the extent access is necessary to comply with the requirements of such agencies as applicable to Facility, CCO or Payers.

iii) **Access to CCO.** Facility will provide CCO or its designees access to Facility Records for purposes of CCO's health care operations and other administrative obligations, including without limitation, utilization management, quality assurance and improvement, claims payment, and review or audit of Facility's compliance with the provisions of this Agreement and appropriate billing practices.

Facility will provide access to Facility Records by providing CCO electronic medical records ("EMR") access and electronic file transfer. When the requested Facility Records are not available through EMR access and electronic file transfer, Facility will submit those Facility Records through other means reasonably acceptable to CCO, such as facsimile, compact disc, or mail, that is suitable to the purpose for which CCO requested the Facility Records.

Facility Records provided by EMR access will be available to CCO on a 24 hour/7 day a week basis. Facility Records provided by electronic file transfer will be available to CCO within [24] hours of CCO's request for those Facility Records or a shorter time as may be required for urgent requests for Facility Records. Facility Records provided by other means will be available in the time frame specified in the request for the Facility Records; provided, however, Facility will have up to 14 days to provide the Facility Records for requests not related to urgent requests. Urgent requests are those requests for Facility Records to address allegations of fraud or abuse, matters related to the health and safety of a Customer, or related to an expedited appeal or grievance.

Facility may meet the requirements of this section 4.10 directly or through a subcontractor.

iv) **Audits.** Pursuant to paragraph (iii) above, CCO may request Facility Records from Facility for purposes of performing an audit of Facility's compliance with this Agreement, Facility's billing practices, or CCO's health care operations, including

without limitation claims payments. In addition, CCO may perform audits at Facility's locations upon 14 days' prior notice. Facility will cooperate with CCO on a timely basis in connection with any such audit including, among other things, in the scheduling of and participation in an interview to review audit findings, within 30 days after CCO's request.

v) When Facility has provided records through EMR access or file transfer, CCO will not request duplicative paper records from Facility.

vi) Facility will provide Facility Records free of charge**.**

4.11 Access to data. Facility represents that in conducting its operations, it collects and reviews certain quality data relating to care rendered by Facility that is reported in a manner which has been validated by a third party as having a clear, evidence-based link to quality or safety (e.g., AHRQ standards) or which has been created by employer coalitions as proxies for quality (e.g., Leapfrog standards).

CCO recognizes that Facility has the sole discretion to select the metrics which it will track from time to time and that Facility's primary goal in so tracking is to advance the quality of patient care. If the information that Facility chooses to report on is available in the public domain in a format that includes all data elements required by CCO, CCO will obtain quality information directly from the source to which Facility reported. If the Facility does not report metrics in the public domain, on a quarterly basis, Facility will share these metrics with CCO as tracked against a database of all discharged, patients (including patients who are not CCO customers). CCO may publish this data to entities to which CCO renders services or seeks to render services, and to Customers. Notwithstanding the foregoing, Facility agrees that it will participate in The Leapfrog Group's annual patient safety survey if Facility is among the hospitals Leapfrog seeks to survey.

4.12 Compliance with law. Facility will comply with applicable regulatory requirements, including but not limited to those relating to confidentiality of Customer medical information.

4.13 Electronic connectivity. When made available by CCO, Facility will do business with CCO electronically, including EMR access and connectivity, and HL7 admission discharge and transfer (ADT). Facility will use the CCO service tool, found at portal.com, and/or other electronic connectivity as available, to check eligibility status, claims status, and submit requests for claims adjustment for products supported by CCO's online resources and other electronic connectivity. Facility will use other tools for additional functionalities (for example, notification of admission, prior authorization and any other available transaction or viewing) after CCO informs Facility that these functionalities have become available for the applicable Customer.

4.14 Implementation of quality improvement and patient safety programs. Facility will implement quality programs applicable to Facility that are recommended by nationally recognized third parties (such as The Leapfrog Group and CMS), as designated by CCO from

time-to-time, such as The Leapfrog Group's programs related to Computer Physician Order Entry (CPOE), Evidence-based Hospital Referral (EHR), ICU Physician Staffing (IPS), and the 27 other patient safety practices arrived at by national consensus (National Quality Forum Safe Practices), as may be updated from time to time in the Protocols.

4.15 Never events. In the event a "never event" occurs in connection with Facility rendering services to a Customer, Facility will take the then current steps recommended by the Leapfrog Group. At present, these steps are set forth in the Leapfrog Group's "Position Statement on Never Events" (http://www.leapfroggroup.org) and are as follows:

i) Apologize to the patient and/or family affected by the never event.

ii) Report the event to CCO and to at least one of the following agencies: The Joint Commission, as part of its Sentinel Events policy; state reporting program for medical errors; or a Patient Safety Organization (e.g. Maryland Patient Safety Center).

iii) Perform a root cause analysis, consistent with instructions from the chosen reporting agency.

iv) Waive all costs directly related to the event. In order to waive such costs, Facility will not submit a claim for such costs to CCO or Payer (except as required by an applicable Payment Policy) and will not seek or accept payment for such costs from the Customer or anyone acting on behalf of the Customer.

v) Interview patients and/or families who are willing and able, to gather evidence for the root cause analysis.

vi) Inform the patient and/or his/her family of the action(s) that Facility will take to prevent future recurrences of similar events based on the findings from the root cause analysis.

vii) Have a protocol in place to provide support for caregivers involved in never events, and make that protocol known to all caregivers and affiliated clinicians.

viii) Perform an annual review to ensure compliance with each element of Leapfrog's Never Events Policy for each never event that occurred.

ix) Make a copy of this policy available to patients upon request.

For purposes of this section 4.15, a "never event" is an event included in the list of "serious reportable events" published by the National Quality Forum (NQF), as the list may be updated from time to time by the NQF and adopted by Leapfrog.

Additional Language:
[4.15] [4.16] [Service Standards. Facility will comply with the additional requirements in the attached Service Standards Exhibit.]

Article V
Duties of CCO and Payers

5.1 Payment of claims. As described in further detail in Article VI of this Agreement, Payers will pay Facility for rendering Covered Services to Customers. CCO will make its Payment Policies available to Facility online and upon request. CCO may change its Payment Policies from time to time, and will make information available describing the change.

5.2 Liability insurance. CCO will procure and maintain professional and general liability insurance and other insurance, as CCO reasonably determines may be necessary to protect CCO and CCO's employees against claims, liabilities, damages or judgments that arise out of services provided by CCO or CCO's employees under this Agreement.

5.3 Licensure. CCO will maintain, without material restriction, such licensure, registration, and permits as are necessary to enable CCO to lawfully perform this Agreement.

5.4 Notice by CCO. CCO will give written notice to Facility within 10 days after any event that causes CCO to be out of compliance with section 5.2 or 5.3 of this Agreement, or of any change in CCO's name, ownership, control, or Taxpayer Identification Number. This section does not apply to changes of ownership or control that result in CCO being owned or controlled by an entity with which it was already affiliated prior to the change.

5.5 Compliance with law. CCO will comply with applicable regulatory requirements, including but not limited to those relating to confidentiality of Customer medical information and those relating to prompt payment of claims, to the extent those requirements are applicable.

5.6 Electronic connectivity. As described in section 4.13 of this Agreement, CCO will do business with Facility electronically. CCO will communicate enhancements in its electronic connectivity functionality as they become available.

5.7 Employees and Subcontractors. CCO will assure that its employees, affiliates and any individuals or entities subcontracted by CCO to render services in connection with this Agreement adhere to the requirements of this Agreement. The use of employees, affiliates or Subcontractors to render services in connection with this Agreement will not limit CCO's obligations and accountability under this Agreement with regard to those services.

Article VI
Submission, Processing, and Payment of Claims

6.1 Form and content of claims. Facility must submit claims for Covered Services as described in the Protocols, using current, correct and applicable coding.

6.2 Electronic filing of claims. Within six months after the Effective Date of this Agreement, Facility will use electronic submission for all of its claims under this Agreement that CCO is able to accept electronically.

6.3 Time to file claims. Unless a longer timeframe is required under applicable law, all information necessary to process a claim must be received by CCO no more than 90 days from the date of discharge or from the date outpatient Covered Services are rendered. If Payer is not the primary payer on a claim, and Facility is pursuing payment from the primary payer, the period in which Facility must submit the claim will begin on the date Facility receives the claim response from the primary payer.

6.4 Payment of claims for Covered Services. Payer will pay claims for Covered Services according to the amount specified in the applicable Payment Appendix(ices) to this Agreement and in accordance with Payment Policies.

Claims for Covered Services subject to coordination of benefits will be paid in accordance with the Customer's Benefit Plan and applicable law.

The obligation for payment under this Agreement is solely that of Payer and not that of CCO unless CCO is the Payer.

6.5 Denial of claims for not following Protocols, for not filing timely, for Services not Covered under the Customer's Benefit Plan, or for lack of medical necessity.

A) This section 6.5(A) does not initially apply to the following Benefit Plans ("Excluded Benefit Plans"):

[(1) Benefit Plans administered by CCO Affiliate , Inc.]

[(1)][(2)] Benefit Plans listed in the Additional Manuals Appendix to this Agreement, if such Appendix is included in this Agreement.

Excluded Benefit Plans are subject to section 6.5(B) below. If in the future CCO modifies the utilization management program applicable to the Excluded Benefit Plans, so as to make that program consistent with the utilization management program that applies to the other Benefit Plans subject to this Agreement, CCO may cause this entire section 6.5(A) to apply to those Excluded Benefit Plans by giving 90 days written notice to Facility.

i) **Non-compliance with Protocol.** Compliance with Protocols and timely claim filing are conditions precedent to payment under this Agreement. CCO will, at its discretion, deny payment in whole or in part if Facility does not comply with a Protocol or does not file a timely claim as required under the Agreement.

In the event payment is denied under this subsection 6.5(A)(i) for Facility's failure to comply with a Protocol regarding notification or regarding lack of coverage approval on file, Facility may request reconsideration of the denial, and the denial under this subsection 6.5(A)(i) will be reversed if Facility can show:

a) the denial was incorrect because Facility complied with the Protocol; or
b) Facility's services were medically necessary (as "medically necessary" is defined in subsection 6.5(A)(vii)); or
c) at the time the Protocols required notification or prior authorization, Facility did not know and was unable to reasonably determine that the patient was a Customer, Facility took reasonable steps to learn that the patient was a Customer, and Facility promptly submitted a claim after learning the patient was a Customer.

The grounds stated in clause (b) above are also a basis for reconsideration of a denial under subsection (iii), (iv) or (v) of this section 6.5(A).

The grounds stated in clause (c) above are also a basis for reconsideration of a denial for lack of timely claim filing under section 6.3 of this Agreement.

A claim denied under this subsection 6.5(A)(i) is also subject to denial for other reasons permitted under the Agreement; reversal of a denial under this subsection 6.5(A)(i) does not preclude CCO from upholding a denial for one of these other reasons.

ii) **Non-Covered Services.** Services not covered under the applicable Benefit Plan are not subject to the rates or discounts of this Agreement. Facility may seek and collect payment from a Customer for such services (provided that Facility obtained the Customer's written consent), except as provided below in subsections 6.5(A)(iv), (v) and (vi).

If an inpatient service is not a Covered Service because a discharge order has been written by a physician treating the Customer but the Customer has elected to remain an inpatient, Facility may seek and collect payment from the Customer for those non-Covered Services, but only if, (a) prior to receiving the service, the Customer had knowledge of the discharge order and the lack of coverage for additional inpatient service and specifically agreed in writing to be responsible for payment of those charges; or (b) Facility maintains a written record of the Customer's refusal to agree in writing to be responsible for those charges.

iii) **Denials for lack of medical necessity through the prior authorization process.** If a service would otherwise be a Covered Service, but is not a Covered Service under the applicable Benefit Plan because it is determined through the prior authorization process to not meet the Benefit Plan's requirement of medical necessity, as defined in the Benefit Plan or applicable law (or not meet a similar concept in the Benefit Plan, such as not being consistent with nationally recognized scientific evidence as available, or not being consistent with prevailing medical standards and clinical guidelines), Facility may seek or collect payment from the Customer but only if, prior to receiving the service, the Customer had knowledge

of the determination of non-coverage and specifically agreed in writing to be responsible for payment of those charges.

iv) **Clinical review of inpatient bed days.** If a determination is made after a Customer becomes an inpatient that services are not medically necessary (including cases in which some days are determined to be medically necessary and additional days in the same admission are determined to not be medically necessary), the claim with regard to services that are not medically necessary (including room, board, and other services for a given day) may be denied and Facility must not seek or collect payment from the Customer. Payment will be made in accordance with the applicable payment appendix for the part of the admission that is determined to be medically necessary, and Facility may collect from the Customer the applicable copayment, deductible or coinsurance for that part of the admission. A claim may also be denied in whole or in part under this subsection 6.5(A)(iv) in cases in which services cannot be determined to be medically necessary due to omission of information or failure to respond timely to CCO's request for information; Facility may request reconsideration of such a denial on grounds of medical necessity.

CCO will not reduce payment under this subsection 6.5(A)(iv) when the contract rate for the claim is not impacted by the length of stay, because the contract rate is determined by an MS-DRG or similar methodology and is not subject to an inpatient outlier provision.

v) **Level of care determinations.** CCO may determine that the level of care provided for a given service was not medically necessary, because the service could appropriately have been rendered at a lower level of care (for instance, observation or ambulatory surgery rather than inpatient). If Facility submits a claim for the level of care deemed not medically necessary, CCO may deny the claim, and Facility will not seek or collect payment from the Customer. A claim may also be denied in whole or in part under this subsection 6.5(A)(v) in cases in which services cannot be determined to be medically necessary due to omission of information or failure to respond timely to CCO's request for information; Facility may request reconsideration of such a denial on grounds of medical necessity.

vi) **Delay in service.** If CCO determines that Facility did not execute a physician's written order (for instance, an admission order) in a timely manner and that, as a result, the Customer's inpatient stay was lengthened, CCO may deny the claims with regard to the bed day(s) at the end of the stay that would not have been needed were it not for the delay in service (including room, board and other services for the given day), and process the claim based on the contract rate that would apply without that day(s); Facility will not seek or collect payment from Customer in excess of the coinsurance, copayment or deductible associated with the claim as processed.

CCO will not reduce payment under this subsection 6.5(A)(vi) when the contract rate for a claim is not impacted by the length of stay, because the contract rate is

determined by an MS-DRG or similar methodology and is not subject to an inpatient outlier provision.

vii) **Definition.** As used in subsection 6.5(A)(iii), "medical necessity" or "medically necessary" will be defined in accordance with the applicable Benefit Plan and applicable law or regulatory requirements.

As used in subsections 6.5(A)(i), (iv) and (v), "medical necessity" or "medically necessary" is defined as follows:

Medically Necessary - health care services provided for the purpose of preventing, evaluating, diagnosing or treating a sickness, injury, substance use disorder, condition, disease or its symptoms, that are all of the following as determined by CCO or its designee, within its sole discretion.

- In accordance with *Generally Accepted Standards of Medical Practice.*
- Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the customer's sickness, injury, substance use disorder, disease or its symptoms.
- Not mainly for the Customer's convenience or that of the customer's physician or other health care provider.
- Not more costly than an alternative drug, service(s) or supply that is at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the Customer's sickness, injury, disease or symptoms.

Generally Accepted Standards of Medical Practice are standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials, or, if not available, observational studies from more than one institution that suggest a causal relationship between the service or treatment and health outcomes.

If no credible scientific evidence is available, then standards that are based on physician specialty society recommendations or professional standards of care may be considered. CCO reserves the right to consult expert opinion in determining whether health care services are Medically Necessary. The decision to apply physician specialty society recommendations, the choice of expert and the determination of when to use any such expert opinion, shall be within CCO's sole discretion.

B) This section 6.5(B) only applies to Excluded Benefit Plans.

Compliance with Protocols and timely claim filing are conditions precedent to payment under this Agreement. Payment will be denied in whole or in part if

Facility does not comply with a Protocol or does not file a timely claim as required under this Agreement. Payment may also be denied for services provided that are determined by CCO to be medically unnecessary, and Facility may not bill the Customer for such services unless the Customer has, with knowledge of CCO's determination of a lack of medical necessity, agreed in writing to be responsible for payment of those charges.

In the event that payment of a claim is denied for lack of notification or for untimely filing, the denial will be reversed if Facility appeals within 12 months after the date of denial and can show all of the following:

i) that, at the time the Protocols required notification or at the time the claim was due, Facility did not know and was unable to reasonably determine that the patient was a Customer,
ii) that Facility took reasonable steps to learn that the patient was a Customer, and
iii) that Facility promptly provided notification, or filed the claim, after learning that the patient was a Customer.

This Agreement does not apply to services not covered under the applicable Benefit Plan. Facility may seek and collect payment from a Customer for such services, provided that the Facility first obtains the Customer's written consent.

6.6 Retroactive correction of information regarding whether patient is a Customer. Prior to rendering services, Facility will ask the patient to present his or her Customer identification card. In addition, Facility may contact CCO to obtain the most current information available to CCO on the patient's status as a Customer.

However, such information provided by CCO is subject to change retroactively, under any of the following circumstances:

i) if CCO has not yet received information that an individual is no longer a Customer;
ii) if the individual's Benefit Plan is terminated retroactively for any reason including, but not limited to, non-payment of premium;
iii) as a result of the Customer's final decision regarding continuation of coverage pursuant to state and federal laws; or
iv) if eligibility information CCO receives is later proven to be false.

If Facility provides health care services to an individual, and it is determined that the individual was not a Customer at the time the health care services were provided, those services are not payable under this Agreement and any payments made with regard to those services may be recovered as overpayments under the process described in section 6.10 of this Agreement. Facility may then directly bill the individual, or other responsible party, for those services.

6.7 Payment under this Agreement is payment in full. Payment as provided under section 6.4 of this Agreement, together with any co-payment, deductible or coinsurance for which

the Customer is responsible under the Benefit Plan, is payment in full for a Covered Service. Facility will not seek to recover, and will not accept, any payment from Customer, CCO, Payer or anyone acting on their behalf, in excess of payment in full as provided in this section 6.7, regardless of whether that amount is less than Facility's billed charge or Customary Charge.

6.8 Customer hold harmless. Facility will not bill or collect payment from the Customer, or seek to impose a lien, for the difference between the amount paid under this Agreement and Facility's billed charge or Customary Charge, or for any amounts denied or not paid under this Agreement due to:

i) Facility's failure to comply with the Protocols,
ii) Facility's failure to file a timely claim,
iii) Payer's Payment Policies,
iv) inaccurate or incorrect claim processing,
v) insolvency or other failure by Payer to maintain its obligation to fund claims payments, if Payer is CCO, or is an entity required by applicable law to assure that its Customers not be billed in these circumstances, or
v) a denial based on lack of medical necessity or based on consistency with nationally recognized scientific evidence as available, and prevailing medical standards and clinical guidelines, except as provided in section 6.5 of this Agreement.

This obligation to refrain from billing Customers applies even in those cases in which Facility believes that CCO or Payer has made an incorrect determination. In such cases, Facility may pursue remedies under this Agreement against CCO or Payer, as applicable, but must still hold the Customer harmless.

Facility may seek payment directly from the Payer or from Customers upon 15 days prior notice to CCO, after Facility seeks and receives confirmation from CCO that the Payer is in default (other than a default covered by the above clause (v) of this section 6.8).For purposes of this paragraph, a default is a systematic failure by a Payer to fund claims payments related to Customers covered through that Payer. A default does not occur in the case of a dispute as to whether certain claims should be paid or the amounts that should be paid for certain claims.
This section 6.8 and section 6.7 will survive the termination of this Agreement, with regard to Covered Services rendered prior to when the termination takes effect.

6.9 Consequences for failure to adhere to Customer protection requirements. If Facility collects payment from, brings a collection action against, or asserts a lien against a Customer for Covered Services rendered (other than for the applicable co-payment, deductible or coinsurance), contrary to section 6.7 or 6.8 of this Agreement, Facility will be in breach of this Agreement. This section 6.9 will apply regardless of whether the Customer or anyone purporting to act on the Customer's behalf has executed a waiver or other document of any kind purporting to allow Facility to collect such payment from the Customer.

In the event of such a breach, Payer may deduct, from any amounts otherwise due Facility, the amount wrongfully collected from Customers, and may also deduct an amount equal to any costs or expenses incurred by the Customer, CCO or Payer in defending the Customer and otherwise enforcing sections 6.7 through 6.9 of this Agreement. Any amounts deducted by Payer in accordance with this provision will be used to reimburse the Customer and to satisfy any costs incurred. The remedy contained in this paragraph does not preclude CCO from invoking any other remedy for breach that may be available under this Agreement.

6.10 Correction of claims payments. If Facility does not seek correction of a given claim payment or denial by giving notice to CCO within 12 months after the claim was initially processed, it will have waived any right to subsequently seek such correction under this section 6.10, or through dispute resolution under Article VII of this Agreement or in any other forum.

Facility will repay overpayments within 30 days of written or electronic notice of the overpayment. Facility will promptly report any credit balance that it maintains with regard to any claim overpayment under this Agreement, and will return the overpayment to CCO within 30 days after posting it as a credit balance.

Recovery of overpayments may be accomplished by offsets against future payments.

Article VII
Dispute Resolution

The parties will work together in good faith to resolve any and all disputes between them ("Disputes") including but not limited to existence, validity, scope or termination of this Agreement or any term thereof, with the exception of any question regarding the arbitrability of the Dispute, and the availability of class arbitration or consolidated arbitration, which is expressly waived below. Disputes also include any dispute in which Facility is acting as the assignee of one or more Customer. In such cases, Facility agrees that the provisions of this Article VII will apply, including without limitation the requirement for arbitration.

If the Dispute pertains to a matter which is generally administered by certain CCO procedures, such as a credentialing or quality improvement plan, the policies and procedures set forth in that plan must be fully exhausted by Facility before Facility may invoke any right to arbitration under this Article VII. For Disputes regarding payment of claims, a party must have timely initiated, and completed, the claim reconsideration and appeal process as set forth in the Administrative Guide in order to initiate the Dispute process.

If the parties are unable to resolve any such Dispute within 60 days following the date one party sent written notice of the Dispute to the other party, and if either party wishes to pursue the Dispute, it may do so only by submitting the Dispute to binding arbitration conducted by the American Arbitration Association ("AAA") in accordance with the AAA Healthcare Payor Provider Arbitration Rules, as they may be amended from time to time (see http://www.adr.org), except

that, in any case involving a Dispute in which a party seeks an award of $1,000,000 or greater or seeks termination of this Agreement, a panel of three arbitrators will be used; a single arbitrator cannot award $1,000,000 or more or order that this Agreement is terminated. The arbitrator(s) will be selected from the AAA National Healthcare Roster (as described in the AAA Healthcare Payor Provider Arbitration Rules) or the AAA's National Roster of Arbitrators. Unless otherwise agreed to in writing by the parties, if the party wishing to pursue the Dispute does not initiate the arbitration within one year after the date on which written notice of the Dispute was given, or, for Disputes subject to the procedures or processes described in the previous paragraph, within one year after the completion of the applicable procedure or process, it will have waived its right to pursue the Dispute in any forum.

Any arbitration proceeding under this Agreement will be conducted in [name of county], [state]. The arbitrator(s) may construe or interpret but must not vary or ignore the terms of this Agreement and will be bound by controlling law. The arbitrator(s) have no authority to award punitive, exemplary, indirect or special damages, except in connection with a statutory claim that explicitly provides for that relief.

Except as may be required by law, neither a party (including without limitation, the parties' representatives, consultants and counsel of record in the arbitration), nor an arbitrator may disclose the existence, content, or results of any arbitration hereunder, or any Confidential Arbitration Information without the prior written consent of all parties. "Confidential Arbitration Information" means any written submissions in an arbitration by either party, discovery exchanged, evidence submitted, transcriptions or other records of hearings in the matter and any orders and awards issued, and any reference to whether either party won, lost, prevailed, or did not prevail against the other party in any arbitration proceeding, as well as any settlement agreement related to an arbitration. However, judgment on the award may be entered under seal in any court having jurisdiction thereof, by either party.

The parties expressly intend that any arbitration be conducted on an individual basis, so that no third parties may be consolidated or joined or allowed to proceed with class arbitration. The parties agree that any arbitration ruling allowing class arbitration, or requiring consolidated arbitration involving any third party(ies), would require immediate judicial review. Notwithstanding anything in this Agreement to the contrary, this paragraph may not be severed from Article VII of the Agreement under any circumstances, including but not limited to unlawfulness, invalidity or unenforceability.

The decision of the arbitrator(s) on the points in dispute will be binding. The parties acknowledge that because this Agreement affects interstate commerce the Federal Arbitration Act applies.

In the event any court determines that this arbitration procedure is not binding or otherwise allows litigation involving a Dispute to proceed, the parties hereby waive any and all right to trial by jury in, or with respect to, the litigation. The litigation would instead proceed with the judge as the finder of fact.

In the event a party wishes to terminate this Agreement based on an assertion of uncured material breach, and the other party disputes whether grounds for the termination exist, the matter will be resolved through arbitration under this Article VII. While the arbitration remains pending, the termination for breach will not take effect.

This Article VII will survive any termination of this Agreement.

Article VIII
Term and Termination

8.1 Term. This Agreement will take effect on the Effective Date. This Agreement has an initial term of [three] years and renews automatically for renewal terms of one year, until terminated pursuant to section 8.2 of this Agreement.

8.2 Termination. This Agreement may be terminated under any of the following circumstances:

i) by mutual written agreement of the parties;
ii) by either party, upon at least 180 days' prior written notice, effective at the end of the initial term or effective at the end of any renewal term;
iii) by either party, upon 60 days' prior written notice, in the event of a material breach of this Agreement by the other party, which notice will include a specific description of the alleged breach; however, the termination will not take effect if the breach is cured within 60 days' after notice of the termination, or if the termination is deferred under Article VII of this Agreement;
iv) by either party, upon 10 days' prior written notice, in the event the other party loses licensure or other governmental authorization necessary to perform this Agreement, or fails to have insurance as required under section 4.7 or section 5.2 of this Agreement;
v) by CCO, upon 10 days' prior written notice, in the event Facility loses accreditation; or
vi) by CCO, immediately upon written notice, in the event:
    a) Facility loses approval for participation under CCO's credentialing plan, or
    b) Facility does not successfully complete the CCO's re-credentialing process as required by the credentialing plan.

8.3 Ongoing Services to certain Customers after termination takes effect.

i) In the event a Customer is receiving any of the Covered Services listed below, as of the date the termination of this Agreement takes effect, Facility will continue to render those Covered Services to that Customer, and this Agreement will continue to apply to those Covered Services, after the termination takes effect, for the length of time indicated below:

Inpatient Covered Services	30 days or until discharge, whichever comes first
Pregnancy , Third Trimester – Low Risk	Through postpartum follow up visit
Pregnancy, First, Second or Third Trimester – Moderate Risk and High Risk	Through postpartum follow up visit
Non-Surgical Cancer Treatment	30 days or a complete cycle of radiation or chemotherapy, whichever is greater
End Stage Kidney Disease and Dialysis	30 days
Symptomatic AIDS undergoing active treatment	30 days
Ongoing services to Medicare Advantage Customers	As described below
Circumstances where Payer is required by applicable law to provide transition coverage of services rendered by Facility after Facility leaves the provider network accessed by Payer.	As applicable

ii) **Medicare Advantage Customers.** This section 8.3(ii) only applies if Facility participates in networks for Medicare Advantage Benefit Plans under this Agreement.

a) Ninety days prior to the effective date of the termination or expiration of this Agreement, CCO may remove Facility from any provider directory, online or in print, unless the parties agree otherwise.
b) To protect existing Medicare Advantage Customers who are patients of Facility from the disruption caused by the termination or expiration of this Agreement during the course of the Customer's Benefit Plan year, Facility will continue to provide Covered Services, and the terms of this Agreement will continue to apply, to Medicare Advantage Customers who have an existing relationship with Facility on the date the termination or expiration would be effective under the notice through the end of the calendar year. If the effective date of the termination or expiration would otherwise occur during the month of December, Facility will continue to provide Covered Services, and the terms of this Agreement will continue to apply, to such Medicare Advantage Customers through the end of the following calendar year. However, payment to Facility for such continued care, as described in this paragraph, will be the greater of the contract rate in place at the time the termination or expiration of the Agreement would have been effective, or 100% of CMS.

Section 8.3(b) does not apply if CCO has terminated this Agreement due to:
1) an uncured material breach,
2) Facility losing licensure or other governmental authorization necessary to perform this Agreement, or

3) Facility failing to have insurance as required under section 4.7 of this Agreement.

Article IX
Miscellaneous Provisions

9.1 Entire Agreement. In order for this Agreement to be binding, it must be executed by all parties through written or electronic signature. This Agreement is the entire agreement between the parties with regard to its subject matter, and supersedes any prior written or unwritten agreements between the parties or their affiliates with regard to the same subject matter.

9.2 Amendment. In order for an amendment to this Agreement to be binding, it must be executed by all parties through written or electronic signature, except as otherwise provided in this section 9.2.

Additionally, CCO may amend this Agreement upon written notice to Facility in order to comply with applicable regulatory requirements but only if that amendment is imposed on a similar basis to all or substantially all of the facilities in CCO's network that would be similarly impacted by the regulation in question. CCO will provide at least 30 days' notice of any such regulatory amendment, unless a shorter notice period is necessary in order to comply with regulatory requirements.

9.3 Nonwaiver. The waiver by either party of any breach of any provision of this Agreement will not operate as a waiver of any subsequent breach of the same or any other provision.

9.4 Assignment. This Agreement may not be assigned by either party without the written consent of the other party, except that this Agreement may be assigned by CCO to any CCO Affiliate.

Additionally, if CCO transfers to a third party all of its business described in a given line item in Appendix 2, section 1, or other line of business, CCO may assign this Agreement, only as it relates to that transferred business, to that third party. Such an assignment will not impact the relationship of the parties under this Agreement with regard to the remainder of CCO's business.

9.5 Relationship of the parties. The sole relationship between the parties to this Agreement is that of independent contractors. This Agreement does not create a joint venture, partnership, agency, employment or other relationship between the parties.

9.6 No third-party beneficiaries. CCO and Facility are the only entities with rights and remedies under this Agreement. Any claims, collection actions or disputes may not be assigned, transferred or sold by either party without the written consent of the other party.

9.7 Calendar days. Unless this Agreement specifically provides otherwise, all references in this Agreement to a period of days refers to calendar days.

9.8 Notice procedures. Any notice required to be given under this Agreement must be in writing, except in cases in which this Agreement specifically permits electronic notice, or as otherwise permitted or required in the Protocols. Acceptable forms of written notice include facsimile, first class mail, certified mail, or overnight delivery by a national, recognized delivery service. All notices of termination of this Agreement by either party must be sent by certified mail, return receipt requested, addressed to the appropriate party at the address set forth on the signature portion of this Agreement. Each party will provide the other with proper addresses, facsimile numbers and electronic mail addresses. All notices will be deemed received upon receipt by the party to which notice is given or on the 5th business day following mailing, whichever occurs first.

9.9 Confidentiality. Neither party may disclose to a Customer, other health care provider, or other third party any of the following information (except as required by an agency of the government):

i) any proprietary business information, not available to the general public, obtained by the party from the other party;
ii) the specific reimbursement amounts provided for under this Agreement, except for purposes of administration of benefits, including informing Customers, Benefit Plan sponsors and/or referring providers about the cost of a particular Covered Service or set of Covered Services; or
iii) any customer list of the other party regardless of how such customer list was generated.

This section 9.9 does not preclude the disclosure of information by CCO to a third party as part of the process by which the third party is evaluating administration of benefits or considering whether to purchase services from CCO.

At least 48 hours before either party issues a press release, advertisement, or other media statement about the business relationship between the parties, that party will give the other party a copy of the material the party intends to issue.

9.10 Governing law. This Agreement will be governed by and construed in accordance with the laws of the state in which Facility renders Covered Services, and any other applicable law.

9.11 Regulatory appendices. One or more regulatory appendices may be attached to this Agreement, setting forth additional provisions included in this Agreement in order to satisfy regulatory requirements under applicable law. These regulatory appendices, and any attachments to them, are expressly incorporated into this Agreement and are binding on the parties to this Agreement. In the event of any inconsistent or contrary language between a regulatory appendix and any other part of this Agreement, including but not limited to

appendices, amendments and exhibits, the regulatory appendix will control, to the extent it is applicable.

9.12 Severability. Except as otherwise set forth in this Agreement, any provision of this Agreement that is unlawful, invalid or unenforceable in any situation in any jurisdiction will not affect the validity or enforceability of the remaining provisions of this Agreement or the lawfulness, validity or enforceability of the offending provision in any other situation or jurisdiction.

9.13 Survival. Notwithstanding the termination of this Agreement, this Agreement will continue to apply to Covered Services rendered while this Agreement was in effect. Additionally, section 9.9 of this Agreement, (except for the last paragraph) will survive the termination of this Agreement.

9.14 Fines; Penalties. Facility will be responsible for any and all fines or penalties that may be assessed against CCO by any government agency that arise from Facility's failure to execute, deliver or perform its obligations under this Agreement.

THIS AGREEMENT CONTAINS A BINDING ARBITRATION PROVISION THAT MAY BE ENFORCED BY THE PARTIES.

[Name of Facility], as signed by its authorized representative:

Signature: _____

Print Name and Title: _____

Date: _____

Address to be used for giving notice to Facility under this Agreement:

Street: _____

City: _____

State: _____ Zip Code: _____

E-mail: _____

CCO, on behalf of itself, HMO, and the other entities that are CCO Affiliates, as signed by its authorized representative:

Signature: _____

Print Name: _____

Title: _____

Date: _____

Address to be used for giving notice to CCO under this Agreement:
Street: _____
City: _____
State: _____ *Zip Code:* _____

For office use only: [_____]
[_____]
Month, day and year in which Agreement is first effective: [_____]

Appendix 1
Facility Location and Service Listings

[Facility System Name]

IMPORTANT NOTES: Facility acknowledges its obligation under section 4.8 to promptly report any change in Facility's name, NPI or Taxpayer Identification Number. Failure to do so may result in denial of claims or incorrect payment.

The location where Covered Services will be rendered ("Service Location") MUST be listed in this Appendix.

FACILITY LOCATION - List BOTH the Service Location and the Billing Address for the Service Location	
Service Location	**Billing Address for the Service Location**
Facility Name	**Facility Name**
Street Address	**Street Address**
City	**City**
State and Zip Code	**State and Zip Code**
Phone Number	**Phone Number**
TIN	
National Provider ID (NPI)	

ADDITIONAL FACILITY LOCATIONS - List BOTH the Service Location and the Billing Address for the Service Location	
Service Location	**Billing Address for the Service Location**
Facility Name	**Facility Name**
Street Address	**Street Address**
City	**City**
State and Zip Code	**State and Zip Code**
Phone Number	**Phone Number**
TIN	

National Provider ID (NPI)	
Facility Name	**Facility Name**
Street Address	**Street Address**
City	**City**
State and Zip Code	**State and Zip Code**
Phone Number	**Phone Number**
TIN	
National Provider ID (NPI)	
Facility Name	**Facility Name**
Street Address	**Street Address**
City	**City**
State and Zip Code	**State and Zip Code**
Phone Number	**Phone Number**
TIN	
National Provider ID (NPI)	

Appendix 2
Benefit Plan Descriptions

Section 1. CCO may allow Payers to access Facility's services under this Agreement for the Benefit Plan types described in each line item below, unless otherwise specified in section 2 of this Appendix 2:

- [Mississippi Medicaid Benefit Plans.]

- [Mississippi CHIP Benefit Plans.]

Section 2. Notwithstanding the above section 1 of this Appendix 2, this Agreement will not apply to the Benefit Plan types described in the following line items:

- [Mississippi Medicaid Benefit Plans.]
- [Mississippi CHIP Benefit Plans.]
- Medicaid and CHIP Benefit Plans other than those separately addressed in this Appendix 2.

Note: Excluding certain Benefit Plans or programs from this Agreement does not preclude the parties or their affiliates from having or entering into a separate agreement providing for Facility's participation in a network for such Benefit Plans or programs.

Section 3. Definitions:

Note: CCO may adopt a different name for a particular Benefit Plan, and/or may modify information referenced in the definitions in this Appendix 2 regarding Customer identification cards. If that happens, section 1 or section 2 of this Appendix 2 will continue to apply to those Benefit Plans as it did previously, and CCO will provide Facility with the updated information. Additionally, CCO may revise the definitions in this Appendix 2 to reflect changes in the names or roles of CCO's business units, provided that doing so does not change Facility's participation status in Benefit Plans impacted by that change, and further provided that CCO provides Facility with the updated information.

MEDICAID, CHIP AND OTHER STATE PROGRAMS:

- **Medicaid Benefit Plans** means Benefit Plans that offer coverage to beneficiaries of a program that is authorized by Title XIX of the federal Social Security Act, and jointly financed by the federal and state governments and administered by the state.

- **Mississippi Medicaid Benefit Plans** means Medicaid Benefit Plans issued in Mississippi that have a reference to "CCO" on the valid identification card of any Customer eligible for and enrolled in that Benefit Plan.

- **Children's Health Insurance Program ("CHIP") Benefit Plans** means Benefit Plans under the program authorized by Title XXI of the federal Social Security Act that is jointly financed by the federal and state governments and administered by the state.

- **Mississippi CHIP Benefit Plans** means CHIP Benefit Plans issued in Mississippi that include a reference to "CCO" and "MSCHIP" on the face of the valid identification card of any Customer eligible for and enrolled in that Benefit Plan.

- **Other Governmental Benefit Plans** means Benefit Plans that are funded wholly or substantially by a state or district government or a subdivision of a state (such as a city or county), but do not include Benefit Plans for:
  i) employees of a state government or a subdivision of a state and their dependents;
  ii) students at a public university, college or school;
  iii) employer-based coverage of private sector employees, even if the employer receives a government subsidy to help fund the coverage;
  iv) Medicaid beneficiaries;
  v) Children's Health Insurance Program (CHIP) beneficiaries; and
  vi) Medicare and Medicaid Enrollees (MME).

Page intentionally left blank.

Additional Manuals Appendix

For some of the Benefit Plans for which Facility may provide Covered Services under this Agreement, Facility is subject to additional requirements of one or more additional provider manuals ("Additional Manuals"). When this Agreement refers to Protocols or Payment Policies, it is also referring to the Additional Manuals. An Additional Manual may be a separate document or it may be a supplement to the CCO Administrative Guide ("CCO Administrative Guide").

For Benefit Plans subject to an Additional Manual, the Additional Manual controls if it conflicts with any of the following: (1) a provision of this Agreement or of the CCO Administrative Guide; or (2) a CCO Protocol or Payment Policy. However, the Additional Manual does not control where it conflicts with applicable statutes or regulations.

The Additional Manuals will be made available to Facility on a designated website and upon request. The names of the Additional Manuals, the websites to view and download them, and the Benefit Plans to which they apply, are listed in Table 1 below. CCO may change the location of a website or the Customer identification card identifier used to identify Customers subject to a given Additional Manual; if CCO does so, CCO will inform Facility.

CCO may make changes to the Additional Manuals subject to this Appendix in accordance with the provisions of this Agreement relating to Protocol and Payment Policy changes.

Table 1

Benefit Plan(s)	**Description of Applicable Additional Manual**	**Website**
[No Additional Manuals Apply]		
[Mississippi CHIP Benefit Plans	CCO Administrative Guide for Mississippi Children's Health Insurance Program (CHIP)	portal.com]
[Mississippi Medicaid Benefit Plans	CCO Administrative Guide for Mississippi Medicaid	portal.com]

Mississippi Medicaid Program
Regulatory Requirements Appendix

MISSISSIPPI MEDICAID PROGRAM

REGULATORY REQUIREMENTS APPENDIX

PROVIDER

THIS MISSISSIPPI MEDICAID PROGRAM REGULATORY REQUIREMENTS APPENDIX (this "Appendix") supplements and is made part of the provider agreement (the "Agreement") between HMO ("HMO") or one of its Affiliates and the party named in the Agreement ("Provider").

SECTION 1
APPLICABILITY

The requirements of this Appendix apply to Medicaid benefit plans sponsored, issued or administered by HMO under the Mississippi Coordinated Access Network Program (the "MississippiCAN Program") governed by the State's designated regulatory agencies. In the event of a conflict between this Appendix and other appendices or any provision of the Agreement, the provisions of this Appendix shall control except with regard to benefit plans outside the scope of this Appendix or unless otherwise required by law. In the event HMO is required to amend or supplement this Appendix as required or requested by the State to comply with federal or State regulations, HMO will unilaterally initiate such additions, deletions or modifications. All provider agreements must be in writing and must include all specific activities and report responsibilities delegated to the Provider by HMO.

SECTION 2
DEFINITIONS

Unless otherwise defined in this Appendix, all capitalized terms shall be as defined in the Agreement. For purposes of this Appendix, the following terms shall have the meanings set forth below; provided, however, in the event any definition set forth in this Appendix or the Agreement is inconsistent with any definitions under the MississippiCAN Program, the definitions shall have the meaning set forth under the MississippiCAN Program.

2.1 **Adverse Benefit Determination:** The denial or limited authorization of a requested service, including determinations on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit; the reduction, suspension, or termination of previously authorized services; the denial, in whole or in part, of payment for a service; HMO's failure to provide services in a timely manner; HMO's failure to resolve Complaints, Grievances, or Appeals within the specified time frames; for residents in a rural area with only one MCO, the denial of a Covered Person's request to exercise his or her right, under 42 C.F.R. §438.52(b)(2)(ii); the denial of a Covered Person's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other enrollee financial liabilities; and determinations by skilled nursing facilities and nursing facilities to transfer or discharge residents and adverse determinations made by a State with regard to the preadmission screening and annual resident review requirements of Section 1919(e)(7) of the Act, if applicable.

2.2 **Affiliate:** Those entities controlling, controlled by, or under common control with HMO.

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

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

2.5 **CMS:** Center for Medicare and Medicaid Services is an agency within the U.S. Department of Health & Human Services responsible for administration of several key federal health care programs.

2.6 **Complaint:** An expression of dissatisfaction received orally or in writing that is of a less serious or formal nature that is resolved within one (1) business day of receipt.

2.7 **Covered Person:** An individual who meets all of the eligibility requirements for Mississippi Medicaid and is currently enrolled with HMO for the provision of services under a MississippiCAN Program. A Covered Person may also be referred to as an Enrollee, Member or Customer under the Agreement.

2.8 **Covered Services:** Health care services or products for which a Covered Person is enrolled with HMO to receive coverage under the State Contract, including all services required by the State Contract and State and federal law.

2.9 **DOM:** Division of Medicaid, Office of the Governor, State of Mississippi.

2.10 **Early, Periodic, Screening, Diagnosis, and Treatment (EPSDT) Services:** Defined by DOM to include:

i) Age appropriate, comprehensive health and development history that includes physician and mental health assessments along with counseling and anticipatory guidance and risk factor reduction interventions;
ii) Calculation of Body Mass Index;
iii) Growth measurements and head circumference;
iv) Nutritional counseling;
v) Developmental surveillance and Developmental and autism Spectrum Disorders Screenings as appropriate;
vi) Comprehensive unclothed exam;
vii) Appropriate laboratory tests (including blood level assessment appropriate to age and risk);

viii) Appropriate immunizations in accordance with Recommended Childhood and Adolescent Immunization Schedule adopted by DOM;
ix) A vision assessment;
x) A hearing assessment;
xi) A dental screening and/or referral to dental care;
xii) Health education; and
xiii) Referrals for identified abnormalities.

2.11 Fraud and Abuse: Fraud is any type of intentional deception or misrepresentation made by an entity or person with the knowledge that the deception could result in some unauthorized benefit to the entity, him or herself, or some other person. The Fraud can be committed by many entities, including a vendor, a subcontractor, a provider, a State employee, or a Covered Person, among others. Abuse is any practice that is inconsistent with sound fiscal, business, or medical practices, and results in an unnecessary cost to the Medicaid program, a vendor, a subcontractor or Provider or in reimbursement for services that are not Medically Necessary or that fail to meet professionally recognized standards for health care.

2.12 Grievance: An expression of dissatisfaction about any matter or aspect of HMO or its operation, other than an Adverse Benefit Determination as defined herein. Grievances may include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the Covered Person's rights regardless of whether remedial action is requested. Grievance includes a Covered Person's right to dispute an extension of time proposed by HMO to make an authorization decision.

2.13 Marketing: The activities that promote visibility and awareness for the MississippiCAN Program and HMO's participation in the program. All marketing activities are subject to prior review and approval by DOM and may not contain misleading information.

2.14 Medical Record: A single complete record, which documents the entire treatment plan developed for, and medical services received by, the Covered Person including inpatient, outpatient, referral services and emergency medical services whether provided by contracted Providers or non-contracted providers.

2.15 Mississippi Coordinated Access Network (MississippiCAN) Program: Mississippi Medicaid's coordinated care program for select Medicaid Beneficiaries.

2.16 Primary Care Provider (PCP): Any physician or health care practitioner or group operating within the scope of his or her licensure who is responsible for supervising, prescribing and providing primary care and primary case management services in the MississippiCAN Program, whose practice is limited to the general practice of medicine or who is an Internist, Pediatrician, Obstetrician, Gynecologist, Family Practitioner, General Practitioner, Certified Nurse Practitioners whose specialty is pediatrics, adult, family, certified nurse midwife, obstetrics/gynecology, or a physician assistant.

2.17 Prior Authorization: A determination to approve a Provider's request, pursuant to services covered in the MississippiCAN Program, to provide a service or course of

treatment of a specific duration and scope to a Member prior to the initiation or continuation of the service.

2.18 Provider Network: The Panel of health service Providers with which HMO contracts for the provision of covered services to Covered Persons and Non-Contracted Providers administering services to Covered Persons.

2.19 State: The State of Mississippi or its designated regulatory agencies.

2.20 State Contract: HMO's contract with the State for the purpose of providing and paying for Covered Services to Covered Persons enrolled in the MississippiCAN Program.

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

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

SECTION 3
PROVIDER REQUIREMENTS

The MississippiCAN Program, through the State Contract and federal and State statutes and regulations, requires the Agreement to contain certain conditions that HMO and Provider agree to undertake, which include the following:

3.1 Definitions Related to the Provision of Covered Services. Provider shall follow the applicable State Contract's requirements for the provision of Covered Services. Provider's decisions affecting the delivery of acute or chronic care services to Covered Persons shall be made on an individualized basis and in accordance with the following definitions:

i) Emergency Medical Condition: A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in any of the following: (a) 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; (b) serious impairment to body functions; or (c) serious dysfunction of any body organ or part.

ii) Emergency Services: Covered inpatient and outpatient services, inclusive of dialysis services, furnished by a provider who is qualified to furnish those health

services and that are needed to evaluate or stabilize an Emergency Medical Condition in accordance with 42 CFR 438.114.

iii) Medically Necessary Services: As set forth in the Social Security Act, Section 1905 (42 USC 1396d(a)), Medically Necessary Services are defined as services, supplies, or equipment provided by a licensed health care professional that are:

a) Appropriate and consistent with the diagnosis or treatment of the Covered Person's condition, illness, or injury;

b) In accordance with the standards of good medical practice consistent with the individual Covered Person's condition(s);

c) Not primarily for the personal comfort or convenience of the Member, family, or Provider;

d) The most appropriate services, supplies, equipment, or levels of care that can be safely and efficiently provided to the Covered Person;

e) Furnished in a setting appropriate to the Covered Person's medical need and condition and, when applied to the care of an inpatient, further mean that the Covered Person's medical symptoms or conditions require that the services cannot be safely provided to the Covered Person as an outpatient;

f) Not experimental or investigational or for research or education;

g) Provided by an appropriately licensed practitioner; and

h) Documented in the patient's record in a reasonable manner, including the relationship of the diagnosis to the service.

Medically Necessary Services may also be those services for children that are necessary to correct or ameliorate defects and physical and mental illnesses and conditions discovered during an interperiodic or periodic EPSDT screen, whether such services are covered or exceed the benefit limits in the Medicaid State Plan and Title 23 of Mississippi Administrative Code.

iv) Urgent Care: Urgent care services are utilized because the Covered Person's primary care physician is not available. An urgent condition is not life threatening but may need prompt attention. Urgent care services are for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe it requires emergency room care.

3.2 Provider Eligibility. Provider must be enrolled in the Mississippi Medicaid program and must use the same National Provider Identifier (NPI) number to participate in HMO's Network. Upon notification from the State that Provider's enrollment has been denied or terminated, HMO must terminate Provider immediately and will notify affected Covered Persons that Provider is no longer participating in the network. HMO will exclude from its

network any provider who has been terminated or suspended from the Medicare or Medicaid program in any state.

3.3 Accessibility Standards. Provider shall provide for timely access for Covered Person appointments in accordance with the appointment availability requirements established under the State Contract, as further described in the applicable provider manual.

Type	Appointment Scheduling Time Frames
PCP (well care visit)	Not to exceed thirty (30) calendar days
PCP (routine sick visit)	Not to exceed seven (7) calendar days
PCP (urgent care visit)	Not to exceed twenty-four (24) hours
Specialists	Not to exceed forty-five (45) calendar days
Dental Providers (routine visits)	Not to exceed forty-five (45) calendar days
Dental Providers (urgent Care)	Not to exceed forty-eight (48) hours
Behavioral Health Providers (routine visit)	Not to exceed fourteen (14) calendar days
Behavioral Health Providers (urgent visit)	Not to exceed twenty-four (24) hours
Behavioral Health Providers (post-discharge from an acute psychiatric hospital when the Contractor is aware of the Member's discharge)	Not to exceed seven (7) calendar days
Urgent Care Providers	Not to exceed twenty-four (24) hours
Emergency Providers	Immediately (twenty-four (24) hours a day, seven (7) days a week) and without Prior Authorization

3.4 Hours of Operation; Appointments. Provider shall offer hours of operation that are no less than the hours of operation offered to commercial beneficiaries or comparable to Medicaid fee-for-service if Provider serves only Medicaid beneficiaries. As applicable, Provider will make Covered Services available 24 hours a day, 7 days a week when medically necessary.

3.5 Hold Harmless. Except for any applicable cost-sharing requirements under the State Contract, Provider shall look solely to HMO for payment of Covered Services provided to Covered Persons pursuant to the Agreement and the State Contract and hold the State, DOM, the U.S. Department of Health and Human Services and Covered Persons harmless in the event that HMO cannot or will not pay for such Covered Services. In accordance with 42 CFR 447.15, as may be amended from time to time, the Covered Person is not liable to Provider for any services for which HMO is liable and as specified under the State's relevant health insurance or managed care statutes, rules or administrative agency guidance. Provider shall not require any copayment or cost sharing for Covered Services provided under the Agreement unless expressly permitted under the State Contract.

Provider shall also be prohibited from charging Covered Persons for missed appointments if such practice is prohibited under the State Contract or applicable law. Neither the State, DOM nor Covered Persons shall be in any manner liable for the debts and obligations of HMO and under no circumstances shall HMO, or any providers used to deliver services covered under the terms of the State Contract, charge Covered Persons for Covered Services.

Covered Person may be responsible for non-covered item(s) and/or service(s), only if the Provider ensures that written documentation in compliance with the Advance Beneficiary Notification (ABN) is received from the Covered Person that an item(s) or service(s) rendered is a non-covered item and/or service(s) and that the Covered Person will be financially responsible for the item(s) and/or service(s). If HMO determines a Covered Person was charged for Covered Services inappropriately, such payment may be recovered, as applicable.

This provision shall survive any termination of the Agreement, including breach of the Agreement due to insolvency.

3.6 Indemnification. To the extent applicable to Provider in performance of the Agreement, Provider shall indemnify, defend, protect, save and hold DOM and its employees and Covered Persons harmless from and against all injuries, deaths, losses, damages, claims, suits, liabilities, judgments, costs and expenses, including, without limitation, court costs, investigative fees and expenses and attorney fees, to the extent proximately caused by any negligent act or other intentional misconduct or omission of Provider, its agents, officers, employees or contractors arising from the Agreement. DOM may waive this requirement for public entities if Provider is a state agency or sub-unit as defined by the State or a public health entity with statutory immunity. This clause shall survive the termination of the Agreement for any reason, including breach due to insolvency.

3.7 Provider Selection. To the extent applicable to Provider in performance of the Agreement, Provider shall comply with 42 CFR 438.214, as may be amended from time to time, which includes, but is not limited to the selection and retention of providers, credentialing and recredentialing requirements and nondiscrimination. If HMO delegates credentialing to Provider, HMO will provide monitoring and oversight and Provider shall ensure that all licensed medical professionals are credentialed in accordance with HMO's and the State Contract's credentialing requirements.

3.8 Restrictions on Referrals. Provider shall not make inappropriate referrals for designated health services to health care entities with which Provider or a member of Provider's family has a financial relationship, pursuant to federal anti-kickback and physician self-referral laws that prohibit such referrals.

3.9 Records Retention. As required under State or federal law or the State Contract, Provider shall maintain an adequate record keeping system for recording services, charges, dates and all other commonly accepted information elements sufficient to disclose the quality, quantity, appropriateness and timeliness of services rendered to Covered Persons. All financial records shall follow generally accepted accounting principles. Medical records and supporting management systems shall include all pertinent information related to the

medical management of each Covered Person. Other records shall be maintained as necessary to clearly reflect all actions taken by Provider related to services provided under the State Contract. Such records, including, as applicable, grievance and appeal records shall be maintained for a period of not less than ten (10) years from the close of the Agreement, or such other period as required by law. If records are under review or audit, they must be retained for a minimum of ten (10) years following resolution of such action. Prior approval for the disposal of records must be requested and approved by HMO if the Agreement is continuous.

3.10 Records Access. Provider agrees to cooperate with HMO to maintain and share a health record of all services provided to a Covered Person, as appropriate and in accordance with applicable laws, regulations and professional standards. Provider acknowledges and agrees that the State, DOM, the U.S. Department of Health and Human Services and other authorized federal and state personnel shall have complete access to all records pertaining to services provided to Covered Persons. Provider shall provide immediate access to facilities, records and supportive materials pertinent to the State Contract for State or Federal fraud investigators. Copies of requested documents shall be provided to the State, DOM, the U.S. Department of Health and Human Services and other authorized federal and state personnel or their designees free of charge.

3.11 Government Audit; Investigations. Provider acknowledges and agrees that the State and the U.S. Department of Health and Human Services, the Centers for Medicare & Medicaid Services, the Office of Inspector General, the General Accounting Office, or any other auditing agency and their designees or their authorized representatives, with prior approval by DOM, shall, at all reasonable time, with or without notice, have the right to inspect, audit or otherwise evaluate the quality, appropriateness, and timeliness of services provided under the terms of the State Contract and any other applicable rules, including the right to inspect and audit any records or documents of Provider and its subcontractors, and the right to inspect the premises, physical facilities, and equipment where Medicaid-related activities or work is conducted. The right to audit under this section exists for 10 years from the end date of the State Contract or from the date of completion of any audit, whichever is later. There shall be no restrictions on the right of the State or federal government to conduct whatever inspections and audits are necessary to assure quality, appropriateness or timeliness of services provided pursuant to the State Contract and the reasonableness of their costs.

3.12 Privacy; HIPAA. Provider shall comply with all applicable privacy rule and security rule provisions of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), and associated implementing regulations, as may be amended from time to time, and shall safeguard information about Covered Persons in accordance with applicable federal and State privacy laws and rules including 42 CFR 438.224 and 42 CFR Part 431, Subpart F, as may be amended from time to time. HMO agrees and shall require Provider to agree that confidential information, including but not limited to medical and other pertinent information relative to Covered Persons, shall not be disclosed to any person or organization for any purpose without the expressed, written authority of DOM or as otherwise required by law and that all such disclosures shall fully comply with HIPAA privacy and security standards.

3.13 Compliance with Law. Provider shall comply with all applicable federal and State laws and regulations, and all provisions of the State Contract, that pertain to a Covered Person's rights, including but not limited to the following to the extent applicable to Provider in performance of the Agreement:

i) Title VI of the Civil Rights Act of 1964; Title XIX of the Social Security Act; 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 Genetic Information Non-Discrimination Act of 2008 (GINA); the Americans with Disabilities Act; section 1557 of the Patient Protection and Affordable Care Act, and their implementing regulations, as may be amended from time to time.

ii) All relevant federal and State statutes, regulations and orders related to equal opportunity in employment, including but not limited to compliance with E.O. 11246, "Equal Employment Opportunity," as amended by E.O. 11375, "Amending Executive Order 11246 Relating to Equal Employment Opportunity," and as supplemented by regulations at 41 CFR part 60, "Office of Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor."

iii) All federal and State professional and facility licensing and accreditation requirements/standards that apply to the services HMO and Provider perform pursuant to the Agreement, including but not limited to:

a) All applicable standards, orders or requirements issued under Section 306 of the Clean Air Act (42 USC 1857 (h)). Section 508 of the Clean Water Act (33 USC 1368), Executive Order 11738, and Environmental Protection Agency (EPA) regulations (40) CFR Part 15), which prohibit the use of facilities included on the EPA list of violating facilities. Any violations must be reported to DSHS, DHHS, and the EPA;

b) Any applicable mandatory standards and policies relating to energy efficiency that are contained in the State Energy Conservation Plan, including the Energy Policy & conservation Act (Pub. L. 94-165), and issued in compliance with the Federal Energy Policy & Conservation Act.

c) Those specified for laboratory services in the Clinical Laboratory Improvement Amendments (CLIA). All laboratory service sites must have a CLIA certificate of registration or waiver, and a CLIA identification number.

d) Section 1128B(d)(1) of the Balanced Budget Act of 1997; and,

e) Any other requirements associated with the receipt of federal funds.

iv) All Medicaid laws, regulations and program instructions to the extent applicable to Provider in Provider's performance of the Agreement. Provider understands that payment of a claim by HMO or the State is conditioned upon the claim and the underlying transaction complying with such laws, regulations, and program

instructions (including, but not limited to, federal requirements on fraud, waste and abuse, disclosure, debarment, termination and exclusion screening), and is conditioned on the Provider's compliance with all applicable conditions of participation in Medicaid. Provider understands and agrees that each claim the Provider submits to HMO constitutes a certification that the Provider has complied with all applicable Medicaid laws, regulations and program instructions in connection with such claims and the services provided therein. Provider's payment of a claim will be denied if Provider is terminated or excluded from participation in federal healthcare programs. Provider's payment of a claim may be temporarily suspended if the State or HMO provides notice that a credible allegation of fraud exists and there is a pending investigation. Provider's payment of a claim may also be temporarily suspended or adjusted if the Provider bills a claim with a code that does not match the service provided. HMO performs coding edit procedures based primarily on National Correct Coding Initiative (NCCI) policies and other nationally recognized and validated policies. Provider agrees that it will provide medical records to HMO upon its request in order to determine appropriateness of coding. Provider may dispute any temporarily suspended or adjusted payment consistent with the terms of the Agreement.

3.14 Physician Incentive Plans. In the event Provider participates in a physician incentive plan ("PIP") under the Agreement, Provider agrees that such PIPs must comply with 42 CFR 417.479, 42 CFR 438.3(i), 42 CFR 422.208, and 42 CFR 422.210, as may be amended from time to time. Neither HMO nor Provider may make a specific payment directly or indirectly under a PIP to a physician or physician group as an inducement to reduce or limit Medically Necessary services furnished to an individual Covered Person. PIPs must not contain provisions that provide incentives, monetary or otherwise, for the withholding of services that meet the definition of Medical Necessity.

3.15 Lobbying. Provider agrees to comply with the following requirements related to lobbying:

i) Prohibition on Use of Federal Funds for Lobbying: By signing the Agreement, Provider certifies to the best of Provider's knowledge and belief, pursuant to 31 U.S.C. Section 1352 and 45 CFR Part 93, as may be amended from time to time, that no federally appropriated funds have been paid or will be paid to any person by or on Provider's behalf for the purpose of influencing or attempting to influence an officer or employee of any agency, a member of Congress, an officer or employee of Congress, or an employee of a member of Congress in connection with the award of any federal contract, the making of any federal grant, the making of any federal loan, the entering into of any cooperative agreement, or the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan, or cooperative agreement.

ii) Disclosure Form to Report Lobbying: If any funds other than federally appropriated funds have been paid or will be paid to any person for the purpose of influencing or attempting to influence an officer or employee of any agency, a member of Congress, an officer or employee of Congress, or an employee of a member of Congress in connection with the award of any federal contract, the making of any federal grant, the

making of any federal loan, the entering into of any cooperative agreement, or the extension, continuation, renewal, amendment or modification of any federal contract, grant, loan, or cooperative agreement and the value of the Agreement exceeds $100,000, Provider shall complete and submit Standard Form-LLL, "Disclosure Form to Report Lobbying," in accordance with its instructions.

3.16 Excluded Individuals and Entities. Provider certifies that neither it nor any of its employees, principals, nor any providers, subcontractors or consultants or persons with an ownership or controlling interest in the Provider (an owner including the Provider himself or herself), or an agent or managing employee of the Provider, with whom Provider contracts and who are providing items or services that are significant and material to Provider's obligations under the Agreement is:

i) excluded from participation in federal health care programs under either Section 1128 or section 1128A of the Social Security Act; or

ii) debarred, suspended or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in nonprocurement activities under regulations issued under Executive Order no. 12549 or under guidelines implementing Executive Order No. 12549; or an affiliate, as defined in the Federal Acquisition Regulation, of such a person.

Provider acknowledges and agrees that payment will not be made for any items or Covered Services provided by an excluded individual pursuant to 42 CFR 1001.1901(b) and is obligated to screen all employees, contractors, and subcontractors for exclusion as required under applicable State and Federal laws. Additionally, Provider acknowledges that pursuant to 42 CFR 1003.102(a)(2) civil monetary penalties may be imposed against Provider if he or she employs or enters into contracts with excluded individuals or entities to provide items or Covered Services to Covered Persons under this Agreement. Provider agrees not to employ or subcontract with individuals or entities whose owner, those with a controlling interest, or managing employees are on a State or Federal exclusion list to provide items or Covered Services under this Agreement. Provider shall immediately report to HMO any exclusion information discovered. Provider can search the HHS-OIG website, at no cost, by the names of any individuals or entities. The database is called LEIE and can be accessed at http://www.oig.hhs.gov/fraud/exclusions.asp. The GSA EPLS/SAM database can be accessed at https://www.sam.gov. Federal and State exclusion databases must be reviewed monthly to ensure that no employee or contractor has been excluded. Applicable state exclusion databases can be accessed through the State's Medicaid website. HMO will terminate the Agreement immediately and exclude from its network any provider who has been excluded from federal health care programs or terminated from the Medicare or the Medicaid program in any state. HMO may also terminate the Agreement if Provider or Provider's owners, agents, or managing employees are found to be excluded on a State or Federal exclusion list.

3.17 Disclosure. Provider must be screened and enrolled in the State's Medicaid program and submit disclosures to the DOM related to ownership and control, significant business transactions, and persons convicted of crimes in accordance with 42 CFR Part 455 .Provider must submit information related to ownership and control of subcontractors or

wholly owned suppliers within thirty-five (35) calendar days of a request for such information in accordance with 42 CFR 455.105. Additionally, Provider must cooperate with DOM for submission of fingerprints upon a request from DOM or CMS in accordance with 42 CFR 455.434.

By executing this Agreement, Provider certifies that neither Provider nor any of its principals is presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in any State or federal health care program or from participating in transactions by any State or federal department or agency. HMO will terminate the Agreement upon becoming aware or receiving notice from DOM, whichever is earlier, that Provider is or has been excluded from participation in any State or federal health care program or by any State or federal agency.

3.18 Cultural Competency and Access. Provider shall participate in HMO's and the State's efforts to promote the delivery of services in a culturally competent manner to all Covered Persons, including those with limited English proficiency, physical or mental disabilities, diverse cultural and ethnic backgrounds and regardless of gender, sexual orientation or gender identity, and shall provide interpreter services in a Covered Person's primary language and for the hearing impaired for all appointments and emergency services. Provider shall provide information to Covered Persons regarding treatment options and alternatives, as well as information on complaints and appeals, in a manner appropriate to the Covered Person's condition and ability to understand. Provider shall provide physical access, reasonable accommodations, and accessible equipment for Covered Persons with physical or mental disabilities.

3.19 Marketing. As required under State or federal law or the applicable State Contract, any marketing materials developed and distributed by Provider as related to the performance of the Agreement must be submitted to HMO at least sixty (60) days prior to planned distribution for timely submission to DOM for prior approval. Provider agrees it will not proceed with the statement or communication until the required approval is obtained.

3.20 Fraud, Waste and Abuse Prevention. Provider shall cooperate fully with HMO's policies and procedures designed to protect program integrity and prevent and detect potential or suspected fraud, waste, and abuse in the administration and delivery of services under the State Contract and shall cooperate and assist DOM and any other State or federal agency charged with the duty of preventing, identifying, investigating, sanctioning or prosecuting suspected fraud, waste, and abuse in state and/or federal health care programs.

In accordance with HMO's policies and the Deficit Reduction Act of 2005 (DRA), Provider shall have written policies for its employees, contractors or agents that: (a) provide detailed information about the federal False Claims Act (established under sections 3729 through 3733 of title 31, United States Code), including if any entity makes or receives annual payments under the State Program of at least $5,000,000, such entity must establish certain minimum written policies and information communicated through an employee handbook relating to the Federal False Claims Act in accordance with 42 CFR 438.600; (b) cite administrative remedies for false claims and statements (established under chapter 38 of title 31, United States Code) and whistleblower protections under federal and state laws; (c) reference state laws pertaining to civil or criminal penalties for false claims

and statements; and (d) with respect to the role of such laws in preventing and detecting fraud, waste, and abuse in federal health care programs (as defined in section 1128B(f)), include as part of such written policies, detailed provisions regarding Provider's policies and procedures for detecting and preventing fraud, waste, and abuse. Provider agrees to train its staff on the aforesaid policies and procedures.

3.21 Data; Reports. Provider shall cooperate with and release to HMO any information necessary for HMO to perform its obligations under the State Contract to the extent applicable to Provider in performance of the Agreement, including the timely submission of reports and information required by HMO, in the format specified by HMO and the State. Such reports shall include child health check-up reporting, if applicable, as well as complete and accurate encounter data in accordance with the requirements of HMO and the State. Data must be provided at the frequency and level of detail specified by HMO or the State. By submitting data to HMO, Provider represents and attests to HMO and the State that the data is accurate, complete and truthful, and upon HMO's request Provider shall certify in writing, that the data is accurate, complete, and truthful, based on Provider's best knowledge, information and belief.

Provider shall be able to receive, maintain and utilize applicable data extracts from HMO or DOM and systematically update its database within five (5) calendar days of receipt of the files. Data extract files include but are not limited to the following, as applicable: 1. Daily Active Provider Extract; 2. Weekly Provider Affiliation Details Extract; 3. 834 Enrollment Files; 4. 835 Claims Payment Remittance Advice Transaction; 5. 277 Claims Acknowledgement; 6. NCPDP Formulary; 7. NCPDP Response File; 8. TPL Resource/Policy Information File, etc.; 9. Claims History Extracts; and 10. Prior Authorization Extracts.

3.22 Encounter Data. Provider agrees to cooperate with HMO to comply with HMO's obligation to prepare encounter data submissions, reports, and clinical information including, without limitation, child and adolescent health check-up reporting, EPSDT encounters, and cancer screening encounters, as applicable, and such other reporting regarding Covered Services as may be required under the State Contract. Encounter data must be accurate and include all services furnished to a Covered Person, including capitated provider's data and rendering provider information. Encounter data must be provided within the timeframes specified and in a form that meets HMO and State requirements. By submitting encounter data to HMO, Provider represents to HMO that the data is accurate, complete and truthful, and upon HMO's request Provider shall certify in writing, that the data is accurate, complete, and truthful, based on Provider's best knowledge, information and belief.

3.23 Claims Information. Provider shall promptly submit to HMO the information needed to make payment and shall identify third party liability coverage, including Medicare and other insurance, and if applicable seek such third party liability payment before submitting claims to HMO. Provider understands and agrees that each claim Provider submits to HMO constitutes a certification that the claim is true and accurate to the best of Provider's knowledge and belief and that the Covered Services are 1) Medically Necessary and 2) have been provided to the Covered Person prior to submitting the claim.

Effective July 1, 2014, Provider must submit claims within six (6) months from the date of service. Claims filed within the appropriate time frame but denied may be resubmitted to the Contractor within ninety (90) calendar days from the date of denial

3.24. Electronic Visit Verification. Provider shall cooperate with State requirements for electronic visit verification for personal care services and home health services, as applicable.

3.25 Licensure. Provider represents that it is currently licensed and/or certified under applicable State and federal statutes and regulations and by the appropriate State licensing body or standard-setting agency, as applicable. Provider represents that it is in compliance with all applicable State and federal statutory and regulatory requirements of the Medicaid program and that it is eligible to participate in the Medicaid program. Provider represents that it does not have a Medicaid provider agreement with DOM that is terminated, suspended, denied, or not renewed as a result of any action of DOM, CMS, HHS, or the Medicaid Fraud Control Unit of the State's Attorney General. Provider shall maintain at all times throughout the term of the Agreement all necessary licenses, certifications, registrations and permits as are required to provide the health care services and/or other related activities delegated to Provider by HMO under the Agreement. If at any time during the term of the Agreement, Provider is not properly licensed as described in this Section, Provider shall discontinue providing services to Covered Persons. As applicable, if Provider performs any laboratory tests on human specimens for the purpose of diagnosis and/or treatment, Provider agrees to acquire and maintain the appropriate CLIA certification or waiver for the type of laboratory testing performed. Provider further agrees to provide a copy of the certification if requested by HMO. A State authorized license or permit that meets the CLIA requirements may be substituted for the CLIA certificate pursuant to State law. Medicare and Medicaid programs require the applicable CLIA certification or waiver for the type of services performed as a condition of payment. Provider must include the appropriate CLIA certificate or waiver number on claims submitted for payment for laboratory services.

3.26 Quality; Utilization Management. Pursuant to any applicable provider manuals and related protocols, or as elsewhere specified under the Agreement, Provider agrees to cooperate with HMO's quality improvement and utilization review and management activities. This shall include, but not be limited to, participation in any internal and external quality assurance, utilization review, peer review, and grievance procedures established by HMO or as required under the State Contract to ensure that Covered Persons have due process for their complaints, grievances, appeals, fair hearings or requests for external review of adverse decisions made by HMO or Provider. Provider shall adhere to the quality assurance and utilization review standards of the MississippiCAN Program and shall monitor quality and initiate corrective action to improve quality consistent with the generally accepted level of care.

3.27 Non-Discrimination. Provider will not discriminate against, nor use any policy or practice that has the effect of discriminating against, Covered Persons on the basis of race, color, creed, sex, religion, age, national origin, ancestry, marital status, sexual orientation, gender identity, language, health status, disease or pre-existing condition (including genetic

information), anticipated need for health care or physical or mental handicap, except where medically indicated. Examples of prohibited practices include, but are not limited to, the following:

i) Denying or not providing a Covered Person any Medicaid Covered Service. Health care and treatment necessary to preserve life must be provided to all Covered Persons who are not terminally ill or permanently unconscious, except where a competent Covered Person objects to such care on his/her own behalf.

ii) Subjecting a Covered Person to segregated, separate, or different treatment, including a different place or time from that provided to other Covered Persons or public or private patients, in any manner related to the receipt of any Medicaid Covered Service, except where Medically Necessary.

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

3.28 Advance Directives. Provider shall comply with the advance directives requirements set forth in the Uniform Health-Care Decisions Act, Section 41-41-215 of the Mississippi Code. When applicable, Provider shall comply with the advance directives requirements for hospitals, nursing facilities, providers of home and health care and personal care services, hospices, and HMOs as specified in 42 CFR Part 49, subpart I, 42 CFR § 417.436(d), 42 CFR § 422.128, and 42 CFR 438.3(i).

3.29 National Provider ID (NPI). Provider shall obtain a National Provider Identification Number (NPI) and when filing claims with HMO, the NPI used is the same NPI used when filing claims with DOM.

3.30 Termination. In the event of termination of the Agreement, Provider shall promptly supply to HMO all information necessary for the reimbursement of any outstanding Medicaid claims.

3.31 Complaints; Grievances and Appeals. Information on how Provider or Provider's authorized representative can submit complaints and file grievances and appeals, and the resolution process, is contained in the applicable provider manual.

3.32 Health Care Acquired/Preventable Conditions. Provider agrees that no payment shall be made for the provision of medical assistance for health care acquired conditions and other provider preventable conditions as may be identified by the State. As a condition of payment, Provider shall identify and report to HMO any provider preventable conditions in accordance with 42 CFR §§ 434.6(a)(12), 438 including but not limited to 438.3(g), and 447.26.

3.33 Quality and Utilization Management Program. Provider shall cooperate with HMO in meeting the Quality Management and Utilization Management Program standards outlined

in the State Contract including, without limitation, any external evaluations and assessments of HMO's performance authorized by DOM under the State Contract and conducted by DOM's contracted External Quality Review Organization (EQRO) or other designee.

3.34 Referrals. Provider shall make referrals for social, vocational, education or human services when a need for such service is identified.

3.35 Insolvency. In the event HMO becomes insolvent or unable to pay Provider, Provider shall not seek compensation for services rendered from the State, DOM, their officers, Agents, or employees, or the Covered Persons or their eligible dependents.

3.36 Third Party Resources. Provider will report all third party resources to HMO identified through the provision of medical services.

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

3.38 Capitated Providers. If Provider is capitated and terminates its agreement with HMO, for any reason, Provider will provide services to Covered Persons assigned to Provider up to the end of the month in which the effective date of termination falls.

3.39 Certification on Relationship to State, DOM and CMS. Provider certifies that no officer, director, employee, subcontractor or agent of Provider, or person with an ownership or control interest in Provider, is also employed by, or is a public official of, the State of Mississippi or any of its agencies, DOM or CMS.

3.40 Funding. Provider recognizes that the obligation of DOM to proceed under its Contract with HMO is conditioned upon the appropriation of funds by the Mississippi State

Legislature and the receipt of State and/or Federal funds. If the funds anticipated for the continuing fulfillment of the agreement are, at any time, not forthcoming or insufficient, either through the failure of the Federal government to provide or the State of Mississippi to appropriate funds, or the discontinuance, or material alteration of the program under which the funds were provided or if funds are not otherwise available to DOM, DOM has the right upon ten (10) working days written notice to HMO to terminate the Contract.

3.41 Gratuities. Provider represents that it has not violated, is not violating, and promises that it will not violate the prohibitions against gratuities set forth in Section 6-204 (Gratuities) of the Mississippi Personal Service Contract Procurement Regulations.

3.42 Assignment/Delegation. Provider shall not assign or delegate the Agreement without the express written consent of HMO or DOM. If Provider subcontracts or delegates any functions of the Agreement, in accordance with the terms of the Agreement and with the express written consent of HMO or DOM, the subcontract or delegation must be in writing and include all of the requirements of this Appendix, and applicable requirements of the State Contract, and applicable laws and regulations. The transfer of five percent (5%) or more of the beneficial ownership in Provider at any time during the term of this Agreement shall be deemed an assignment under this Agreement.

3.43 Notice of Legal Action. Immediately upon obtaining knowledge or receiving notice of any legal action or notice listed below, Provider shall provide to HMO written notice of such legal action or notice and, upon request by HMO, a complete copy of all filings and other documents generated in connection with any such legal action:

i. Any action, suit or counterclaim filed against Provider;

ii. Any regulatory action, or proposed action, respecting Provider's business or operations;

iii. Any notice received by Provider from the Department of Insurance or the State Health Officer;

iv. The filing of a petition in bankruptcy by or against Provider, or the insolvency of Provider;

v. The conviction of any person who has an ownership or control interest in Provider, or who is an agent or managing employee of Provider, of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or Title XX of the Social Security Act; or

vi. A malpractice action against any Provider delivering service under an agreement.

3.44 Federal and State Funds Liability. Providers acknowledges and agrees that payments made to Provider for services provided under the Agreement are derived from federal and State funds and that any false claim or statement in documents or any concealment of material fact related to such services may be a cause for sanctions and prosecution under applicable federal and State laws. Provider shall be subject to all laws applicable to

individuals and entities receiving State and federal funds and may be held civilly or criminally liable to both HMO and DOM in the event of nonperformance, misrepresentation, fraud, or abuse related to services provided pursuant to the State Contract. Provider recognizes that payments made to the Provider are derived from federal and State funds, and are contingent upon and subject to availability and receipt of funds.

3.45 Insurance Requirements. As applicable, Provider shall secure and maintain during the term of the Agreement insurance appropriate to the services to be performed under the Agreement. Provider shall require that its providers secure and maintain during the term of the Agreement general liability insurance, professional liability insurance, and workers' compensation insurance for all employees connected with the provision of services under the Agreement. Such workers compensation insurance shall comply with Mississippi Workers' Compensation Laws. Such comprehensive general liability insurance and professional liability insurance shall provide coverage in an amount established by HMO pursuant to the Agreement or as required under the State Contract.

3.46 Overpayment. Provider shall to report to HMO when it has received an overpayment and will return the overpayment to HMO within 60 calendar days after the date on which the overpayment was identified. Provider will notify HMO in writing of the reason for the overpayment.

SECTION 4
ADDITIONAL PROVIDER REQUIREMENTS FOR SPECIFIC ACTIVITIES

4.1 Behavioral Health Providers. Behavioral Health Providers shall ensure that all Covered Persons receiving inpatient psychiatric services are scheduled for outpatient follow-up and/or continuing treatment prior to discharge from the inpatient psychiatric hospital if the Provider is aware of the Covered Person's inpatient hospitalization status. Behavioral Health Providers will be provided daily reports identifying Covered Persons known to be admitted to an inpatient facility. Behavioral Health Services will be delivered in compliance with the requirements of 42 CFR 438 subpart K insofar as those requirements are applicable.

4.2 PCP Responsibilities. Providers acting as PCPs shall meet the following requirements:

i) PCPs who serve Covered Persons under the age of twenty-one (21) are responsible for conducting all EPSDT screens for individuals on their Panel under the age of twenty-one (21). Should the PCP be unable to conduct the necessary EPSDT screens, the PCP is responsible for arranging to have the necessary EPSDT screens conducted by another network Provider and ensure that all relevant medical information, including the results of the EPSDT screens, are incorporated into the Covered Person's PCP Medical Record.

ii) PCPs who serve Members under the age of twenty-one (21) report encounter data associated with EPSDT screens, using a format approved by DOM, to the Contractor within ninety (90) calendar days from the date of service.

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

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

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

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

4.3 Specialists as PCPs. Covered Persons with disabling conditions, chronic illnesses, or child(ren) with special health care needs may request that their PCP be a specialist. The designation of a specialist as a PCP must be pursuant to a treatment plan approved by HMO, in consultation with the PCP to which the Covered Person is currently assigned, the Covered Person and, as appropriate, the specialist.

The specialist as a PCP shall provide or arrange for all primary care, including routine preventive care, and to provide those specialty medical services consistent with the Covered Person's disabling condition, chronic illness, or special health care need in accordance with HMO's standards and within the scope of the specialty training and clinical expertise.

The specialist as a PCP shall have admitting privileges at a hospital in HMO's network.

4.4 Long-Term Services and Supports (LTSS) Providers. Any LTSS Covered Services under the State Contract that could be authorized through a waiver under section 1915(c) of the Social Security Act (the "Act") or a State Program amendment authorized through sections 1915(i) or 1915(k) of the Act must be delivered in settings consistent with 42 CFR 441.301(c)(4).

SECTION 5
HMO REQUIREMENTS

5.1 Prompt Payment. HMO shall pay Provider pursuant to the State Contract and applicable State and federal law and regulations, including but not limited to Mississippi Code Section 83-9-5, 42 CFR 447.46, 42 CFR 447.45(d)(2), 42 CFR 447.45(d)(3), 42 CFR 447.45(d)(5) and 42 CFR 447.45(d)(6), as applicable and as may be amended from time to time. If a third party liability exists, payment of claims shall be determined in accordance with federal and/or State third party liability law and the terms of the State Contract. Unless HMO otherwise requests assistance from Provider, HMO will be responsible for third party collections in accordance with the terms of the State Contract.

5.2 No Incentives to Limit Medically Necessary Services. HMO shall not structure compensation provided to individuals or entities that conduct utilization management and concurrent review activities so as to provide incentives for the individual or entity to deny, limit, or discontinue Medically Necessary services to any Covered Person.

5.3 Provider Discrimination Prohibition. HMO shall not discriminate with respect to participation, reimbursement, or indemnification of a provider who is acting within the scope of the provider's license or certification under applicable State law, solely on the basis of such license or certification. HMO shall not discriminate against Provider for serving high-risk Covered Persons or if Provider specializes in conditions requiring costly treatments. This provision shall not be construed as prohibiting HMO from limiting a provider's participation to the extent necessary to meet the needs of Covered Persons. This provision also is not intended and shall not interfere with measures established by HMO that are designed to maintain quality of care practice standards and control costs.

5.4 Communications with Covered Persons. Covered Persons are entitled to the full range of their Providers' opinions and counsel about the availability of Medically Necessary Services under the provisions of the State Contract. Any contractual provisions, including gag clauses or rules, that restrict a Provider's ability to advise Covered Persons about Medically Necessary treatment options violate federal law and regulations.

HMO shall not prohibit or otherwise restrict Provider, when acting within the lawful scope of practice, from advising or advocating on behalf of a Covered Person for the following:

i) The Covered Person's health status, medical care, or treatment options, including any alternative treatment that may be self-administered;

ii) Any information the Covered Person needs in order to decide among all relevant treatment options;

iii) The risks, benefits, and consequences of treatment or non-treatment;

iv) The Covered Person's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions; or

v) Information regarding the nature of treatment options including those that may not reflect HMO's position or may not be covered by HMO.

HMO also shall not prohibit a Provider from advocating on behalf of a Covered Person in any grievance system, utilization review process, or individual authorization process to obtain necessary health care services.

5.5 Termination, Revocation and Sanctions. In addition to its termination rights under the Agreement, HMO shall have the right to revoke any functions or activities HMO delegates to Provider under the Agreement or impose other sanctions consistent with the State Contract if in HMO's reasonable judgment Provider's performance under the Agreement is inadequate. HMO shall also have the right to suspend, deny, refuse to renew or terminate

Provider in accordance with the terms of the State Contract and applicable law and regulation. However, HMO shall not exclude or terminate a Provider from participation in HMO's Provider Network due to the fact that the Provider has a practice that includes a substantial number of patients with expensive medical conditions, and shall not terminate a Provider for filing a Complaint, Grievance, or Appeal on a Covered Person's behalf.

5.6 Rights of DOM. DOM shall have the right to invoke against Provider any remedy set forth in the State Contract, including the right to require the termination of the Agreement, for each and every reason for which it may invoke such a remedy against HMO or require termination of the State Contract. Suspected Fraud and Abuse by Provider will be investigated by DOM.

SECTION 6
OTHER REQUIREMENTS

6.1 Compliance with State Contract. All tasks performed under the Agreement shall be performed in accordance with the requirements of the applicable State Contract, as set forth in this Appendix, applicable provider manuals, and protocols, policies and procedures that HMO has provided or delivered to Provider. The applicable provisions of the State Contract are incorporated into the Agreement by reference. Nothing in the Agreement relieves HMO of its responsibility under the State Contract. If any provision of the Agreement is in conflict with provisions of the State Contract, the terms of the State Contract shall control and the terms of the Agreement in conflict with those of the State Contract will be considered waived.

6.2 Monitoring. HMO shall perform ongoing monitoring (announced or unannounced) of services rendered by Provider under the Agreement and shall perform periodic formal reviews of Provider according to a schedule established by the State, consistent with industry standards or State managed care organization laws and regulations or requirements under the State Contract. As a result of such monitoring activities, HMO shall identify to Provider any deficiencies or areas for improvement mandated under the State Contract and Provider and HMO shall take appropriate corrective action. Provider shall comply with any corrective action plan initiated by HMO and/or required by the MississippiCAN Program. In addition, Provider shall monitor and report the quality of services delivered under the Agreement and initiate a plan of correction where necessary to improve quality of care, in accordance with that level of care which is recognized as acceptable professional practice in the respective community in which HMO and Provider practice and/or the performance standards established under the State Contract.

6.3 Enrollment. The parties acknowledge and agree that DOM is responsible for enrollment, reenrollment and disenrollment of Covered Persons.

6.4 No Exclusivity. Nothing in the Agreement or this Appendix shall be construed as prohibiting or penalizing Provider for contracting with a managed care organization other than HMO or as prohibiting or penalizing HMO for contracting with other providers. HMO may not require Providers who agree to participate in the MississippiCAN Program to contract with HMO's other lines of business.

6.5 **Delegation.** The parties agree that, prior to execution of the Agreement, HMO evaluated Provider's ability to perform any duties delegated to Provider under the Agreement. Any delegated duties and reporting responsibilities shall be set forth in the Agreement or other written delegation agreement or addendum between the parties. HMO shall have the right to revoke any functions or activities HMO delegates to Provider under the Agreement if in HMO's reasonable judgment Provider's performance under the Agreement is inadequate.

MississippiCHIP
Regulatory Requirements Appendix

MississipiCHIP

REGULATORY REQUIREMENTS APPENDIX

PROVIDER

THIS MISSISSIPPICHIP PROGRAM REGULATORY REQUIREMENTS APPENDIX (this "Appendix") supplements and is made part of the provider agreement (the "Agreement") between HMO contracting on behalf of itself and the other entities that are its affiliates (collectively, "CCO") and the party named in the Agreement ("Provider").

SECTION 1
APPLICABILITY

This Appendix applies with respect to the provision of direct or health care related services provided by Provider under the Mississippi Children's Health Insurance Program (the "MississippiCHIP Program") as governed by the State's designated regulatory agencies. In the event of a conflict between this Appendix and other appendices or any provision of the Agreement, the provisions of this Appendix shall control except with regard to benefit plans outside the scope of this Appendix or unless otherwise required by law. In the event CCO is required to amend or supplement this Appendix as required or requested by the State to comply with federal or State regulations, CCO will unilaterally initiate such additions, deletions or modifications. All provider agreements must be in writing and must include all specific activities and report responsibilities delegated to the Provider by CCO.

SECTION 2
DEFINITIONS

Unless otherwise defined in this Appendix, all capitalized terms shall be as defined in the Agreement. For purposes of this Appendix, the following terms shall have the meanings set forth below; provided, however, in the event any definition set forth in this Appendix or the Agreement is inconsistent with any definition under the MississippiCHIP Program Contract, the definition shall have the meaning set forth under the MississippiCHIP Program Contract.

2.1 **Abuse:** Any practice that is inconsistent with sound fiscal, business, or medical practices, and results in an unnecessary cost to CHIP, CCO, a subcontractor, or a provider or in reimbursement for services that are not Medically Necessary or that fail to meet professionally recognized standards for healthcare.

2.2 **Adverse Benefit Determination:** The denial or limited authorization of a requested service, including determinations on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit; the reduction, suspension, or termination of previously authorized services; the denial, in whole or in part, of payment for a service; CCO's failure to provide services in a timely manner; CCO's failure to resolve Complaints, Grievances, or Appeals within the specified time frames; for residents in a rural area with only one MCO, the denial of a Covered Person's request to exercise his or her right, under 42 C.F.R. §438.52(b)(2)(ii); the denial of a Covered Person's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other enrollee financial liabilities; and determinations by skilled nursing facilities and nursing facilities to transfer or discharge residents and adverse determinations made by a State with regard to the preadmission

screening and annual resident review requirements of Section 1919(e)(7) of the Act, if applicable.

2.3 **Agreement:** An agreement between the CCO and an individual, business, university, government entity, affiliate, or nonprofit organization to perform part or all of CCO's responsibilities under the MississippiCHIP Program Contract. Agreements must be approved in writing by DOM prior to the start date of the Agreement.

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

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

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

2.7 **Benchmark Plan:** The State School Employee's Health Insurance Plan.

2.8 **Child:** An individual who is under nineteen (19) years of age who is not eligible for Medicaid benefits and is not covered by other health insurance. Child is also referred to as Member.

2.9 **CHIP:** The Children's Health Insurance Program as defined in Title XXI of the Social Security Act.

2.10 **Complaint:** An expression of dissatisfaction received orally or in writing that is of a less serious or formal nature that is resolved within one (1) business day of receipt.

2.11 **Coordinated Care Organization (CCO):** An organization that meets the requirements for participation as a Contractor in CHIP and manages the purchase and provision of health care services under CHIP. For purposes of this Appendix, CCO is a CCO.

2.12 **Co-Payment:** The fixed amount certain CHIP Members pay for a covered health care service. The amount may vary based on healthcare service being provided.

2.13 **Cost Sharing:** In accordance with 42 C.F.R. §457.10, premium charges, enrollment fees, deductibles, coinsurance, Co-Payments, or other similar fees that the Member has responsibility for paying.

2.14 **Covered Services:** Health care services or products for which a Member is enrolled with CCO to receive coverage under the MississippiCHIP Program Contract, including all services required by the State Contract and State and federal law.

2.15 Disenrollment: Action taken by DOM, or its Agent, to remove a Member's name from the monthly Member Listing Report following DOM's receipt and approval of a request for Disenrollment or a determination that the Member is no longer eligible for Enrollment in Contractor.

2.16 DOM: The Division of Medicaid, Office of the Governor, State of Mississippi.

2.17 Fraud: Fraud is any type of intentional deception or misrepresentation made by an entity or person with the knowledge that the deception could result in some unauthorized benefit to the entity, him or herself, or some other person. The Fraud can be committed by many entities, including a vendor, a subcontractor, a provider, a State employee, or a Member among others.

2.18 Grievance: An expression of dissatisfaction about any matter or aspect of CCO or its operation, other than an Adverse Benefit Determination as defined herein. Grievances may include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the Covered Person's rights regardless of whether remedial action is requested. Grievance includes a Covered Person's right to dispute an extension of time proposed by CCO to make an authorization decision.

2.19 Marketing: The activities that promote visibility and awareness for the MississippiCHIP Program and the CCOs participating in the program. All marketing activities are subject to prior review and approval by DOM and may not contain misleading information.

2.20 Medical Record: A single complete record, which documents the entire treatment plan developed for, and medical services received by, the Member including inpatient, outpatient, referral services and emergency medical services whether provided by Contracted Providers or Non-Contracted Providers.

2.21 Member: An individual who meets all of the eligibility requirements for CHIP, enrolls in a CCO under CHIP, and receives health benefits coverage through CHIP.

2.22 MississippiCHIP Program: The Mississippi Medicaid child health program for select individuals under the age of nineteen (19) years of age who are not eligible for Medicaid benefits and are not covered by other health insurances.

2.23 MississippiCHIP Program Contract: The DOM contract with CCO, for the purpose of providing and paying for Covered Services to Members enrolled in the MississippiCHIP Program.

2.24 Primary Care Provider (PCP): Any physician or health care practitioner or group operating within the scope of his or her licensure who is responsible for supervising, prescribing and providing primary care and primary case management services in the MississippiCHIP Program, whose practice is limited to the general practice of medicine or who is an Internist, Pediatrician, Obstetrician/Gynecologist, Family and General Practitioner, Nurse Practitioners (who meet requirements of Section 4.B, Choice of a Health Care Professional), Physician Assistants, specialists who perform primary care functions upon request, and other providers approved by DOM.

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

2.26 Provider Network: The Panel of health service Providers with which the CCO contracts for the provision of covered services to Members and Non-Contracted Providers administering services to Member.

2.27 State: The State of Mississippi or its designated regulatory agencies.

2.28 State Child Health Plan: The State of Mississippi's plan submitted to HHS for the administration of CHIP.

2.29 Third Party Liability/Resource: Any resource available to a Member for the payment of medical expenses associated with the provision of covered services, including but not limited to, insurers and workers' compensation plan.

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

2.31 Well-Baby and Well-Child Care Services: Regular or preventive diagnostic and treatment services necessary to ensure the health of babies, children, and adolescents as defined by DOM in the State Child Health Plan. For the purposes of Cost Sharing, the term has the meaning assigned at 42 C.F.R. § 457.520.

SECTION 3
PROVIDER REQUIREMENTS

The MississippiCHIP Program, through contractual requirements and federal and State statutes and regulations, requires that providers who provide services to Members enrolled in the MississippiCHIP Program comply with certain requirements as set forth below and elsewhere in this Appendix.

3.1 Definitions Related to the Provision of Covered Services. Provider shall follow the applicable MississippiCHIP Program Contract's requirements for the provision of Covered Services. Provider's decisions affecting the delivery of acute or chronic care services to Members shall be made on an individualized basis and in accordance with the following definitions:

i) Emergency Medical Condition: In accordance with Section 1932(b) of the Act and 42 CFR §457.10, a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in any of the following: (1) 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; (2) serious impairment to body functions; or (3) serious dysfunction of any body organ or part.

ii) Emergency Services: Covered inpatient and outpatient services, inclusive of dialysis services, furnished by a provider who is qualified to furnish those health services and that

are needed to evaluate or stabilize an Emergency Medical Condition in accordance with 42 CFR 438.114.

iii) Medically Necessary Services: As set forth in the Social Security Act, Section 1905 (42 U.S.C. 1396d(a)), Medically Necessary Services are defined as services, supplies, or equipment provided by a licensed health care professional that are:

a) Appropriate and consistent with the diagnosis or treatment of the patient's condition, illness, or injury;

b) In accordance with the standards of good medical practice consistent with the individual patient's condition(s);

c) Not primarily for the personal comfort or convenience of the Member, family, or Provider;

d) The most appropriate services, supplies, equipment, or levels of care that can be safely and efficiently provided to the Member;

e) Furnished in a setting appropriate to the patient's medical need and condition and, when applied to the care of an inpatient, further mean that the Member's medical symptoms or conditions require that the services cannot be safely provided to the Member as an outpatient;

f) Not experimental or investigational or for research or education;

g) Provided by an appropriatelylicensed practitioner; and

h) Documented in the patient's record in a reasonable manner, including the relationship of the diagnosis to the service.

Medically Necessary Services may also be those services for children that are necessary to correct or ameliorate defects and physical and mental illnesses and conditions discovered during an interperiodic or Well-Baby and Well-Child Care Services, whether such services are covered or exceed the benefit limits in the Medicaid State Plan and Title 23 of Mississippi Administrative Code.

3.2 Accessibility Standards. Provider shall provide for timely access for Member appointments in accordance with the appointment availability requirements established under the MississippiCHIP Program Contract, as further described in the applicable provider manual.

Type	Appointment Scheduling Time Frames
PCP (well care visit)	Not to exceed thirty (30) calendar days
PCP (routine sick visit)	Not to exceed seven (7) calendar days
PCP (urgent care visit)	Not to exceed twenty-four (24) hours
Specialists	Not to exceed forty-five (45) calendar days

Dental Providers (routine visits)	Not to exceed forty-five (45) calendar days
Dental Providers (urgent Care)	Not to exceed forty-eight (48) hours
Behavioral Health Providers (routine visit)	Not to exceed fourteen (14) calendar days
Behavioral Health Providers (urgent visit)	Not to exceed twenty-four (24) hours
Behavioral Health Providers (post-discharge from an acute psychiatric hospital when the Contractor is aware of the	Not to exceed seven (7) calendar days
Urgent Care Providers	Not to exceed twenty-four (24) hours
Emergency Providers	Immediately (twenty-four (24) hours a day, seven (7) days a week) and without Prior

3.3 Hours of Operation; Appointments. Provider shall offer hours of operation that are no less than the hours of operation offered to commercial beneficiaries. As applicable, Provider will make Covered Services available 24 hours a day, 7 days a week when medically necessary.

3.4 PCP Responsibilities. If applicable, and Provider is a PCP, Provider shall comply with the following:

i) PCPs who serve Members under the age of nineteen (19) are responsible for conducting all Well-Baby and Well-Child Care services. Should the PCP be unable to conduct the necessary Well-Baby and Well-Child Care services screens, the PCP is responsible for arranging to have the necessary Well-Baby and Well-Child Care services screens conducted by another network provider and ensure that all relevant medical information, including the results of the Well-Baby and Well-Child Care services screens, are incorporated into the Member's PCP Medical Record.

ii) PCPs who serve Members under the age of nineteen (19) report encounter data associated with Well-Baby and Well-Child Care services, using a format approved by DOM, to Contractor within one hundred and eighty (180) calendar days from the date of service.

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

a) Contact Members identified in the quarterly Encounter lists as not complying with Well-Baby, Well-Child Care, and immunization schedules for Children;

b) Identify to Contractor any such Members who have not come into compliance with Well-Baby, Well-Child Care, and immunization schedules within one (1) month of such notification to the site by Contractor; and

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

iv) PCP shall provide Well-Baby and Well-Child Care Services, including vision screening, laboratory

tests and hearing screenings, according to recommendations of the U.S. Preventive Services Task Force. Vision and hearing screenings shall be included as part of periodic Well-Child assessments. PCP shall have written policies and procedures related to the provision of the full-range of Well-Baby Care, Well-Child Care, and childhood and adolescent immunization services as defined in, and in accordance with, the State Child Health Plan, 42 C.F.R. §457.495, and this provisions of the MississippiCHIP Program Contract. Services shall include, without limitation, 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). PCP shall make all reasonable efforts to identify all Members whose Medical Records do not indicate up-to-date immunizations and shall ensure that these Members receive necessary immunizations. Immunizations are purchased and distributed through the Mississippi State Department of Health. CCO shall reimburse PCP for the administration of the immunizations.

CCO requires that PCP cooperate to the maximum extent possible with the efforts to improve the health status of Mississippi citizens, and to actively work to improve the percentage of Members receiving appropriate screenings, and meet or exceed DOM's targets.

a) The following minimum elements must be included in the periodic health screening assessment of children:

i. Comprehensive health and development history (including assessment of both physical and mental development);

ii. Measurements (e.g. head circumference for infants, height, weight, body mass index);

iii. Comprehensive unclothed physical examination;

iv. Immunizations appropriate to age and health history;

v. Assessment of nutritional status;

vi. Laboratory tests (including tuberculosis screening and Federally required blood lead screenings);

vii. Vision screening;

viii. Hearing screening;

ix. Dental and oral health assessment; and

x. Developmental and behavioral assessment.

v) If a suspected problem is detected by a screening examination, the child must be evaluated as necessary for further diagnosis. This diagnosis is used to determine treatment needs. PCP must establish a tracking system that provides information on compliance with Well-Baby and Well-Child Care services and immunization services provision requirements in the following areas:

a) Initial visit for newborns;

b) Well-Baby and Well-Child Care services and reporting of all assessment results; and

c) Diagnosis and/or treatment for Children.

vi) PCP must have an established process for reminders, follow-ups and outreach to Members that includes:

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

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

c) Protocols for conducting outreach with non-compliant Members, including home visits, as appropriate; and

d) A process for outreach and follow-up to Members with special health care needs.

vii) PCP may develop an alternate process for follow-up and outreach subject to prior written approval from CCO and DOM.

viii) **Specialists as PCPs**. Members with disabling conditions, chronic conditions, or with special health care needs may request that their PCP be a specialist. The designation of a specialist as a PCP must be pursuant to a treatment plan approved by Contractor; in consultation with the PCP to which the Member is currently assigned, the Member and, as appropriate, the specialist. When possible, the specialist must be a provider participating in Contractor's network. The specialist as a PCP must agree to provide or arrange for all primary care, including routine preventive care, and to provide those specialty medical services consistent with the Member's disabling condition, chronic illness, or special health care need in accordance with Contractor's standards and within the scope of the specialty training and clinical expertise. To accommodate the full spectrum of care, the specialist as a PCP must also have admitting privileges at a hospital in Contractor's network.

3.5 Provider Selection. To the extent applicable to Provider in performance under the Agreement, Provider shall comply with 42 CFR §438.214, as may be amended from time to time, which includes, but is not limited to the selection and retention of providers, credentialing and re-credentialing requirements and nondiscrimination. If CCO delegates credentialing to Provider, CCO will provide monitoring and oversight and Provider shall ensure that all licensed medical professionals are credentialed in accordance with CCO's and the MississippiCHIP Program Contract's credentialing requirements.

3.6 Records Retention. As required under State or federal law or the MississippiCHIP Program Contract, Provider shall maintain a record keeping system of current, detailed, and organized records for recording services, charges, dates and all other commonly accepted information elements sufficient to disclose the quality, quantity, appropriateness and timeliness of services rendered to Members. All financial records shall follow generally accepted accounting principles. Medical records and supporting management systems shall include all pertinent information related to the medical management of each Member. Other records shall be maintained as necessary to clearly reflect all actions taken by Provider related to services provided under the MississippiCHIP Program Contract. Such records, including, as applicable, grievance and appeals records shall be maintained for a period of not less than ten (10) years from the close of the Agreement, or such other period as required by law. If records are under review or audit or are the subject of litigation they must be retained for a minimum of ten (10) years following resolution of such action. Prior approval for the disposal of records must be requested and approved by CCO if the Agreement is continuous. Provider shall have written records retention policies and procedures and will make such policies and procedures available to CCO or DOM upon request. DOM requires ready access to any and all documents and records of transactions pertaining to the provisions of services provided by Provider and those copies of requested documents/records will be provided to DOM or its designee free of charge.

3.7 **Records Access.** Provider agrees to cooperate with CCO to maintain and share a health record of all services provided to a Covered Person, as appropriate and in accordance with applicable laws, regulations and professional standards. Provider acknowledges and agrees and shall require Provider to acknowledge and agree that DOM, the U.S. Department of Health and Human Services and other authorized federal and state personnel shall have complete access to all records pertaining to services provided to Members. Provider shall provide immediate access to facilities, records and supportive materials pertinent to the MississippiCHIP Program Contract for State or Federal fraud investigators.

3.8 **Government Audit; Investigations.** Provider acknowledges and agrees and shall require Provider to acknowledge and agree that the State or any of its duly authorized representatives, DOM, the U.S. Department of Health and Human Services, the Centers for Medicare & Medicaid Services, the Office of Inspector General, the General Accounting Office, or any other auditing agency or their authorized representatives and their designees, with prior approval by DOM, at any time during the term of the Agreement, shall, at all reasonable time and within regular business hours, with or without notice, have the right to inspect, audit or otherwise evaluate the quality, appropriateness, and timeliness of services provided under the terms of the MississippiCHIP Program Contract and any other applicable federal and State law and regulation.

This shall include, but not be limited to, the right to enter onto Provider's premises, access to and the right to audit, inspect, monitor, and examine any pertinent books, documents, papers, medical records, financial records, surveys and computer databases and/or to otherwise evaluate the performance of Provider related to Provider's performance under the Agreement. Such monitoring activities may also include, without limitation, on-site inspections of all service locations and facilities; auditing and/or review of all records developed under the MississippiCHIP Program Contract or the Agreement; reviewing management systems and procedures developed under the MississippiCHIP Program Contract or the Agreement; and review of any other areas of materials relevant or pertaining to the MississippiCHIP Program Contract or the Agreement. All reviews and audits shall be performed in such a manner as will not unduly delay the work of Provider. There will be no restrictions on the right of the State or federal authorities to conduct inspections and audits as necessary.

The Provider must fully cooperate with any and all reviews and/or audits by state or federal agencies, such as the Department of Audit, Department of Health and Human Services, Centers for Medicare and Medicaid Services, Office of Inspector General, General Accounting Office, or any other auditing agency approved by DOM, by assuring that appropriate employees and involved parties are available for interviews relating to the reviews or audits.

All records shall be maintained and available for review by authorized federal and state agencies during the entire term of the MississippiCHIP Program Contract and for a period of ten (10) years thereafter, unless an audit, litigation, or other legal action is in progress. When an audit or litigation is in progress or audit findings are unresolved, records shall be kept for a period of ten (10) years or until all issues are finally resolved, whichever is later. The Provider must have written policies and procedures for storing this information. Records must be kept in an original paper state or preserved on micro media or electronic format.

3.9 **Data; Reports.** Provider shall and shall require that Provider cooperate with and release to CCO any information necessary for CCO to perform its obligations under the MississippiCHIP Program Contract to the extent applicable to Provider in performance of the Agreement, including the timely submission of reports and information required by CCO, in the format specified by CCO and the State. Such reports shall include well-baby/well-child reporting, as well as complete and accurate encounter and utilization management data in accordance with the requirements of CCO and DOM. Data must be provided at the frequency and level of detail specified by CCO or the State. By submitting data to CCO, Provider represents and attests to CCO and the State that the data is accurate, complete and truthful, and upon

CCO's request Provider shall certify in writing, that the data is accurate, complete, and truthful, based on Provider's best knowledge, information and belief.

Provider shall be able to receive, maintain and utilize applicable data extracts from CCO or DOM and systematically update its database within five (5) calendar days of receipt of the files. Data extract files include but are not limited to the following, as applicable: 1. Daily Active Provider Extract; 2. Weekly Provider Affiliation Details Extract; 3. 834 Enrollment Files; 4. 835 Claims Payment Remittance Advice Transaction; 5. 277 Claims Acknowledgement; 6. NCPDP Formulary; 7. NCPDP Response File; 8. TPL Resource/Policy Information File, etc.; 9. Claims History Extracts; and 10. Prior Authorization Extracts.

3.10 Encounter Data. Provider shall agree to cooperate with CCO to comply with CCO's obligation to prepare encounter data submissions, reports, and clinical information including, without limitation, and well-baby/well-child reporting and encounters, as applicable, and such other reporting regarding Covered Services as may be required under the MississippiCHIP Program Contract. Encounter data must be accurate and include all services furnished to a Covered Person, including capitated provider's data and rendering provider information. Encounter data must be provided within the timeframes specified and in a form that meets CCO and State requirements. By submitting encounter data to CCO, Provider represents to CCO that the data is accurate, complete and truthful, and upon CCO's request Provider shall certify in writing, that the data is accurate, complete, and truthful, based on Provider's best knowledge, information and belief.

3.11 Claims Information. Provider shall promptly submit to CCO the information needed to make payment and shall identify third party liability coverage, including Medicare and other insurance, and if applicable seek such third party liability payment before submitting claims to CCO. Provider understands and agrees that each claim Provider submits to CCO constitutes a certification that the claim is true and accurate to the best of Provider's knowledge and belief and that the Covered Services are 1) Medically Necessary and 2) have been provided to the Member prior to submitting the claim.

Provider must submit claims within six (6) months from the date of service. Claims filed within the appropriate time frame but denied may be resubmitted to CCO within ninety (90) calendar days from the date of denial.

3.12 Third Party Resources. Provider shall report all Third Party Resources to CCO identified through the provision of medical services.

3.13 Privacy; HIPAA. Provider shall comply with all applicable privacy rule and security rule provisions of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), and associated implementing regulations, as may be amended from time to time, and shall safeguard information about Members in accordance with applicable federal and State privacy laws and rules including 42 CFR §438.224 and 42 CFR Part 431, Subpart F, as may be amended from time to time. Provider agrees that confidential information, including but not limited to, medical and other pertinent information relative to Members, shall not be disclosed to any person or organization for any purpose without the expressed, written authority of DOM or as otherwise required by law and that all such disclosures shall fully comply with HIPAA privacy and security standards.

3.14 Cultural Competency and Access. Provider shall participate in CCO's and DOM's efforts to

promote the delivery of services in a culturally competent manner to all Members, including those with limited English proficiency, physical or mental disabilities, diverse cultural and ethnic backgrounds and regardless of gender, sexual orientation or gender identity, and shall provide interpreter services in a Member's primary language and for the hearing impaired for all appointments and emergency services. Provider shall provide information to Members regarding treatment options and alternatives, as well as information on complaints and appeals, in a manner appropriate to the Member's condition and ability to understand. Provider shall provide physical access, reasonable accommodations, and accessible equipment for Covered Persons with physical or mental disabilities.

3.15 Approval of Marketing Materials. As required under State or federal law or the applicable MississippiCHIP Program Contract, any marketing materials developed and distributed by Provider as related to the performance of the Agreement must be submitted to CCO at least sixty (60) days prior to planned distribution for timely submission to DOM for prior approval. Provider agrees it will not proceed with the statement or communication until the required approval is obtained.

3.16 Independent Contractor Relationship. Provider expressly agrees that Provider is acting in an independent capacity in the performance of the Agreement and not as an officer, agent or employee of DOM, CMS or the State. Provider further expressly agrees that the Agreement shall not be construed as a partnership or joint venture between Provider and DOM, CMS or the State. Nothing in the Agreement shall be construed, nor shall it be deemed to create, any right or remedy in any third party.

3.17 Certification on Relationship to State, DOM and CMS. Provider certifies that no officer, director, employee, subcontractor or agent of Provider, or person with an ownership or control interest in Provider, is also employed by, or is a public official of, the State of Mississippi or any of its agencies, DOM or CMS.

3.18 Ownership and Control Information. If applicable, Provider shall cooperate with CCO in obtaining and providing information to DOM related to ownership and control, significant business transactions, and persons convicted of a criminal offense in compliance with§1128 of the Social Security Act, 42 USC §1320a-7 and 42 CFR Part 455, as amended and shall provide information upon request. Provider shall submit information related to ownership and control of subcontractors or wholly owned supplier within thirty-five (35) calendar days of a request for such information.

By executing the Agreement, Provider certifies that neither Provider nor any of its principals is presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in any State or federal health care program or from participating in transactions by any State or federal department or agency. CCO will terminate the Agreement upon becoming aware or receiving notice from DOM, whichever is earlier, that Provider is or has been excluded from participation in any State or federal health care program or by any State or federal agency.

3.19 Excluded Individuals and Entities. Provider certifies that neither it nor any of its employees, principals, nor any providers, subcontractors or consultants or persons with an ownership or controlling interest in the Provider (an owner including the Provider himself or herself), or an agent or managing employee of the Provider, with whom Provider contracts and who are providing items or services that are significant and material to Provider's obligations under the

Agreement is:

i) excluded from participation in federal health care programs under either Section 1128 or section 1128A of the Social Security Act; or

ii) debarred, suspended, proposed for debarment, declared ineligible, or otherwise voluntarily excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549; or an affiliate, as defined in the Federal Acquisition Regulation, of such a person.

Provider acknowledges and agrees and shall require that Provider acknowledge and agree that payment will not be made for any items or Covered Services provided by an excluded individual pursuant to 42 CFR §1001.1901(b) and is obligated to screen all employees, contractors, and subcontractors for exclusion as required under applicable State and Federal laws. Additionally, Provider acknowledges that pursuant to 42 CFR §1003.102(a)(2) civil monetary penalties may be imposed against Provider if he or she employs or enters into contracts with excluded individuals or entities to provide items or Covered Services to Member under the Agreement. Provider agrees not to employ or subcontract with individuals or entities whose owner, those with a controlling interest, or managing employees are on a State or Federal exclusion list to provide items or Covered Services under the Agreement. Provider shall immediately report to CCO any exclusion information discovered. Provider can search the HHS-OIG website, at no cost, by the names of any individuals or entities. The database is called LEIE and can be accessed at http://www.oig.hhs.gov/fraud/exclusions.asp. The GSA EPLS/SAM database can be accessed at https://www.sam.gov. Federal and State exclusion databases must be reviewed monthly to ensure that no employee or contractor has been excluded. Applicable state exclusion databases can be accessed through the State's Medicaid website. CCO will terminate the Agreement immediately upon becoming aware or receiving notice from DOM, whichever is earlier, that Provider's owners, agents, managing employees, or any provider is or has been excluded from federal health care programs or terminated from the Medicare or the Medicaid program in any state.

3.20 Licensure. Provider represents that it is currently licensed and/or certified under applicable State and federal statutes and regulations and by the appropriate State licensing body or standard-setting agency, as applicable. Provider represents that it does not have a Medicaid provider agreement with DOM that is terminated, suspended, denied, or not renewed as a result of any action of DOM, CMS, HHS, or the Medicaid Fraud Control Unit of the State's Attorney General. Provider shall maintain at all times throughout the term of the Agreement all necessary licenses, certifications, registrations and permits as are required to provide the health care services and/or other related activities delegated to Provider by CCO under the Agreement. If at any time during the term of the Agreement, Provider is not properly licensed as described in this Section, Provider shall discontinue providing services to Members.

3.21 National Provider ID (NPI). If applicable, Provider shall and shall require that Providers obtain a National Provider Identification Number (NPI) and when filing claims with Provider, the NPI number used is the same NPI number used when filing claims with DOM.

3.22 Funding. Provider recognizes that the obligation of DOM to proceed under its MississippiCHIP Program Contract with CCO is conditioned upon the appropriation of funds by the Mississippi

State Legislature and the receipt of State and/or Federal funds. If the funds anticipated for the continuing fulfillment of the agreement are, at any time, not forthcoming or insufficient, either through the failure of the Federal government to provide or the State of Mississippi to appropriate funds, or the discontinuance, or material alteration of the program under which the funds were provided or if funds are not otherwise available to DOM, DOM has the right upon ten (10) working days written notice to CCO to terminate the MississippiCHIP Program Contract.

3.23 Federal and State Funds Liability. Providers acknowledges and agrees that payments made to Provider for services provided under the Agreement are derived from federal and State funds and that any false claim or statement in documents or any concealment of material fact related to such services may be a cause for sanctions and prosecution under applicable federal and State laws. Provider shall be subject to all laws applicable to individuals and entities receiving State and federal funds and may be held civilly or criminally liable to both CCO and DOM in the event of nonperformance, misrepresentation, fraud, or abuse related to services provided pursuant to the MississippiCHIP Program Contract. Provider recognizes that payments made to the Provider are derived from federal and State funds, and are contingent upon and subject to availability and receipt of funds.

3.24 Insolvency. In the event CCO becomes insolvent or unable to pay Provider, Provider shall not seek compensation for services rendered from DOM, its officers, Agents, or employees, or the Members or their eligible dependents.

3.25 Termination. In the event of termination of the Agreement, Provider shall promptly supply to CCO all information necessary for the reimbursement of any outstanding MississippiCHIP Program claims.

3.26 Capitated Providers. If a Provider that is capitated terminates its agreement with CCO, for any reason, Provider will provide services to Members assigned to Provider up to the end of the month in which the effective date of termination falls.

3.27 Fraud, Waste, and Abuse Prevention. Provider shall cooperate fully with the CCO's policies and procedures designed to protect program integrity and prevent and detect potential or suspected fraud, waste, and abuse in the administration and delivery of services under the MississippiCHIP Program Contract and shall cooperate and assist DOM and any other State or federal agency charged with the duty of preventing, identifying, investigating, sanctioning or prosecuting suspected fraud, waste, and abuse in state and/or federal health care programs. Provider and CCO are responsible for reporting suspected fraud and abuse by participating and non-participating providers, as well as Members, when detected.

In accordance with CCO's policies and the Deficit Reduction Act of 2005 (DRA), Provider shall have written policies for its employees, contractors or agents that: (a) provide detailed information about the federal False Claims Act (established under sections 3729 through 3733 of title 31, United States Code), including if any entity makes or receives annual payments under the State Program of at least $5,000,000, such entity must establish certain minimum written policies and information communicated through an employee handbook relating to the Federal False Claims Act in accordance with 42 CFR 438.600; (b) cite administrative remedies for false claims and statements (established under chapter 38 of title 31, United States Code) and whistleblower protections under federal and state laws; (c) reference state laws pertaining to civil or criminal penalties for false

claims and statements; and (d) with respect to the role of such laws in preventing and detecting fraud, waste, and abuse in federal health care programs (as defined in section 1128B(f)), include as part of such written policies, detailed provisions regarding Provider's policies and procedures for detecting and preventing fraud, waste, and abuse. Provider agrees to train its staff on the aforesaid policies and procedures.

3.28 Quality Utilization Management. Pursuant to any applicable provider manuals and related protocols, or as elsewhere specified under the Agreement, Provider agrees to cooperate with CCO's quality improvement and utilization review and management activities. This shall include, but not be limited to, participation in any internal and external quality assurance, utilization review, peer review, and grievance procedures established by CCO or as required under the MississippiCHIP Program Contract to ensure that Members have due process for their complaints, grievances, appeals, fair hearings or requests for external review of adverse decisions made by CCO or Provider. Provider shall adhere to the quality assurance and utilization review standards of the MississippiCHIP Program and shall monitor quality and initiate corrective action to improve quality consistent with the generally accepted level of care.

3.29 Quality and Utilization Management Program. Provider shall cooperate with CCO in meeting the Quality Management and Utilization Management Program standards outlined in the MississippiCHIP Program Contract.

3.30 Referrals. Provider shall make referrals for social, vocational, education or human services when a need for such service is identified.

3.31 Restrictions on Referrals. Provider shall not make inappropriate referrals for designated health services to health care entities with which Provider or a member of Provider's family has a financial relationship, pursuant to federal anti-kickback and physician self-referral laws that prohibit such referrals.

3.32 Complaints, Grievances and Appeals. Information on how Provider or Provider's authorized representative shall submit complaints and file grievances and appeals, and the resolution process, is contained in the CCO MississippiCHIP Provider Manual.

3.33 Health Care Acquired/Preventable Conditions. Provider agrees that no payment shall be made for the provision of medical assistance for health care acquired conditions and other provider preventable conditions as may be identified by the State. As a condition of payment, Provider shall identify and report to CCO any provider preventable conditions in accordance with 42 CFR §§ 434.6(a)(12), 438 including but not limited to 438.3(g), and 447.26.

3.34 Compliance with Laws. Provider shall comply with all applicable federal and State laws and regulations and all provisions of the MississippiCHIP Program Contract that pertain to a Member's rights, including but not limited to the following, to the extent applicable to Provider in performance of the Agreement:

i) Title VI of the Civil Rights Act of 1964; (b) Title XIX of the Social Security Act; Title IX of the Education Amendments of1972 (regarding education programs and activities); the Age Discrimination Act of 1975; the Rehabilitation Act of 1973; and The Genetic Information Non-Discrimination Act of 2008 (GINA); the Americans with Disabilities Act;

section 1557 of the Patient Protection and Affordable Care Act, and their implementing regulations, as may be amended from time to time.

ii) All federal and State professional and facility licensing and accreditation requirements/standards that apply to the services Provider perform pursuant to the Agreement, including but not limited to:

a) All applicable standards, orders or requirements issued under Section 306 of the Clean Air Act (42 USC 1857 (h)). Section 508 of the Clean Water Act (33 USC 1368), Executive Order 11738, and Environmental Protection Agency (EPA) regulations (40) CFR Part 15), which prohibit the use of facilities included on the EPA list of violating facilities. Any violations must be reported to DSHS, DHHS, and the EPA;

b) Any applicable mandatory standards and policies relating to energy efficiency that are contained in the State Energy Conservation Plan, including the Energy Policy & conservation Act (Pub. L. 94-165), and issued in compliance with the Federal Energy Policy & Conservation Act.

iii) All relevant federal and State statutes, regulations and orders related to equal opportunity in employment, including but not limited to compliance with E.O. 11246, "Equal Employment Opportunity," as amended by E.O. 11375, "Amending Executive Order 11246 Relating to Equal Employment Opportunity," and as supplemented by regulations at 41 CFR Part 60, "Office of Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor."

iv) If the Agreement is for an amount in excess of $100,000, Provider shall comply with all applicable standards, orders or regulations issued pursuant to the Clean Air Act, 42 U.S.C. 7401 et seq., and the Federal Water Pollution Control Act, as amended, 33 U.S.C. 1251 et seq. Any violations shall be reported to DHHS and the appropriate Regional Office of the Environmental Protection Agency.

v) Those specified for laboratory services in the Clinical Laboratory Improvement Amendments (CLIA). All laboratory service sites must have a CLIA certificate of registration or waiver, and a CLIA identification number.

vi) The American with Disabilities Act (ADA). Provider shall make reasonable accommodation for Members with disabilities in accord with the ADA for all Covered Services and shall assure physical and communication barriers do not inhibit Members with disabilities from obtaining Covered Services;

vii) Section 1128B(d)(1) of the Balanced Budget Act of 1997; and,

viii) Any other requirements associated with the receipt of federal funds.

ix) All Medicaid laws, regulations and program instructions to the extent applicable to Provider in Provider's performance of the Agreement. Provider understands that payment of a claim by CCO or the State is conditioned upon the claim and the underlying transaction complying with such laws, regulations, and program instructions (including, but not limited

to, federal requirements on fraud, waste and abuse, disclosure, debarment, termination and exclusion screening), and is conditioned on the Provider's compliance with all applicable conditions of participation in Medicaid. Provider understands and agrees that each claim the Provider submits to CCO constitutes a certification that the Provider has complied with all applicable Medicaid laws, regulations and program instructions in connection with such claims and the services provided therein. Provider's payment of a claim will be denied if Provider is terminated or excluded from participation in federal healthcare programs. Provider's payment of a claim may be temporarily suspended if the State or CCO provides notice that a credible allegation of fraud exists and there is a pending investigation. Provider's payment of a claim may also be temporarily suspended or adjusted if the Provider bills a claim with a code that does not match the service provided. CCO performs coding edit procedures based primarily on National Correct Coding Initiative (NCCI) policies and other nationally recognized and validated policies. Provider agrees that it will provide medical records to CCO upon its request in order to determine appropriateness of coding. Provider may dispute any temporarily suspended or adjusted payment consistent with the terms of the Agreement.

3.35 Non-Discrimination. Provider will not discriminate against, nor use any policy or practice that has the effect of discriminating against, Covered Persons on the basis of race, color, creed, sex, religion, age, national origin, ancestry, marital status, sexual orientation, gender identity, language, health status, disease or pre-existing condition (including genetic information), anticipated need for health care or physical or mental handicap, except where medically indicated. Examples of prohibited practices include, but are not limited to, the following:

i) Denying or not providing a Member any MississippiCHIP Covered Service. Health care and treatment necessary to preserve life must be provided to all Members who are not terminally ill or permanently unconscious, except where a competent Member objects to such care on his/her own behalf.

ii) Subjecting a Member to segregated, separate, or different treatment, including a different place or time from that provided to other Members or public or private patients, in any manner related to the receipt of any MississippiCHIP Covered Service, except where Medically Necessary.

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

3.36 Advance Directives. Provider shall comply with the advance directives requirements with 42 C.F.R §422.128 and with the Uniform Health-Care Decisions Act (Miss. Code Ann. § 41-41-201, *et. seq*.). When applicable, Provider shall comply with the advance directives requirements for hospitals, nursing facilities, providers of home and health care and personal care services, hospices, and HMOs as specified in 42 CFR Part 49, subpart I, 42 CFR § 417.436(d), 42 CFR § 422.128, and 42 CFR 438.3(i).

3.37 Physician Incentive Plans. In the event Provider participates in a physician incentive plan

("PIP") under the Agreement, Provider agrees that such PIPs must comply with 42 CFR § 417.479, 42 CFR § 438.3, 42 CFR § 422.208, and 42 CFR § 422.210, as may be amended from time to time. CCO or Provider may not make a specific payment directly or indirectly under a PIP to a physician or physician group as an inducement to reduce or limit Medically Necessary services furnished to an individual Member. PIPs must not contain provisions that provide incentives, monetary or otherwise, for the withholding of services that meet the definition of Medical Necessity. Provider shall disclose annually to CCO any PIP arrangement Provider may have with any physicians even if there is not substantial financial risk between CCO and such physicians.

3.38 Lobbying. Provider agrees to comply with the following requirements related to lobbying:

i) Prohibition on Use of Federal Funds for Lobbying: By signing the Agreement, Provider certifies to the best of Provider's knowledge and belief, pursuant to 31 U.S.C. § 1352 and 45 CFR Part 93, as may be amended from time to time, that no federally appropriated funds have been paid or will be paid to any person by or on Provider's behalf for the purpose of influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the award of any federal contract, the making of any federal grant, the making of any federal loan, the entering into of any cooperative agreement, or the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan, or cooperative agreement.

ii) Disclosure Form to Report Lobbying: If any funds other than federally appropriated funds have been paid or will be paid to any person for the purpose of influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the award of any federal contract, the making of any federal grant, the making of any federal loan, the entering into of any cooperative agreement, or the extension, continuation, renewal, amendment or modification of any federal contract, grant, loan, or cooperative agreement and the value of the Agreement exceeds $100,000, Provider shall complete and submit Standard Form-LLL, "Disclosure Form to Report Lobbying," in accordance with its instructions.

iii) Contractor shall abide by lobbying laws of the State of Mississippi.

3.39 Gratuities. Provider represents that it has not violated, is not violating, and promises that it will not violate the prohibitions against gratuities set forth in Section 6-204 (Gratuities) of the Mississippi Personal Service Contract Procurement Regulations.

3.40 Compliance with Mississippi Employment Protection Act (MEPA). Represents and warrants and shall require that Provider represent and warrant that it will ensure its compliance with the Mississippi Employment Protection Act, Section 71-11-1 et set of the Mississippi Code Annotated (Supp. 2008), and will register and participate in the status verification system for all newly hired employees. The term "employee" as used herein means any person that is hired to perform work within the State of Mississippi. As used herein, "status verification system" means the Illegal Immigration Reform and Immigration Responsibility Act of 1996 that is operated by the United States Department of Homeland Security, also known as the E-Verify Program, or any other

successor electronic verification system replacing the E-Verify Program. Provider agrees and shall require that Provider agree to maintain records of such compliance and, upon request of the State and approval of the Social Security Administration or Department of Homeland Security, where required, to provide a copy of each such verification to the State. Provider represents and warrants that any person assigned to perform services hereunder meets the employment eligibility requirements of all immigration laws of the State of Mississippi. Provider acknowledges and agrees that any breach of these warranties may subject Provider to the following: (a) termination of the Agreement and ineligibility for any state or public contract in Mississippi for up to three (3) years, with notice of such cancellation/termination being made public, or (b) the loss of any license, permit, certification or other document granted to Provider by an agency, department or governmental entity for the right to do business in Mississippi for up to one (1) year, or (c) both.

3.41 Insurance Requirements. As applicable, Provider shall and shall require that Provider secure and maintain during the term of the Agreement general liability insurance, professional liability insurance, and workers' compensation insurance for all employees connected with the provision of services under the Agreement. Such workers compensation insurance shall comply with Mississippi Workers' Compensation Laws. Such comprehensive general liability insurance and professional liability insurance shall provide coverage in an amount established by CCO pursuant to the Agreement or as required under the MississippiCHIP Program Contract.

3.42 Indemnification. To the extent applicable to Provider in performance under the Agreement, Provider shall indemnify, defend, protect, save and hold DOM and its employees and Members harmless from and against all injuries, deaths, losses, damages, claims, suits, demands, actions, recovery, liabilities, judgments, costs and expenses, including without limitation, court costs, investigative fees and expenses, and attorney fees, to the extent proximately caused by any negligent act or other intentional misconduct or omission of Provider, its agents, officers, employees or contractors arising from the Agreement. DOM may waive this requirement for public entities if Provider is a state agency or sub-unit as defined by the State or a public health entity with statutory immunity. This clause shall survive the termination of the Agreement for any reason, including breach due to insolvency.

3.43 Notice of Legal Action. Immediately upon obtaining knowledge or receiving notice of any legal action or notice listed below, Provider shall provide to CCO written notice of such legal action or notice and, upon request by CCO, a complete copy of all filings and other documents generated in connection with any such legal action:

i) Any action, suit or counterclaim filed against Provider;

ii) Any regulatory action, or proposed action, respecting Provider's business or operations;

iii) Any notice received by Provider from the Department of Insurance or the State Health Officer;

iv) The filing of a petition in bankruptcy by or against Provider, or the insolvency of Provider;

v) The conviction of any person who has an ownership or control interest in Provider, or who is an agent or managing employee of Provider, of a criminal offense related to that person's

involvement in any program under Medicare, Medicaid, or Title XX of the Social Security Act; or

vi) A malpractice action against any Provider delivering service under an agreement.

3.44 Hold Harmless. Except for any applicable cost-sharing requirements under the MississippiCHIP Program Contract, Provider shall look solely to CCO for payment of Covered Services provided to Members pursuant to the Agreement and the MississippiCHIP Program Contract and hold DOM, the State, the U.S. Department of Health and Human Services and Members harmless in the event that CCO cannot or will not pay for such Covered Services. In accordance with 42 CFR § 447.15, as may be amended from time to time, the Member is not liable to Provider for any services for which CCO is liable and as specified under the State's relevant health insurance or managed care statutes, rules or administrative agency guidance. Provider shall not require any copayment or cost sharing for Covered Services provided under the Agreement unless expressly permitted under the MississippiCHIP Program Contract. Provider shall also be prohibited from charging Members for missed appointments if such practice is prohibited under the MississippiCHIP Program Contract or applicable law. Neither the State, DOM, nor Member shall be in any manner liable for the debts and obligations of CCO and under no circumstances shall CCO, or any providers used to deliver services covered under the terms of the MississippiCHIP Program Contract, charge Members for Covered Services.

3.45 Assignment/Delegation. Provider shall not assign or delegate the Agreement without the express written consent of CCO or DOM. If Provider subcontracts or delegates any functions of the Agreement, in accordance with the terms of the Agreement and with the express written consent of CCO or DOM, the subcontract or delegation must be in writing and include all of the requirements of this Appendix, and applicable requirements of the State Contract, and applicable laws and regulations. The transfer of five percent (5%) or more of the beneficial ownership in Provider at any time during the term of this Agreement shall be deemed an assignment under this Agreement.

3.46 Behavioral Health Providers. Behavioral Health Providers shall ensure that all Covered Persons receiving inpatient psychiatric services are scheduled for outpatient follow-up and/or continuing treatment prior to discharge from the inpatient psychiatric hospital if the Provider is aware of the Covered Person's inpatient hospitalization status. Behavioral Health Providers will be provided daily reports identifying Covered Persons known to be admitted to an inpatient facility. Behavioral Health Services will be delivered in compliance with the requirements of 42 CFR 438 subpart K insofar as those requirements are applicable.

3.47 Provider Eligibility. Provider must be enrolled in the Mississippi CHIP program and must use the same National Provider Identifier (NPI) number to participate in CCO's Network. Upon notification from the State that Provider's enrollment has been denied or terminated, CCO must terminate Provider immediately and will notify affected Covered Persons that Provider is no longer participating in the network. CCO will exclude from its network any provider who has been terminated or suspended from the Medicare, Medicaid or CHIP program in any state.

3.48 Disclosure. Provider must be screened and enrolled in the State's CHIP program and submit disclosures to the DOM related to ownership and control, significant business transactions, and persons convicted of crimes in accordance with 42 CFR Part 455 .Provider must submit information related to ownership and control of subcontractors or wholly owned suppliers within thirty-five (35)

calendar days of a request for such information in accordance with 42 CFR 455.105. Additionally, Provider must cooperate with DOM for submission of fingerprints upon a request from DOM or CMS in accordance with 42 CFR 455.434.

3.49 Electronic Visit Verification. Provider shall cooperate with State requirements for electronic visit verification for personal care services and home health services, as applicable.

3.50 Clinical Laboratory Improvements Act (CLIA) Certification or Waiver. As applicable, if Provider performs any laboratory tests on human specimens for the purpose of diagnosis and/or treatment, Provider agrees to acquire and maintain the appropriate CLIA certification or waiver for the type of laboratory testing performed. Provider further agrees to provide a copy of the certification if requested by CCO. A State authorized license or permit that meets the CLIA requirements may be substituted for the CLIA certificate pursuant to State law. Medicare and Medicaid programs require the applicable CLIA certification or waiver for the type of services performed as a condition of payment. Provider must include the appropriate CLIA certificate or waiver number on claims submitted for payment for laboratory services.

3.51 Overpayment. Provider shall to report to CCO when it has received an overpayment and will return the overpayment to CCO within 60 calendar days after the date on which the overpayment was identified. Provider will notify CCO in writing of the reason for the overpayment.

SECTION 4
CCO REQUIREMENTS

4.1 Communications with Members. Members are entitled to the full range of their Providers' opinions and counsel about the availability of Medically Necessary Services under the provisions of the MississippiCHIP Program Contract. Any contractual provisions, including gag clauses or rules, that restrict a Provider's ability to advise Members about Medically Necessary treatment options violate federal law and regulations. CCO shall not prohibit or otherwise restrict Provider, when acting within the lawful scope of practice, from advising or advocating on behalf of a Member for the following:

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

ii) Any information the Member needs in order to decide among all relevant treatment options;

iii) The risks, benefits, and consequences of treatment or non-treatment;

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

v) Information regarding the nature of treatment options including those that may not reflect CCO's position or may not be covered by CCO.

CCO shall not prohibit a Provider from advocating on behalf of a Member in any grievance system,

utilization review process, or individual authorization process to obtain necessary health care services.

4.2 Prompt Payment. CCO shall pay Provider pursuant to the MississippiCHIP Program Contract and applicable State and federal law and regulations, including but not limited to Miss. Code Ann. §83-9-5, 42 CFR §447.46, 42 CFR §447.45(d)(2), 42 CFR §447.45(d)(3), 42 CFR §447.45(d)(5) and 42 CFR §447.45(d)(6), as applicable and as may be amended from time to time. If a third party liability exists, payment of claims shall be determined in accordance with federal and/or State third party liability law and the terms of the MississippiCHIP Program Contract. Unless CCO otherwise requests assistance from Provider, CCO will be responsible for third party collections in accordance with the terms of the MississippiCHIP Program Contract.

4.3 No Incentives to Limit Medically Necessary Services. CCO shall not structure compensation provided to individuals or entities that conduct utilization management and concurrent review activities so as to provide incentives for the individual or entity to deny, limit, or discontinue Medically Necessary services to any Member.

4.4 Provider Discrimination Prohibition. CCO shall not discriminate with respect to participation, reimbursement, or indemnification of a provider who is acting within the scope of the provider's license or certification under applicable State law, solely on the basis of such license or certification. CCO shall not discriminate against Provider for serving high-risk Members or if Provider specializes in conditions requiring costly treatments. This provision shall not be construed as prohibiting CCO from limiting a provider's participation to the extent necessary to meet the needs of Members. This provision also is not intended and shall not interfere with measures established by CCO that are designed to maintain quality of care practice standards and control costs. CCO shall not provide false or misleading information to any person or entity in an attempt to recruit Providers for CCO's network.

4.5 Termination, Revocation and Sanctions. In addition to its termination rights under the Agreement, CCO shall have the right to revoke any functions or activities CCO delegates to Provider under the Agreement or impose other sanctions consistent with the MississippiCHIP Program Contract if in CCO's reasonable judgment Provider's performance under the Agreement is inadequate. CCO shall also have the right to suspend, deny, refuse to renew or terminate the subcontract in accordance with the terms of the MississippiCHIP Program Contract and applicable law and regulation. However, CCO shall not exclude or terminate a Provider from participation in CCO's Provider Network due to the fact that the Provider has a practice that includes a substantial number of patients with expensive medical conditions, and shall not terminate a Provider for filing a Complaint, Grievance, or Appeal on a Member's behalf.

SECTION 5
OTHER REQUIREMENTS

5.1 Compliance with MississippiCHIP Program Contract. All tasks performed under the Agreement shall be performed in accordance with the requirements of the MississippiCHIP Program Contract, as applicable, as set forth in this Appendix, applicable provider manuals, and protocols, policies and procedures that CCO has provided or delivered to Provider. The applicable provisions of the MississippiCHIP Program Contract are incorporated into the Agreement by reference. Nothing in the Agreement or this Appendix relieves CCO of its responsibility under the

MississippiCHIP Program Contract. If any provision of the Agreement is in conflict with provisions of the MississippiCHIP Program Contract, the terms of the MississippiCHIP Program Contract shall control and the terms of the Agreement in conflict with those of the MississippiCHIP Program Contract will be considered waived.

5.2 Monitoring. In accordance with 42CFR § 457.950, CCO shall perform ongoing monitoring (announced or unannounced) of services rendered by Provider under the Agreement and shall perform periodic formal reviews of Provider according to a schedule established by the State, consistent with industry standards or State managed care organization laws and regulations or requirements under the MississippiCHIP Program Contract. As a result of such monitoring activities, and/or as a result of the inspecting, auditing and monitoring activities of DOM or other authorities pursuant to section 4.4 above, CCO shall identify to Provider any deficiencies or areas for improvement mandated under the MississippiCHIP Program Contract and Provider and CCO shall take appropriate corrective action within the relevant timeframe permitted, as applicable. Provider shall comply with any corrective action plan initiated by CCO and/or required by the MississippiCHIP Program. In addition, Provider shall monitor and report the quality of services delivered under the Agreement and initiate a plan of correction where necessary to improve quality of care, in accordance with that level of care which is recognized as acceptable professional practice in the respective community in which CCO and Provider practice and/or the performance standards established under the MississippiCHIP Program Contract.

5.3 Enrollment. The parties acknowledge and agree that DOM is responsible for enrollment, reenrollment and disenrollment of Members.

5.4 No Exclusivity. Nothing in the Agreement or this Appendix shall be construed as prohibiting or penalizing Provider for contracting with a managed care organization other than CCO or as prohibiting or penalizing CCO for contracting with other providers. The CCO may not require Providers who agree to participate in the MississippiCHIP Program to contract with the Contractor's other lines of business.

5.5 Revoking Delegation. The parties agree that, prior to execution of the Agreement, CCO evaluated Provider's ability to perform any duties delegated to Provider under the Agreement. Any delegated duties and reporting responsibilities shall be set forth in the Agreement or other written delegation agreement or addendum between the parties. In addition to its termination rights under the Agreement, CCO shall have the right to revoke any functions, assignment authority, or activities CCO delegates to Provider under the Agreement or impose other sanctions if in CCO's reasonable judgment Provider's performance under the Agreement is inadequate or untimely.

5.6 Rights of DOM. DOM shall have the right to invoke against Provider any remedy set forth in the MississippiCHIP Program Contract, including the right to require the termination of the Agreement, for each and every reason for which it may invoke such a remedy against CCO or require termination of the MississippiCHIP Program Contract. Suspected Fraud and Abuse by Provider will be investigated by DOM.

Mississippi
Regulatory Requirements Appendix

Mississippi Regulatory Requirements Appendix

This Mississippi Regulatory Requirements Appendix (the "Appendix") is made part of the agreement ("Agreement") entered into between **CCO,** contracting on behalf of itself, **HMO**, and the other entities that are CCO's Affiliates (collectively referred to as "CCO") and the health care professional or entity named in the Agreement ("Provider").

This Appendix applies to all products or benefit plans sponsored, issued or administered by or accessed through CCO to the extent such products are regulated under Mississippi laws; provided, however, that the requirements in this Appendix will not apply to the extent they are preempted by the Medicare Modernization Act or other applicable law.

CCO and Provider each agree to be bound by the terms and conditions contained in this Appendix. In the event of a conflict or inconsistency between this Appendix and any term or condition contained in the Agreement, this Appendix shall control, except with regard to Benefit Plans outside the scope of this Appendix.

If any of the capitalized terms in this Appendix are used or defined (or the equivalent terms are used or defined) in the Agreement, then the terms used in this Appendix will have the same meaning as the terms (or equivalent terms) used or defined in the Agreement. For example, "Benefit Plans," as used in this Appendix, will have the same meaning as "benefit contracts"; "Customer," as used in this Appendix, will have the same meaning as "member," "enrollee," or "covered person"; "Payer," as used in this Appendix, will have the same meaning as "participating entity"; "Provider," as used in this Appendix, will have the same meaning as "Facility," "Medical Group," "Ancillary Provider," "Physician," or "Practitioner." Additionally, if the Agreement uses pronouns to refer to the contracted entities, then "CCO" will have the same meaning as "we" or "us," and "Provider" will have the same meaning as "you" or "your."

This Appendix will be deemed to be updated to incorporate any changes to the laws and regulations referenced herein, including any changes to definitions referenced herein, effective as of the date of such changes.

1. Customer Hold Harmless and Continuation of Services. Provider agrees that in no event, including but not limited to nonpayment by CCO, Payer or intermediary, insolvency of CCO, Payer or intermediary, or breach of this Agreement, shall Provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against a Customer or a person (other than CCO, Payer or intermediary) acting on behalf of the Customer for services provided pursuant to this Agreement. This Agreement does not prohibit Provider from collecting coinsurance, deductibles or copayments, as specifically provided in the evidence of coverage, or fees for uncovered services delivered on a fee-for-service basis to Customers. Nor does this Agreement prohibit Provider (except for a health care professional who is employed full-time on the staff of CCO and has agreed to provide services exclusively to CCO's Customers and no others) and a Customer from agreeing to continue services solely at the expense of the Customer, as long as the provider has clearly informed the Customer that CCO or Payer

may not cover or continue to cover a specific service or services. Except as provided herein, this Agreement does not prohibit Provider from pursuing any available legal remedy.

In the event of CCO, Payer or intermediary insolvency or other cessation of operations, Covered Services to Customers will continue through the period for which a premium has been paid to CCO or Payer on behalf of the Customer or until the Customer's discharge from an inpatient facility, whichever time is greater. Covered Services to Customers confined in an inpatient facility on the date of insolvency or other cessation of operations will continue until their continued confinement in an inpatient facility is no longer medically necessary.

The provisions in this section 1 shall be construed in favor of the Customer, shall survive the termination of the Agreement regardless of the reason for termination, including the insolvency of CCO or Payer, and shall supersede any oral or written contrary agreement between Provider and a Customer or the representative of a Customer if the contrary agreement is inconsistent with the hold harmless and continuation of Covered Services provisions required by this section 1.

In no event shall Provider collect or attempt to collect from a Customer any money owed to Provider by CCO or Payer.

2. CCO Programs. As applicable, Provider shall comply with CCO's administrative policies and programs, including but not limited to terms, including payment, utilization review, quality assessment and improvement programs, credentialing, grievance procedures, data reporting requirements, confidentiality requirements and any applicable federal or state programs.

3. Treatment Options. CCO shall not prohibit Provider from discussing treatment options with Customers irrespective of CCO's position on the treatment options, or from advocating on behalf of Customers within the utilization review or grievance processes established by CCO or a person contracting with CCO.

4. Records. Provider shall make health records available to appropriate state and federal authorities involved in assessing the quality of care or investigating the grievances or complaints of Customers, and to comply with the applicable state and federal laws related to the confidentiality of medical or health records.

5. Termination. CCO and Provider shall provide advance written notice to each other in the form and for the length of time as provided in the Agreement but in no case less than sixty (60) before terminating the Agreement without cause. CCO shall make a good faith effort to provide written notice of a termination within thirty (30) days of receipt or issuance of a notice of termination to all Customers who are patients seen on a regular basis by Provider whose Agreement is terminating, irrespective of whether the termination was for cause or without cause. Where a contract termination involves a primary care professional, all Customers who are patients of that primary care professional shall also be notified. Within five (5) working days of the date that Provider either gives or receives notice of termination, Provider shall supply CCO with a list of those patients of Provider that are covered by a Benefit Plan subject to this Appendix.

6. Assignment. The rights and responsibilities under this Agreement shall not be assigned or delegated by Provider without the prior written consent of CCO.

7. Provision of Covered Services. Provider shall furnish Covered Services to all Customers without regard to the Customer's enrollment in the plan as a private purchaser of the plan or as a participant in publicly financed programs of health care services. This requirement does not apply to circumstances when Provider should not render services due to limitations arising from lack of training, experience, skill or licensing restrictions.

8. Coinsurance, Copayments and Deductibles. Provider shall collect applicable coinsurance, copayments or deductibles from Customers pursuant to the Benefit Plan and, as applicable, Provider shall notify Customers of their personal financial obligations for non-covered services.

9. No Penalty for Reporting to Authorities. CCO shall not penalize Provider because Provider, in good faith, reports to state or federal authorities any act or practice by CCO that jeopardizes patient health or welfare.

10. Definitions. To the extent a definition or other provision in the Agreement conflicts with the Benefit Plan or the Managed Care Plan Network Adequacy Regulation (the "Regulation"), the Benefit Plan or the Regulation will control.

11. Prompt Pay. Provider and CCO shall comply with the prompt payment requirements set forth in the Mississippi Code Section 83-9-5(1)(h). Claims will be paid within twenty-five (25) days after receipt where claims are submitted electronically, and within thirty-five (35) days after receipt where claims are submitted in paper format.

12. Reciprocal Time Limitations. If the Agreement includes a time limit in which Provider is required to submit a claim for payment, CCO or Payer shall have the same time limit following payment of the claim to perform any review or audit for reconsidering the validity of the claim and requesting reimbursement for payment of an invalid claim or overpayment of a claim. If CCO or Payer does not limit the time in which Provider is required to submit a claim for payment, CCO may not request reimbursement or offset another claim payment for reimbursement of an invalid claim or overpayment of a claim more than twelve (12) months after the payment of an invalid or overpaid claim. This provision does not apply to claims submitted in the context of misrepresentation, omission, concealment, or fraud by Provider.

13. Intermediaries. The following provisions apply to intermediaries as defined in the Regulation.

a) Intermediaries and participating providers with whom they contract shall comply with all the applicable requirements of sections 1-10 of this Appendix (section 14.06 of the Regulation).
b) CCO's statutory responsibility to monitor the offering of Covered Services to Customers shall not be delegated or assigned to the intermediary.

c) CCO shall have the right to approve or disapprove participation status of a subcontracted provider in its own or a contracted network for the purpose of delivering Covered Services to the carrier's Customers.
d) CCO shall maintain copies of all intermediary health care subcontracts at its principal place of business in the state, or ensure that it has access to all intermediary subcontracts, including the right to make copies to facilitate regulatory review, upon twenty (20) days prior written notice from CCO.
e) If applicable, an intermediary shall transmit utilization documentation and claims paid documentation to CCO. CCO shall monitor the timeliness and appropriateness of payments made to providers and health care services received by Customers.
f) If applicable, an intermediary shall maintain the books, records, financial information and documentation of services provided to Customers at its principal place of business in the state and preserve them in a manner that facilitates regulatory review.
g) An intermediary shall allow the commissioner access to the intermediary's books, records, financial information and any documentation of services provided to Customers, as necessary to determine compliance with the Regulation.
h) CCO shall have the right, in the event of the intermediary's insolvency, to require the assignment to CCO of the provisions of a provider's contract addressing the provider's obligation to furnish covered services.

Hospital Payment Appendix

[APR-DRG with Fixed Outpatient MS State Specific Medicaid Payment Appendix]

[APR-DRG with Fixed Outpatient MS State Specific CHIP Payment Appendix]

[APR-DRG with Fixed Outpatient MS State Specific Medicaid and CHIP Payment Appendix]

APPLICABILITY

Facility or Facilities subject to this Appendix as of this Appendix Effective Date: _____
Tax ID: _____
Provider ID: _____
This Appendix applies to the following types of Benefit Plans as described in the Agreement: • [Mississippi Medicaid Benefit Plans] • [Mississippi CHIP Benefit Plans] This Appendix does not apply, to the extent another agreement or appendix between the parties or their affiliates specifically applies to a given Benefit Plan that would otherwise be subject to this Appendix.
This Appendix is effective for dates of service on or after: _____ Any prior Appendix applicable to the same Benefit Plan(s) are superseded by this Appendix.

SECTION 1
Definitions

Unless otherwise defined in this Section, capitalized terms used in this Appendix have the meanings assigned to them in the Agreement. If any definition in this Appendix conflicts with another definition in the Agreement, the definition in this Appendix controls, with regard to Benefit Plans subject to this Appendix.

Admission: The admittance of a Customer to a licensed hospital bed, excluding Observation. Admission applies only to those services provided by order of a Physician.

Agency: Mississippi Medicaid agency, responsible for sponsoring the Benefit Plans subject to this Appendix.

Agency APR-DRG (All Patient Refined Diagnosis-Related Groups): A system of classification, adopted by the Agency, for inpatient hospital services based on the principal diagnosis, secondary diagnoses, present on admission indicator, surgical procedures, age, sex, birth weight for neonatal patients, and discharge status. For purposes of determining the contract rate under this Appendix, the Agency APR-DRG at discharge will be

controlling. All changes in the definition of Agency APR-DRGs including applicable reimbursement components and/or rates specified by the Agency will be implemented under this Appendix following publication by the Agency.

The Payment Method designated "Agency APR-DRG" in this Appendix is applicable to Covered Services rendered to a Customer for an entire Admission.

Agency Rates: The rates set by the Agency for Covered Services for the Payment Methods in this Appendix.

CMS: Centers for Medicare and Medicaid Services.

Customer Expenses: Copayments, deductibles, or coinsurance that are the financial responsibility of the Customer according to the Customer's Benefit Plan.

Eligible Charges: The Customary Charge for Covered Services, except for any Covered Services listed under Section 3.4 and 3.5 of this Appendix.

Institutional Claim: Any UB04 or electronic version or successor form.

Outpatient Encounter: Covered Services rendered to a Customer by Facility on an outpatient on a one-calendar day period basis from the time of registration for outpatient services until discharge.

Payment Method: A methodology for determining contract rates under this Appendix. Unless otherwise specified in this Appendix, payment under this Appendix, less any applicable Customer Expenses, is considered payment in full for all Covered Services rendered to the Customer including (as applicable), but not limited to:

• Physician and other professional fees billed by Facility on an Institutional Claim
• Services rendered by non-Physician personnel (regardless of whether those personnel are employed by Facility and regardless of whether those services are characterized as professional services)
• Preadmission services or outpatient services related to an Admission that occur within three calendar days prior to Admission
• Nursing care
• Observation
• Critical care
• Surgical services
• Diagnostic and therapeutic services (including but not limited to diagnostic imaging)
• Ancillary services
• Durable medical equipment
• Supplies (including, but not limited to, anesthesia supplies)
• Medications
• Room and board

Filing Note: Per Diem definition to be included if any Per Diem service categories are added to Table 1.
[**Per Diem:** The Payment Method applicable to Covered Services rendered to a Customer for each day during an Admission.]

Per Unit via Facility Fee Schedule: The Payment Method in this Appendix, based on the CPT/HCPCS specific fee listed in the applicable fee schedule for each unit of service and applicable to Covered Services rendered to a Customer for which a Per Unit via Facility Fee Schedule Payment Method is indicated in this Appendix. Facility is required to identify procedures by revenue code and CPT/HCPCS code to receive payment. The number of units for each procedure or service rendered will be billed in accordance with the guidelines in the latest edition of the Current Procedural Terminology (CPT) manual as published by the American Medical Association or the latest edition of the HCPCS manual as published by CMS. The units reported for Covered Services for which the contract rate is a Per Unit via Facility Fee Schedule must always equal the number of times a procedure or service is performed.

PPR (Percentage Payment Rate): The percentage applied to Facility's detail line item Eligible Charge to determine the contract rate for those Covered Services for which the contract rate is calculated as a percentage of Eligible Charges.

Physician: A Doctor of Medicine ("M.D."), a Doctor of Osteopathy ("D.O.") or another health care professional as authorized under applicable law and Facility bylaws to admit or refer patients for Covered Services.

Professional Claim: Any CMS 1500 or electronic version or successor form.

SECTION 2
Contract Rate for Covered Services

2.1 Contract Rate. For Covered Services rendered by Facility to a Customer, the contract rate will be the lesser of (1) Facility's Eligible Charges, or (2) the applicable contract rate determined in accordance with Sections 2.2, 2.3 and/or 3 of this Appendix, less any Customer Expenses. Payment by CCO of the contract rate under this Appendix will be less any applicable Customer Expenses, and is subject to the requirements set forth in the Agreement.

2.2 Inpatient Covered Services. For the provision of Covered Services to a Customer during an Admission, the contract rate is determined as described in this Section. Unless otherwise specified in this Appendix, the negotiated percentage for an entire Admission is the negotiated percentage in effect on the first day of the Admission.

Table 1: Inpatient Service Category Table

SERVICE CATEGORY	PAYMENT METHOD	CONTRACT RATE AS OF THE EFFECTIVE DATE OF THIS APPENDIX	NEGOTIATED PERCENTAGE OF AGENCY RATE
All Agency APR-DRGs * (except those listed in Section 3.40 [, and those service categories defined below]	**Agency APR-DRG**	**As calculated**	**[XX]% Agency APR-DRG Payment**

[Skilled Nursing Services^ ~ Bill Type 211-219	**Per Diem**	**$[XX.XX]**	**[AA]% of Agency Rate]**
[Hospice^ Revenue Codes 0115, 0125, 0135, 0145, 0155, 0655-0656	**Per Diem**	**$[XX.XX]**	**[AA]% of Agency Rate]**
[Rehabilitation Services^ ~ Revenue Codes 0118, 0128, 0138, 0148, 0158	**Per Diem**	**$[XX.XX]**	**[AA]% of Agency Rate]**

Notes to Table 1

*Covered Services rendered to a mother and her newborn child will be paid as separate Admissions.

Filing Note: The bracketed notes below will be added if bracketed service categories in Table 1 are included.
[~ If Facility has a separate Inpatient Skilled Nursing unit, Hospice unit, or Rehabilitation unit, the charges for the Inpatient Skilled Nursing, Hospice, or Rehabilitation stay are to be submitted separately from the acute hospital stay.

^ However, this service category does not apply where one of these revenue codes is billed in connection with Covered Services included in any Per Case Payment Method service category or any service category defined by Agency APR-DRGs or any service category defined by Bill Types on this Inpatient Service Category Table or Section 3.5.]

Facility's Agency APR-DRG contract rates will be priced in accordance with Agency's methodology for calculating these contract rates applicable DRG to Medicaid business, including the Agency APR-DRG base rate, as defined by Agency. The Agency APR-DRG Contract Rate will include Capital payments, but will not include disproportionate share hospital (DSH), upper payment limits (UPL) and graduate medical education (GME).

CCO will group each claim to a Agency APR-DRG based on the coding information provided on the claim. The contract rate is determined by multiplying the Agency APR-DRG base rate, as defined by Agency, in effect for the date of discharge, by the relative weight of the Agency APR-DRGs (as determined by CCO from the coding information) in effect under this Appendix as of the date of discharge.

If a Customer is admitted to Facility for a particular service or for treatment of a particular condition and the Customer is subsequently transferred, Facility will be paid according to Section 2.2.1.

2.2.1 Transfer of Customer. This section applies with regard to an Admission in which Facility makes a transfer of the Customer. When a Customer is admitted to Facility and is subsequently transferred for additional and appropriate treatment as defined by Agency, the contract rate will be determined according to this Section. The contract rate will be calculated as a Per Diem determined by dividing the Agency APR-DRG Contract Rate, by

the Average Length of Stay (ALOS), both as defined by Agency. The contract rate for the first day of the Admission is two times the calculated Per Diem rate and the contract rate for each subsequent day of the Admission is the calculated Per Diem rate. The final payment is the lesser of the transfer adjusted payment or the full Agency APR-DRG payment.

2.2.2 Cost Outlier. When a Cost Outlier is applicable, Facility will be reimbursed in accordance to this Section.

When Facility's Eligible Charges for inpatient Covered Services exceeds $[XX,XXX] ("Inpatient Outlier Threshold") as defined by Agency, during a single Admission, not including any Eligible Charges for codes identified in Sections 3.4 and/or 3.5, Facility will be eligible for the Cost Outlier calculation. The Cost Outlier will be calculated as follows: a) The estimated loss will be determined by multiplying the Eligible Charges by the Cost to Charge ("CCR") ratio, as determined by Agency; b) then subtract the estimated loss amount from the Agency APR-DRG contract rate for the applicable inpatient stay; c) determine if the estimated loss is greater than the Inpatient Outlier Threshold as stated above; d) the final Cost Outlier will be the difference between the estimated loss and Inpatient Outlier Threshold multiplied by the DRG Marginal Cost Percentage, as determined by Agency.

2.3 Outpatient Covered Services. For Outpatient Covered Services, appropriate CPT and/or HCPCS codes, as described by the National Uniform Billing Committee and CPT/HCPCS code guidelines, must be submitted on the Institutional Claim in order to be eligible for reimbursement. Revenue Codes and CPT/HCPCS codes that are used by Agency outside of the National Uniform Billing Committee guidelines and CPT/HCPCS code guidelines are not considered valid and are not eligible for reimbursement.

2.3.1 Outpatient Service Categories. For the provision of Covered Services rendered by Facility to a Customer on an Outpatient Encounter, the contract rate will be determined according to Sections 2.3 and 2.3.1, and the applicable table included therein. Unless otherwise specified in this Appendix, the negotiated percentage identified in this Section for an entire Outpatient Encounter is the percentage in effect on the date the Outpatient Encounter begins.

Table 2: Outpatient Covered Service Category Table

SERVICE CATEGORY	PAYMENT METHOD	CONTRACT RATE AS OF THE EFFECTIVE DATE OF THIS APPENDIX	NEGOTIATED PERCENTAGE OF AGENCY RATE
Chemotherapy Revenue Codes 0330-0339	**Per Unit via Facility Fee Schedule #_____**	**As calculated**	**[XX]% of the "Source Fee" as described in Chemotherapy Fee Schedule Exhibit**
All Other Outpatient Services[1]	**Per Unit via Facility Fee Schedule #_____**	**As calculated**	**[XX]% of the "Source Fee" as described in**

			Outpatient Facility Fee Schedule Exhibit

Notes to Table 2

[1] Facility's Emergency department visits coding guidelines will be consistent with the coding principles described and updated by CMS, including without limitation the 11 principles listed by CMS in the CY 2008 OPPS/ASC final rule with comment period (72 FR 66805). Within 14 days of a request from CCO, Facility will provide its Emergency department visits coding guidelines. In addition Facility will provide Customer medical records pursuant to Section 4.10 of the Agreement. In the event Facility changes its Emergency department visits coding guidelines, Facility will notify CCO at least 90 days prior to the implementation date of any change. In the event such change has a negative projected financial impact to CCO or its Payers, CCO and Facility, within 30 days of above notification, will evaluate and agree upon contract rates going forward that will assure that changes to Facility's Emergency department visits coding guidelines do not have the impact of increasing the amount paid by CCO or its Payers under this Appendix. Based on the agreed upon rate adjustment, both parties will execute an amendment to implement the adjusted contract rates going forward. In the event that CCO determines that an overpayment to Facility has resulted due to Facility's failure to give timely notice as required under this Section, or due to Facility providing inaccurate information, CCO may recover those overpayments, as outlined in the Facility Participation Agreement.

In the event the parties are unable to agree on contract rates going forward, the matter may be resolved in accordance with the dispute resolution provisions of the Agreement. In addition to determining the impact of Facility's Emergency department visits coding guidelines changes, the Arbitrator may determine the new contract rates going forward necessary to ensure that CCO and its Payers are not impacted by Facility's coding guideline changes from the effective date of the coding guideline change.

Chemotherapy Fee Schedule Notes:

Calculation of the contract rate for Chemotherapy Services is based on the following:

- Facility is required to identify procedures by revenue code and CPT/HCPCS code, and modifier codes as applicable, to receive payment.
- The Chemotherapy Fee Schedule Exhibit was created based on the CPT/HCPCS codes priced according to Agency.
- There will be an annual update to the Chemotherapy Fee Schedule Exhibit to set fixed contract rates for new codes and any rate adjustments that Agency makes to previously established codes, in either case published throughout the previous year. The contract rates will be set based on the same methodology used to establish the contract rates for the existing codes and will change due to a retroactive correction to the amount provided by the fee source. These changes will be effective on the same date Agency rates become effective and any claims affected will be addressed.
- Appropriate National Drug Codes (NDC) for each Covered Service must be billed in compliance with Agency billing requirements.
- Chemotherapy services listed on the Chemotherapy Fee Schedule will be reimbursed at the appropriate rates when billed in accordance to Agency billing requirements.

- Unless otherwise specified, appropriately billed codes for a valid Covered Service that are not listed on the current Chemotherapy Fee Schedule Exhibit will not be eligible for reimbursement.

Outpatient Facility Fee Schedule Notes:

Calculation of the contract rate for All Other Outpatient Services is based on the following:

- Facility is required to identify procedures by revenue code and CPT/HCPCS code, and modifier codes as applicable, to receive payment.
- The Outpatient Facility Fee Schedule Exhibit was created based on the CPT/HCPCS codes priced according to Agency.
- There will be an annual update to the Outpatient Facility Fee Schedule Exhibit to set fixed contract rates for new codes and any rate adjustments that Agency makes to previously established codes, in either case published throughout the previous year. The contract rates will be set based on the same methodology used to establish the contract rates for the existing codes and will change due to a retroactive correction to the amount provided by the fee source. These changes will be effective on the same date Agency rates become effective and any claims affected will be addressed.
- When multiple Outpatient Procedures, listed with a multiple procedure reduction (MPR) indicator in the State Specific Note column of the Outpatient Fee Schedule Exhibit, are performed on a Customer by Facility during one Outpatient Encounter, the contract rate is as follows: (1) 100% of the highest contract rate specified in Section 2.3.1 Table 2 for which an Outpatient Procedure has been performed; plus (2) 50% of the contract rate specified in Section 2.3.1 Table 2 for all subsequent Outpatient Procedures.
- When multiple Outpatient Dental Procedures, listed with a D-MPR indicator in the State Specific Note column of the Outpatient Fee Schedule Exhibit, are performed on a Customer by Facility during one Outpatient Encounter, the contract rate is as follows: 1) 100% of the highest contract rate specified in Section 2.3.1 Table 2 for which an Outpatient Procedure has been performed; plus (2) 25% of the contract rate specified in Section 2.3.1 Table 2 for all subsequent Outpatient Procedures.
- Appropriate National Drug Codes (NDC) for each Covered Service must be billed in compliance with Agency billing requirements.
- Unless otherwise specified, appropriately billed codes for a valid Covered Service that are not listed on the current Outpatient Fee Schedule Exhibit will not be eligible for reimbursement.

SECTION 3
Miscellaneous Provisions

3.1 Inclusive Rates. The contract rates established by this Appendix are all-inclusive, including without limitation applicable taxes, for the provision of all Covered Services to the Customer that are in the service category that corresponds to the contract rate and which are generally provided as a part of the service category. All items and non-Physician services provided to Customers at Facility must be directly furnished by Facility or billed by Facility when services are provided by another entity. For example, surgical procedures for implantable DME or implantable prosthetic devices performed at Facility include the cost of the device in the contract rates listed in Section 2, as applicable. No additional payments will be made for any services or items covered under the Customer's Benefit Plan and billed for separately by Facility.

Notwithstanding the foregoing, Facility will only bill for inpatient and outpatient laboratory services provided by Facility. Facility will not bill, nor be reimbursed for laboratory/pathology services performed by another provider entity and not by Facility.

3.2 Payment Code Updates. CCO will update CPT codes, HCPCS codes, ICD-10-CM codes or successor version, and/or revenue codes according to Health Insurance Portability and Accountability Act requirements based on (a) the latest edition of the Current Procedural Terminology (CPT) manual which is revised by the American Medical Association, (b) the latest edition of the HCPCS manual which is revised by CMS (c) the latest edition of the ICD-10-CM manual or successor version which is issued by the U.S. Department of Health and Human Services and (d) the latest revenue code guidelines from the National Uniform Billing Committee.

3.3 Facility-based Physician and Other Provider Charges. Facility will make its best efforts to assure that all Facility-based Physicians and other providers are participating providers as long as the Agreement is in effect.

At any time after the effective date of this Appendix, the current contract rates for all Covered Services under this Appendix will be reduced by CCO by [XX]% for each specialty type, for which the Facility-based Physician or other provider group is not a participating provider (unless charges for the services of those Physicians or providers are included in Facility's charges under this Appendix). However, in the case of Emergency Physicians where the Facility-based Physician or other provider group is not a participating provider the contract rates for Emergency Room Services will be reduced by [XX]%. The reductions will be cumulative (so that if two Facility-based Physicians or provider groups are non-participating, for instance, the reduction would be [XX]%), as further illustrated in the Rate Reduction Table below. The reductions described in this paragraph will be implemented with 30 days written notice and would apply to claims for services rendered on or after the effective date of the reduction. These reductions will remain in effect until the Facility-based Physician or provider group becomes a participating provider or is replaced at Facility by another Facility-based Physician or provider group that is a participating provider. CCO warrants that it will negotiate with each Facility-based Physician and provider group in good faith.

The following calculation will be used to determine the contract rates going forward to account for the percentage reduction:

Current Contract Rate (Current Contract Rate x Percentage Reduction) = New Contract Rate

Rate Reduction Table.

Facility-Based Physician Group	Contract Rates Reduced	Percentage Reduction
Anesthesiologists	All contract rates for Covered Services of any kind	[XX]%
Emergency Physicians	Emergency Room Services	[XX]%
Pathologists	All contract rates for Covered Services of any kind	[XX]%
Radiologists	All contract rates for Covered Services of any kind	[XX]%

3.4 Services Always Included Within the Contract Rate for Other Covered Services and Not Eligible for Consideration in Other Calculations for Payment. Services or items listed in the table below and billed with indicated codes are not subject to additional payment and are not considered in any calculation for payment. When these services are Covered Services, per the Customer's Benefit Plan, Facility may not bill and collect from the Customer for the services, as prohibited under the Agreement. In these cases the contract rate applicable to the Admission or Outpatient Encounter is considered payment in full. However, when these services are not Covered Services, per the Customer's Benefit Plan, Facility may bill and collect from the Customer for the services, as permitted under the Agreement.

Table 3: Services Always Included Within the Contract Rate for Other Covered Services and Not Eligible for Consideration in Other Calculations for Payment

Revenue Code	Description	Revenue Code	Description
0167	Self Care	0624	FDA Invest Device
0180-0189	Leave of Absence	0670-0679	Outpatient Special Residence
0220-0229	Special Charges	0770	Preventative Care Svr/General
0253	Drugs/Take Home	0931-0932	Med Rehab Day Program
0256	Drugs/Experimental	0990-0999	Patient Convenience
0273	Supply/Take Home	2100, 2102, 2104-2109	Alternative Therapy Services
0277	Oxygen/Take Home		

3.5 Services Not Payable Under This Appendix But May Be Payable Under Another Appendix To The Agreement Or Under Another Agreement. Services or items billed with the listed codes in the table below are not subject to payment under this Appendix. In the event Facility is a party to another agreement with CCO or an affiliate of CCO that is applicable to those services rendered to a Customer, or another appendix to the Agreement applies to these services rendered to a Customer, the services below may be payable under that appendix or agreement. When these services are Covered Services, per the Customer's Benefit Plan, Facility will not bill and

collect from the Customer for the services, as prohibited under the Agreement. However, when these services are not Covered Services, per the Customer's Benefit Plan, Facility may bill and collect from the Customer for the services, to the extent permitted under the Agreement.

If Covered Services with the listed codes in the table below are not subject to payment under another appendix to the Agreement or under another agreement, payment will be determined in accordance with CCO rules for providers that are not participating with Benefit Plans subject to this Appendix.

In addition to the Covered Services with the listed codes in the table below, this Appendix does not apply when Facility has an agreement with Optum Health and the services are provided pursuant to an authorization or notification from Optum Health.

Table 4: Services Not Payable Under This Appendix But May be Payable Under Another Appendix To The Agreement Or Under Another Agreement.

Revenue Code	Description	Revenue Code	Description
0114	Psych/Room & Board/Private	0570-0579	Home Health - Home Health Aide
0116	Detox/Private	0580-0589	Home Health - Other Visits
0124	Psych/2 bed	0590	Home Health - Units of Service
0126	Detox/2 bed	0600-0609	Home Health Oxygen
0134	Psych/3&4 bed	0640-0649	Home IV Therapy Services
0136	Detox/3&4 bed	0650-0652, 0657-0659	Hospice Services
0144	Psych/Room & Board Pvt/Deluxe	0660-0669	Respite Care
0146	Detox/Pvt/Deluxe	0810-0819 w/o HCPCS Code V2785	Donor Bank/Bone, Organ, Skin, Bank @
0154	Psych/Ward	0870-0875	Cell/Gene Therapy @
0156	Detox/Ward	0882	Dialysis/Home Aid Visit
0204	ICU/Psych	0901-0907	Psychiatric/Psychological Treatments
0213	CC/Transplant @	0911-0916, 0919	Psychiatric/Psychological Services
0290-0299	Durable Medical Equipment	0941	Recreation/RX
0362	OR/Organ Transplant @	0944	Drug Rehab
0367	OR/Kidney Transplant @	0945	Alcohol Rehab
0512	Clinic - Dental Clinic	0953	Chemical Dependency (Drug and Alcohol)
0513	Clinic - Psychiatric Clinic	0960-0989	Professional Fees
0521-0522, 0524-0525, 0527-0528	Rural Health Clinic (RHC)/ Federally Qualified Health Center (FQHC)	1000-1006	Behavioral Health Accommodations

Revenue Code	Description	Revenue Code	Description
0550-0559	Home Health - Skilled Nursing	3101-3109	Adult Care
0560-0569	Home Health - Medical Social Services		
Agency APR-DRGs	**Description**	**Agency APR-DRGs**	**Description**
001	Liver Transplant &/or Intestinal Transplant	006	Pancreas Transplant
002	Heart &/or Lung Transplant	440	Kidney Transplant
007	Allogeneic Bone Marrow Transplant		
008	Autologous Bone Marrow Transplant or T-Cell Immunotherapy		

@ This Section applies when billed in conjunction with a transplant claim. If part of the care management of a transplant patient, this service will be treated as a transplant service and will not be payable under this Appendix. This service is payable under this Appendix only if it is a Covered Service and is not part of the care management of a transplant patient. When this service is not part of the care management of a transplant patient, this service is considered priced according to the terms of this Appendix. These services are part of the care management of a transplant patient, even if a Customer ultimately does not receive a transplant, if the services were part of the progression for a transplant, the patient was accepted for evaluation as a transplant patient, or if the service was covered pursuant to the Customer's transplant benefits under the applicable Benefit Plan.

3.6 Temporary Transfer. If a Customer is temporarily transferred by Facility, without being discharged from Facility, for services arranged by Facility, facility services (including the services provided at the facility that receives the temporary transfer) will be paid to Facility as one continuous Admission. In such case, Facility is responsible for reimbursing the facility that receives the temporary transfer.

If Facility temporarily transfers Customer, without discharging Customer from Facility, via ambulance for services arranged by Facility, charges for the ambulance services are included in Facility's contracted inpatient rate as determined in Section 2.2 and neither Customer nor Payer will be billed separately.

If a Customer is temporarily transferred to Facility, without being discharged from the transferring facility, for services arranged by the transferring facility, Facility will bill the transferring facility for those services provided to such Customer, and neither Customer nor Payer will be billed.

3.7 Facility Reimbursement for No Cost Items. If an applicable program is available to provide items or payment directly to Facility for specific Covered Services for Customers subject to this Appendix that would otherwise be payable under this Appendix, the applicable program will apply and not this Appendix. However, related items for services not provided or paid under the program may be payable under this Appendix. (For example, the Campath Distribution program currently provides Campath (alemtuzumab) free of charge, and therefore no amount will be payable under this Appendix for Campath (alemtuzumab). However, the

administration of Campath (alemtuzumab) may be payable under this Appendix, because payment is not provided to facilities under the Campath Distribution program.)

3.8 Changes to Agency Rates. Unless otherwise specified in this Appendix, contract rates based on Agency Rates (including a contract rate that is a fixed percentage of the Agency Rate), will be automatically updated within 28 days, or as specified by the Agency, ("Update Period") following publication of new Agency Rates with an effective date as published by the Agency. CCO will reprocess any claims at the updated contract rate.

3.9 Changes to Agency Payment Method. If the Agency changes the Payment Method set forth in this Appendix, CCO will make commercially reasonable efforts to implement new Payment Method within a reasonable time frame. Facility agrees it will accept the current methodologies as set forth in this Appendix, until CCO can implement the change in Payment Method. CCO will communicate the change and the effective date of the change.

If CCO is unable to incorporate all of the Agency Payment Method changes, CCO will notify Facility within 90 days after the Agency published the Payment Method change. The parties will negotiate an amendment to replace this Appendix with an appendix with Payment Methods CCO can administer. If the parties have not reached an agreement within 90 days, either party may initiate dispute resolution according to the Agreement.

SECTION 4
Adjustment to Contract Rates Due to Changes in Facility's Customary Charges

4.1 Intent. The intent of this Section is to allow Facility to modify its Customary Charges when and how Facility chooses, while assuring that increases to Facility's Customary Charges do not have the impact of increasing the amount paid by Payers separately for inpatient or outpatient Covered Services under this Appendix.

Contract rates in this Appendix are subject to change according to this Section as a result of changes to Facility's Customary Charges. Additionally, adjustments to the contract rates pursuant to this Section of this Appendix will carry forward into subsequent years.

4.2 Duty to Give Notice. Facility will notify CCO at least 60 days prior to the implementation date of any increase by Facility to its Customary Charges or a change in an algorithm or formula used to determine the mark up to be applied to the acquisition price for any items or services which is likely to result in an increase in Customary Charges for either inpatient or outpatient Covered Services.

4.3 Content of Notice. Any notice required by Section 4.2 will include, separately for inpatient and outpatient Covered Services, the following:

(a) Facility's Chargemaster data before and after the increase in Facility's Customary Charges with the following criteria and in the format described in the attached Chargemaster Notice Exhibit:

(i) by service item with revenue code mapping, excluding revenue codes listed in the Services Always Included Within the Contract Rate for Other Covered Services and Not Eligible for Consideration in Other Calculations for Payment Table and the Services Not Payable Under This

Appendix But May be Payable Under Another Appendix To The Agreement Or Under Another Agreement Table of this Appendix, and

(ii) in a mutually acceptable format.

(b) The effective date of the Facility's new Chargemaster;

c) Utilization for Payers to which this Appendix is applicable for the most recent twelve months of data available prior to the increase in Facility's increase to its Customary Charges. Utilization is to be reported with the following criteria:

(i) by service item with revenue code mapping, excluding revenue codes listed in the Services Always Included Within the Contract Rate for Other Covered Services and Not Eligible for Consideration in Other Calculations for Payment Table and the Services Not Payable Under This Appendix But May be Payable Under Another Appendix To The Agreement Or Under Another Agreement Table of this Appendix,

(ii) in a mutually acceptable format, and

(iii) separately for inpatient and outpatient services.

(d) Facility's estimate of the new inpatient and outpatient PPR contract rates rounded to the nearest digit to the right of the decimal point going forward at which the cost to Payers of PPR Covered Services will be no greater than the cost during the previous contract year. Facility's estimates will be in the format described in the attached Chargemaster Notice Exhibit. Facility will use the formula(s) in the attached Chargemaster Notice Exhibit to calculate its estimate of the new PPR contract rates. Facility's estimate will assume that utilization reported in (c) above will be the same before and after the Customary Charge increase.

(e) Facility's estimate of the fixed contract rates going forward, at which the cost to Payers of fixed rate Covered Services will be the same as it was prior to the Customary Charge increase triggering the lesser of logic calculation. Facility's estimate will assume that utilization reported in (c) above will be the same before and after the Customary Charge increase.

4.4 Cooperation with CCO. Facility will cooperate with CCO in administration of this Section by timely meeting with CCO to discuss and explain the information provided in accordance with Section 4.3, including Facility's calculation of the new PPR contract rates and fixed contract rates (impacted by lesser of).

4.5 Adjustment to Contract Rates. Upon receipt of the notice described in Section 4.3, CCO will adjust the inpatient and outpatient PPR contract rates (excluding any Fee Schedule Default PPR rate) and fixed contract rates (impacted by lesser of) using the estimates in the notice. CCO will create and implement a new version of this Appendix. The revised appendix will be identical to this Appendix, other than the revised PPR contract rates and fixed contract rates (impacted by lesser of) set forth in the notice. CCO may implement the revised appendix without Facility's consent; provided that the revised appendix contains no other changes. CCO will provide Facility with a copy of the revised appendix, along with the effective date of the revised appendix.

4.6 CCO's right to audit. In addition to any other audit rights that CCO may have under the Agreement, CCO may conduct audits in connection with this Section 4. The purpose of the audit may be to identify any instance in which Facility did not give the required notice, or provided inaccurate information, or provided incorrect estimates of the necessary changes to the PPR contract rates or fixed contract rates (impacted by lesser of). Facility will cooperate with the audit process and will provide to CCO documentation that CCO reasonably requests in order to perform such audits.

4.7 Recovery of overpayments. In the event that CCO determines that an overpayment to Facility has resulted due to Facility's failure to give timely notice as required under this Section 4, or due to Facility providing inaccurate information, or due to Facility providing incorrect estimates of the adjustments needed to the PPR contract rates or fixed contract rates (impacted by lesser of), CCO may recover those overpayments. CCO will give Facility notice of, and CCO's intent to, recover the overpayment. The notice will identify CCO's basis for believing that an overpayment has occurred, how CCO will recover the overpayment and how CCO will prospectively adjust the PPR contract rates and fixed contract rates (impacted by lesser of) to prevent additional overpayments from occurring. CCO's right to collect overpayments under this Section 4.7 is in addition to any other rights to adjust claims or collect overpayments CCO may have under the Agreement and is not subject to any time limitations otherwise set forth in the Agreement.

CCO will timely meet with Facility, upon Facility's request, to discuss and explain the information in CCO's notice, how CCO calculated that information, and why CCO believes this information to be correct.

In the event that Facility initiates dispute resolution as further described under Section 4.8, the recovery and adjustments described in this Section 4.7 will not take place until the conclusion of the dispute resolution process.

4.8 Dispute resolution. In the event Facility disagrees with CCO as to the existence of an overpayment or the amount of the overpayment or with the amount of the contract rate adjustment described in Section 4.7, the issue will be resolved through the dispute resolution process set forth in the Agreement.

Chemotherapy Fee Schedule Exhibit

As described in Table 2 of this Appendix, Chemotherapy, the negotiated percentage is [XX]% of the "Source Fee" as described in the Chemotherapy Fee Schedule Exhibit, as noted under the column header "Negotiated Percentage of Agency Rate".

Outpatient Facility Fee Schedule Exhibit

As described in Table 2 of this Appendix, All Other Outpatient Services, the negotiated percentage is [XX]% of the "Source Fee" as described in the Outpatient Facility Fee Schedule Exhibit, as noted under the column header "Negotiated Percentage of Agency Rate".

CHARGEMASTER NOTICE EXHIBIT

Indian Health Services
MS State Specific
Medicaid Payment Appendix

Indian Health Services MS State Specific Medicaid Payment Appendix

APPLICABILITY

Facility or Facilities subject to this Appendix as of this Appendix Effective Date: _____
Tax ID: _____
Provider ID: _____
This Appendix applies to the following types of Benefit Plans as described in the Agreement: • [Mississippi Medicaid Benefit Plans] • [Mississippi CHIP Benefit Plans] This Appendix does not apply, to the extent another agreement or appendix between the parties or their affiliates specifically applies to a given Benefit Plan that would otherwise be subject to this Appendix.
This Appendix is effective for dates of service on or after: _____ Any prior Appendix applicable to the same Benefit Plan(s) are superseded by this Appendix.

Unless another Appendix to the Agreement applies specifically to a particular Benefit Plan as it covers a particular Customer, the provisions of this Appendix apply to Covered Services rendered by or at Facility when it is acting as an Indian Health Services provider to Customers with regard to Benefit Plans subject to this Appendix.

SECTION 1
Definitions

Unless otherwise defined in this Section, capitalized terms used in this Appendix have the meanings assigned to them in the Agreement. If any definition in this Appendix conflicts with another definition in the Agreement, the definition in this Appendix controls, with regard to Benefit Plans subject to this Appendix.

Admission: The admittance of a Customer to a licensed hospital bed, excluding Observation. Admission applies only to those services provided by order of a Physician.

Agency: Mississippi Medicaid agency, responsible for sponsoring the Benefit Plans subject to this Appendix.

Agency Rates: The rates set by the Agency for Covered Services for the Payment Methods in this Appendix.

CMS: Centers for Medicare and Medicaid Services.

Customer Expenses: Copayments, deductibles, or coinsurance that are the financial responsibility of the Customer according to the Customer's Benefit Plan.

Eligible Charges: The Customary Charge for Covered Services, except for Covered Services listed under Sections 3.3 and/or 3.4 of this Appendix.

IHS (Indian Health Services): A facility or location that meets the current criteria set forth by CMS for being designated as, and is currently designated by CMS as, an Indian Health Services facility which provides

diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services to federally recognized Tribes and Alaska Natives receiving inpatient or outpatient services.

Institutional Claim: Any UB04 or electronic version or successor form.

Outpatient Encounter: Covered Services rendered to a Customer by Facility on an outpatient basis from the time of registration for outpatient services until discharge.

Payment Method: A methodology for determining contract rates under this Appendix. Unless otherwise specified in this Appendix, payment under this Appendix, less any applicable Customer Expenses, is considered payment in full for all Covered Services rendered to the Customer including (as applicable), but not limited to:

• Physician and other professional fees billed by Facility on an Institutional Claim
• Services rendered by non-Physician personnel (regardless of whether those personnel are employed by Facility and regardless of whether those services are characterized as professional services)
• Preadmission services or outpatient services related to an Admission that occur within three calendar days prior to Admission
• Nursing care
• Observation
• Critical care
• Surgical services
• Diagnostic and therapeutic services (including but not limited to diagnostic imaging)
• Ancillary services
• Durable medical equipment
• Supplies (including, but not limited to, anesthesia supplies)
• Medications
• Room and board

Per Diem: The Payment Method applicable to Covered Services rendered to a Customer for each day during an Admission.

Per Visit: The Payment Method applicable to Covered Services rendered to a Customer during one-calendar day period, for each Service Category. Facility is required to identify each date of service when submitting claims spanning multiple dates of service.

Physician: A Doctor of Medicine ("M.D."), a Doctor of Osteopathy ("D.O.") or another health care professional as authorized under applicable law and Facility bylaws to admit or refer patients for Covered Services.

SECTION 2
Contract Rate for Covered Services

2.1 Contract Rate. For Covered Services rendered by Facility to a Customer, the contract rate will be the lesser of (1) Facility's Eligible Charges, or (2) the applicable contract rate determined in accordance with Sections 2.2, 2.3 and/or 3 of this Appendix, less any Customer Expenses. Payment by CCO of the contract rate under this Appendix will be less any applicable Customer Expenses, and is subject to the requirements set forth in the Agreement.

2.2 Inpatient Covered Services. For the provision of Covered Services to a Customer during an Admission, the contract rate is determined as described in this Section. Unless otherwise specified in this Appendix, the negotiated percentage for an entire Admission is the negotiated percentage in effect on the first day of the Admission.

Table 1: Inpatient Service Category Table

SERVICE CATEGORY	PAYMENT METHOD	CONTRACT RATE AS OF THE EFFECTIVE DATE OF THIS APPENDIX	NEGOTIATED PERCENTAGE OF AGENCY RATE
All Inpatient Services (except those listed in Section 3.4) Revenue Codes 0100-0101, 0110-0113, 0115, 0117-0123, 0125, 0127-0133, 0135, 0137-0143, 0145, 0147-0153, 0155, 0157-0160, 0164, 0169, 0170-0174, 0179, 0190-0194, 0199, 0200-0203, 0206-0212, 0214, 0219, 0655-0656	**Per Diem**	**$_____**	**[XX]% of Agency Rate**

2.3 Outpatient Covered Services. For Outpatient Covered Services, appropriate CPT and/or HCPCS codes, as described by the National Uniform Billing Committee and CPT/HCPCS code guidelines, must be submitted on the Institutional Claim in order to be eligible for reimbursement. Revenue codes and CPT/HCPCS codes that are used by Agency outside of the National Uniform Billing Committee guidelines and CPT/HCPCS code guidelines are not considered valid and are not eligible for reimbursement.

2.3.1 Outpatient Service Categories. For the provision of Covered Services rendered by Facility to a Customer during an Outpatient Encounter, the contract rate will be determined according to Sections 2.3 and 2.3.1, and the applicable table included therein. Unless otherwise specified in this Appendix, the negotiated percentage identified in this Section for an entire Outpatient Encounter is the percentage in effect on the date the Outpatient Encounter begins.

Table 2: Outpatient Service Category Table

SERVICE CATEGORY	PAYMENT METHOD	CONTRACT RATE AS OF THE EFFECTIVE DATE OF THIS APPENDIX	NEGOTIATED PERCENTAGE

			OF AGENCY RATE
All Outpatient Services Revenue Codes: 0230-0235, 0239, 0240-0243, 0249, 0250-0252, 0254-0255, 0257-0259, 0260-0264, 0269, 0270-0272, 0274-0276, 0278-0279, 0280, 0289, 0300-0307, 0309, 0310-0312, 0314, 0319-0324, 0329-0333,0335,0339-0344, 0349-0352, 0359, 0360, 0361, 0369, 0370-0374, 0379, 0380-0387, 0389, 0390-0392, 0399, 0400- 0404, 0409-0410, 0412-0413, 0419, 0420-0424, 0429, 0430-0434, 0439, 0440-0444, 0449, 0450-0452, 0456, 0459-0460, 0469, 0470-0472, 0479, 0480-0483, 0489, 0490, 0499, 0500, 0509, 0510-0512, 0514-0519, 0530-0531, 0539, 0540-0549, 0610-0612, 0614-0616, 0618, 0619, 0621-0623, 0631-0637, 0681-0684, 0689, 0690-0696, 0699, 0700, 0710, 0720-0724, 0729, 0730-0732, 0739, 0740, 0750, 0760-0762, 0769, 0770-	**Per Visit**	**$_____**	**[XX]% of Agency Rate**

0771, 0780, 0790, 0820-0825, 0829, 0830-0835, 0839-0845, 0849-0855, 0859, 0900, 0917-0918, 0920-0925, 0929, 0940, 0942, 0943, 0946-0949, 0951-0953			

SECTION 3
Miscellaneous Provisions

3.1 Inclusive Rates. The contract rates established by this Appendix are all-inclusive, including without limitation applicable taxes, for the provision of all Covered Services to the Customer that are in the service category that corresponds to the contract rate and which are generally provided as a part of the service category. All items and non-Physician services provided to Customers at Facility must be directly furnished by Facility or billed by Facility when services are provided by another entity. For example, surgical procedures for implantable DME or for implantable prosthetic devices performed at Facility include the cost of the device in the contract rates listed in Section 2, as applicable. No additional payments will be made for any services or items covered under the Customer's Benefit Plan and billed for separately by Facility.

Notwithstanding the foregoing, Facility will only bill for inpatient and outpatient laboratory services provided by Facility. Facility will not bill, nor be reimbursed for laboratory/pathology services performed by another provider entity and not by Facility.

3.2 Payment Code Updates. CCO will update any codes, such as revenue codes, ICD-10-CM codes, or successor version, HCPCS codes and/or CPT codes from time to time according to changes in the industry, including among other things (a) the latest edition of the Current Procedural Terminology (CPT) manual which is revised by the American Medical Association, (b) the latest edition of the HCPCS manual which is revised by CMS, (c) the latest edition of the ICD-10-CM manual, or successor version, which is issued by the U.S. Department of Health and Human Services and, (d) the latest revenue code guidelines from the National Uniform Billing Committee.

3.3 Services Always Included Within the Contract Rate for Other Covered Services and Not Eligible for Consideration in Other Calculations for Payment. Services or items listed in the table below and billed with indicated codes are not subject to additional payment and are not considered in any calculation for payment. When these services are Covered Services, per the Customer's Benefit Plan, Facility may not bill and collect from the Customer for the services, as prohibited under the Agreement. In these cases the contract rate applicable to the Admission or Outpatient Encounter is considered payment in full. However, when these services are not Covered Services, per the Customer's Benefit Plan, Facility may bill and collect from the Customer for the services, as permitted under the Agreement.

Table 3: Services Always Included Within the Contract Rate for Other Covered Services and Not Eligible for Consideration in Other Calculations for Payment

Revenue Code	Description	Revenue Code	Description
0167	Self Care	0624	FDA Invest Device
0180-0189	Leave of Absence	0670-0679	Outpatient Special Residence
0220-0229	Special Charges	0770	Preventative Care Svc/General
0253	Drugs/Take Home	0931-0932	Med Rehab Day Program
0256	Drugs/Experimental	0990-0999	Patient Convenience
0273	Supply/Take Home	2100, 2102, 2104-2109	Alternative Therapy Services
0277	Oxygen/Take Home		

3.4 Services Not Payable Under This Appendix But May Be Payable Under Another Appendix To The Agreement Or Under Another Agreement. Services or items billed with listed codes in the table below are not subject to payment under this Appendix. In the event Facility is a party to another agreement with CCO or an affiliate of CCO that is applicable to those services rendered to a Customer, or if another appendix to the Agreement applies to these services rendered to a Customer, the services below may be payable under that agreement or appendix. When these services are Covered Services, per the Customer's Benefit Plan, Facility will not bill and collect from the Customer for the services, as prohibited under the Agreement. However, when these services are not Covered Services, per the Customer's Benefit Plan, Facility may bill and collect from the Customer for the services, to the extent permitted under the Agreement.

If Covered Services with the listed codes in the table below are not subject to payment under another appendix to the Agreement or under another agreement, reimbursement will be determined in accordance with CCO rules for providers that are not participating with Benefit Plans subject to this Appendix.

In addition to the Covered Services with the listed codes in the table below, this Appendix does not apply when Facility has an agreement with Optum Health and the services are provided pursuant to an authorization or notification from Optum Health.

Table 4: Services Not Payable Under This Appendix But May Be Payable Under Another Appendix To The Agreement Or Under Another Agreement.

Revenue Code	Description	Revenue Code	Description
0114	Psych/Room & Board/Private	0570-0579	Home Health - Home Health Aide
0116	Detox/Private	0580-0589	Home Health - Other Visits
0124	Psych/2 bed	0590	Home Health - Units of Service
0126	Detox/2 bed	0600-0609	Home Health Oxygen
0134	Psych/3&4 bed	0640-0649	Home IV Therapy Services
0136	Detox/3&4 bed	0650-0652, 0657-0659	Hospice Services
0144	Psych/Room & Board Pvt/Deluxe	0660-0669	Respite Care

Revenue Code	Description	Revenue Code	Description
0146	Detox/Pvt/Deluxe	0810-0819 w/o HCPCS Code V2785	Donor Bank/Bone, Organ, Skin, Bank @
0154	Psych/Ward	0870-0875	Cell/Gene Therapy @
0156	Detox/Ward	0882	Dialysis/Home Aid Visit
0204	ICU/Psych	0901-0907	Psychiatric/Psychological Treatments
0213	CC/Transplant @	0911-0916, 0919	Psychiatric/Psychological Services
0290-0299	Durable Medical Equipment	0941	Recreation/RX
0362	OR/Organ Transplant @	0944	Drug Rehab
0367	OR/Kidney Transplant @	0945	Alcohol Rehab
0513	Clinic - Psychiatric Clinic	0953	Chemical Dependency (Drug and Alcohol)
0521-0522, 0524-0525 0527-0528	Rural Health Clinic (RHC)/Federally Qualified Health Center(FQHC)	0960-0989	Professional Fees - Psychiatric
0550-0559	Skilled Nursing	1000-1006	Behavioral Health Accommodations
0560-0569	Home Health - Medical Social Services	3101-3109	Adult Care

@ This Section applies when billed in conjunction with a transplant claim. If part of the care management of a transplant patient, this service will be treated as a transplant service and will not be payable under this Appendix. This service is payable under this Appendix only if it is a Covered Service and is not part of the care management of a transplant patient. When this service is not part of the care management of a transplant patient, this service is considered priced according to the terms of this Appendix. These services are part of the care management of a transplant patient, even if a Customer ultimately does not receive a transplant, if the services were part of the progression for a transplant, the patient was accepted for evaluation as a transplant patient, or if the service was covered pursuant to the Customer's transplant benefits under the applicable Benefit Plan.

3.5 Facility Reimbursement for No Cost Items. If an applicable program is available to provide items or payment directly to Facility for specific Covered Services for Customers subject to this Appendix that would otherwise be payable under this Appendix, the applicable program will apply and not this Appendix. However, related items for services not provided or paid under the program may be payable under this Appendix. (For example, the Campath Distribution program currently provides Campath (alemtuzumab) free of charge, and therefore no amount will be payable under this Appendix for Campath (alemtuzumab). However, the administration of Campath (alemtuzumab) may be payable under this Appendix, because payment is not provided to facilities under the Campath Distribution program.)

3.6 Changes to Agency Rates. Unless otherwise specified in this Appendix, contract rates based on Agency Rates (including a contract rate that is a fixed percentage of the Agency Rate), will be automatically updated within 28 days, or as specified by the Agency, ("Update Period") following publication of new Agency Rates with an effective date as published by the Agency. CCO will reprocess any claims at the updated contract rate.

3.7 Changes to Agency Payment Method. If the Agency changes the Payment Method set forth in this Appendix, CCO will make commercially reasonable efforts to implement new Payment Method within a reasonable time frame. Facility agrees it will accept the current methodologies as set forth in this Appendix, until CCO can implement the change in Payment Method. CCO will communicate the change and the effective date of the change.

If CCO is unable to incorporate all of the Agency Payment Method changes, CCO will notify Facility within 90 days after the Agency published the Payment Method change. The parties will negotiate an amendment to replace this Appendix with an appendix with Payment Methods CCO can administer. If the parties have not reached an agreement within 90 days, either party may initiate dispute resolution according to the Agreement.

Ancillary Provider Participation Agreement

Ancillary Provider Participation Agreement

This Agreement is entered into by and between CCO, contracting on behalf of itself, HMO and the other entities that are CCO's Affiliates (collectively referred to as "CCO") and _____ ("Facility").

This Agreement is effective on the later of the following dates (the "Effective Date"):

i) _____, ___ or

ii) the first day of the first calendar month that begins at least 30 days after the date when this Agreement has been executed by all parties.

Through contracts with physicians and other providers of health care services, CCO maintains one or more networks of providers that are available to Customers. Facility is a provider of health care services.

CCO wishes to arrange to make Facility's services available to Customers. Facility wishes to provide those services, under the terms and conditions set forth in this Agreement.

The parties therefore enter into this Agreement.

Article I
Definitions

The following terms when used in this Agreement have the meanings set forth below:

1.1 **Benefit Plan** means a certificate of coverage, summary plan description, or other document or agreement, whether delivered in paper or electronic format, under which a Payer is obligated to provide coverage of Covered Services for a Customer.

1.2 **Covered Service** is a health care service or product for which a Customer is entitled to receive coverage from a Payer, pursuant to the terms of the Customer's Benefit Plan with that Payer.

1.3 **Customary Charge** is the fee for health care services charged by Facility that does not exceed the fee Facility would ordinarily charge another person regardless of whether the person is a Customer.

1.4 **Customer** is a person eligible and enrolled to receive coverage from a Payer for Covered Services.

1.5 **Payment Policies** are the guidelines adopted by CCO for calculating payment of claims to facilities (including claims of Facility under this Agreement). The Payment Policies operate in conjunction with the specific reimbursement rates and terms set forth in the Payment

Appendix or Payment Appendices to this Agreement. The Payment Policies may change from time to time as discussed in section 5.1 of this Agreement.

1.6 **Payer** is an entity obligated to a Customer to provide reimbursement for Covered Services under the Customer's Benefit Plan, and authorized by CCO to access Facility's services under this Agreement.

1.7 **Protocols** are the programs and administrative procedures adopted by CCO or a Payer to be followed by Facility in providing services and doing business with CCO and Payers under this Agreement. These Protocols may include, among other things, credentialing and recredentialing processes, utilization management and care management processes, quality improvement, peer review, Customer grievance, or concurrent review. The Protocols may change from time to time as discussed in section 4.4 of this Agreement.

1.8 **CCO's Affiliates** are those entities controlling, controlled by, or under common control with CCO.

Article II
Representations and Warranties

2.1 **Representations and warranties of Facility**. Facility, by virtue of its execution and delivery of this Agreement, represents and warrants as follows:

i) Facility is a duly organized and validly existing legal entity in good standing under the laws of its jurisdiction of organization.

ii) Facility has all requisite corporate power and authority to conduct its business as presently conducted, and to execute, deliver and perform its obligations under this Agreement. The execution, delivery and performance of this Agreement by Facility have been duly and validly authorized by all action necessary under its organizational documents and applicable corporate law. This Agreement has been duly and validly executed and delivered by Facility and (assuming the due authorization, execution and delivery of this Agreement by CCO) constitutes a valid and binding obligation of Facility, enforceable against Facility in accordance with its terms, except as enforceability may be limited by the availability of equitable remedies or defenses and by applicable bankruptcy, insolvency, reorganization, moratorium or similar laws affecting the enforcement of creditors' rights generally.

iii) The execution, delivery and performance of this Agreement by Facility do not and will not violate or conflict with (a) the organizational documents of Facility, (b) any material agreement or instrument to which Facility is a party or by which Facility or any material part of its property is bound, or (c) applicable law.

iv) Facility has obtained and holds all registrations, permits, licenses, and other approvals and consents, and has made all filings, that it is required to obtain from or make with all governmental entities under applicable law in order to conduct its business as presently conducted and to enter into and perform its obligations under this Agreement.

v) Facility has been given an opportunity to review the Protocols and Payment Policies. See the Additional Manuals Appendix for additional information regarding the Protocols and Payment Policies applicable to Customers enrolled in certain Benefit Plans.

vi) Each submission of a claim by Facility pursuant to this Agreement constitutes the representation and warranty by it to CCO that (a) it has complied with the requirements of this Agreement with respect to the Covered Services involved and the submission of the claim, (b) the charge amount set forth on the claim is the Customary Charge and (c) the claim is a valid claim.

2.2 Representations and warranties of CCO. CCO, by virtue of its execution and delivery of this Agreement, represents and warrants as follows:

i) CCO is a duly organized and validly existing legal entity in good standing under the laws of its jurisdiction of organization.

ii) CCO has all requisite corporate power and authority to conduct its business as presently conducted, and to execute, deliver and perform its obligations under this Agreement. The execution, delivery and performance of this Agreement by CCO have been duly and validly authorized by all action necessary under its organizational documents and applicable corporate law. This Agreement has been duly and validly executed and delivered by CCO and (assuming the due authorization, execution and delivery of this Agreement by Facility) constitutes a valid and binding obligation of CCO, enforceable against CCO in accordance with its terms, except as enforceability may be limited by the availability of equitable remedies or defenses and by applicable bankruptcy, insolvency, reorganization, moratorium or similar laws affecting the enforcement of creditors' rights generally.

iii) The execution, delivery and performance of this Agreement by CCO do not and will not violate or conflict with (a) the organizational documents of CCO, (b) any material agreement or instrument to which CCO is a party or by which CCO or any material part of its property is bound, or (c) applicable law.

iv) CCO has obtained and holds all registrations, permits, licenses, and other approvals and consents, and has made all filings, that it is required to obtain from or make with all governmental entities under applicable law in order to conduct its business as presently conducted and to enter into and perform its obligations under this Agreement.

Article III
Applicability of this Agreement

3.1 Facility's services.

i) This Agreement applies to Covered Services provided at Facility's service locations set forth in Appendix 1. If the service location is not listed in Appendix 1, this section 3.1 and this Agreement should nevertheless be understood as applying to the actual service locations that existed when this Agreement was executed, rather than to a billing address, post office box, or any other address set forth in Appendix 1.

In the event Facility begins providing services at other service locations, at new types of facilities, or under other Taxpayer Identification Number(s), those additional Taxpayer Identification Numbers, new types of facilities or locations, will become subject to this Agreement only upon the written agreement of the parties. This subsection 3.1(i) applies to cases when Facility adds the location itself (such as through new construction or through

conversion of a free-standing location to provider-based), and when Facility acquires, merges or comes under common ownership with an existing provider that was not already under contract with CCO or one of CCO's Affiliates to participate in a network of health care providers). For purposes of this section 3.1, "new types of facilities" include any type of health care provider other than _____.

Substitute (for Lab or SNF only):

[3.1 Facility's services.

i) This Agreement applies to Covered Services provided at Facility's service locations set forth in Appendix 1. If the service location is not listed in Appendix 1, this section 3.1 and this Agreement should nevertheless be understood as applying to the actual service locations that existed when this Agreement was executed, rather than to a billing address, post office box, or any other address set forth in Appendix 1.

In the event Facility begins providing services at other service locations, or under other Taxpayer Identification Number(s), those additional Taxpayer Identification Numbers, or locations will become subject to this Agreement only upon the written agreement of the parties. This subsection 3.1(i) applies to cases when Facility adds the location itself (such as through new construction or through conversion of a free-standing location to provider-based), and when Facility acquires, merges or comes under common ownership with an existing provider that was not already under contract with CCO or one of CCO's Affiliates to participate in a network of health care providers).]

ii) In the event Facility acquires or is acquired by, merges with, or otherwise becomes affiliated with another provider of health care services that is already under contract with CCO or one of CCO's Affiliates to participate in a network of health care providers, the payment rates for each of Facility's locations specified in this Agreement and the payment rates for the other provider will be (a) the rates set forth in the other agreement, or (b) the rates set forth in the applicable Payment Appendix to this Agreement, as decided by CCO with written notice to Facility.

iii) Facility will not transfer all or some of its assets to any other entity during the term of this Agreement, with the result that all or some of the Covered Services subject to this Agreement will be rendered by the other entity rather than by Facility, without the express written agreement of CCO. This subsection 3.1(iii) applies to arrangements under which another provider leases space from Facility after the Effective Date of this Agreement, so that Covered Services that were subject to this Agreement as of the Effective Date of this Agreement are rendered instead by another provider after the lease takes place.

3.2 Payers and Benefit Plans. CCO may allow Payers to access Facility's services under this Agreement for certain Benefit Plans, as described in Appendix 2. Appendix 2 may be modified by CCO upon 30 days written or electronic notice.

Section 8.3 of this Agreement will apply to Covered Services provided to Customers covered by Benefit Plans that are added to the list in Appendix 2 of Benefit Plans excluded from this Agreement as described above.

3.3 Patients who are not Customers. This Agreement does not apply to services rendered to patients who are not Customers at the time the services were rendered. Section 6.6 of this Agreement addresses circumstances in which claims for services rendered to those patients are inadvertently paid.

3.4 Health care. This Agreement and Customer Benefit Plans do not dictate the health care provided by Facility, or govern Facility's determination of what care to provide its patients, even if those patients are Customers. The decision regarding what care is to be provided remains with Facility and with Customers and their physicians, and not with CCO or any Payer.

***LAB Substitute**:*

[**3.4 Health care.** This Agreement and Customer Benefit Plans do not dictate the health care provided by Facility. The decision regarding what care is to be provided remains with Customers and their physicians, and not with CCO or any Payer.]

3.5 Communication with Customers. Nothing in this Agreement is intended to limit Facility's right or ability to communicate fully with a Customer and the Customer's physician regarding the Customer's health condition and treatment options. Facility is free to discuss all treatment options without regard to whether or not a given option is a Covered Service. Facility is free to discuss with a Customer any financial incentives Facility may have under this Agreement, including describing at a general level the payment methodologies contained in this Agreement. Facility may also assist a Customer in estimating the cost of a given Covered Service.

Ancillary Additional – Emergency Transport Services only:

[3.6 Services rendered by a Facility that is a provider of emergency transport and other related health care services. The following provisions of this Agreement do not apply to services rendered by Facility that is a provider of emergency transport and other related health care services when taking Customer to the nearest emergency facility in an emergent situation in order for Customer to be stabilized and to receive screening examinations:

i) the requirement in section 6.5(ii) that Facility first obtain the Customer's written consent in order to seek and collect payment from a Customer for non-covered services (however, Facility will obtain the Customer's consent as soon as it is reasonable to do so consistent with Facility's legal obligations regarding the provision of emergency transport and other related health care services when taking Customer to the nearest emergency facility in an emergent situation in order for Customer to be stabilized and to receive screening examinations and then, only if the consent is not obtained by the admissions personnel of the emergency facility to which the Customer is brought);

ii) the statement in section 3.4 that the decision regarding what care is to be provided remains with Facility and with Customers and their physicians. Instead the decision regarding what care is to be provided remains with Facility and with Customers to the extent they are able to discuss the care to be provided by Facility;

iii) the requirements in section 4.3; however, Facility will provide services 24 hours per day, seven days per week;

iv) sections 4.4(i) and 4.4(ii);

v) the requirement in section 4.9 that Facility obtain the Customer's consent to authorize Facility to provide access to requested information or records as contemplated in section 4.10 (however, Facility will obtain the Customer's consent as soon as it is reasonable to do so consistent with Facility's legal obligations regarding the provision of emergency transport and other related health care services when taking Customer to the nearest emergency facility in an emergent situation in order for Customer to be stabilized and to receive screening examinations and then, only if the Facility keeps medical records);

vi) the requirements in section 4.10 regarding medical records (but only if Facility does not keep medical records because medical records are instead kept by the emergency facility to which the Customer is brought);

vii) the requirements in section 4.11 regarding certain quality data (but only if Facility does not collect and review that quality data because the collection and review of that quality data is instead done by the emergency facility to which the Customer is brought);

viii) the requirement in section 6.6 that, prior to rendering services, Facility ask the patient to present his or her Customer identification card (however, Facility will ask patient to present his or her Customer identification card as soon as it is reasonable to do so consistent with Facility's legal obligations regarding the provision of emergency transport and other related health care services when taking Customer to the nearest emergency facility in an emergent situation in order for Customer to be stabilized and to receive screening examinations and then, only if the role is not instead played by the admissions personnel of the emergency facility to which the Customer is brought).]

Article IV
Duties of Facility

4.1 Provide Covered Services. Facility will provide Covered Services to Customers. Facility must be in compliance with section 2.1(iv) of this Agreement and, to the extent Facility is subject to credentialing by CCO, Facility must be credentialed by CCO or its delegate prior to furnishing any Covered Services to Customers under this Agreement.

4.2 **Nondiscrimination.** Facility will not discriminate against any patient, with regard to quality of service or accessibility of services, on the basis that the patient is a Customer.

4.3 **Accessibility.** At a minimum, Facility will be open during normal business hours, Monday through Friday.

4.4 **Cooperation with Protocols**. Facility will cooperate with and be bound by CCO's and Payers' Protocols. The Protocols include but are not limited to all of the following:

i) For non-emergency Covered Services, Facility will assist Customers to maximize their benefits by referring or directing Customers only to other providers that participate in CCO's network, except as authorized by CCO through CCO's process for approving out-of-network services for in-network benefits.

ii) As further described in the Protocols, Facility will provide notification and participate in utilization management programs regarding certain Covered Services, accept and return telephone calls from CCO staff, and respond to CCO requests for clinical information as required by CCO or Payer.

SNF Only Additional:

[iii) Facility will make reasonable commercial efforts to assure that all Facility-based physician groups participate in CCO's network as long as this Agreement is in effect.

In the event that a Facility-based physician group is not a participating provider with CCO, Facility's Chief Financial Officer or equivalent senior level officer ("Facility Representative") will assist CCO in its efforts to negotiate an agreement with that group. Upon request by CCO, Facility Representative will:

a) meet with Facility-based physician group to encourage participation and require exchange of proposals. Facility Representative will provide CCO with meeting minutes within 15 days after the meeting. Meeting minutes will include a summary of the key discussion points and an outline of any actionable resolution options deemed by Facility Representative.

b) write letter(s) to Facility-based physician group encouraging the group to negotiate in good faith with CCO. The letter will also outline any contractual requirements in the agreement between Facility and Facility-based physician group that requires Facility-based physician group to negotiate in good faith with third party payers, or participate in third party payer networks, and any other provisions related to Facility-based physician group's participation with third party payers.

c) invoke any applicable penalties or other contractual terms in its agreement with Facility-based physician group related to its non-participating status with a third party payer.

d) allow independent legal counsel (mutually agreeable to all relevant parties) to review Facility's agreement with the Facility-based physician group to ensure Facility is fully invoking all the relevant terms and conditions of that agreement to require or promote Facility-based physician group's participation status with CCO.

CCO will negotiate with Facility-based physician groups in good faith. CCO has no responsibility for the credentialing of any employed or sub-contracted Facility-based provider.]

The Protocols will be made available to Facility online or upon request. Some or all Protocols also may be disseminated in the form of an administrative manual or guide or in other communications. Currently, the Protocols may be found at portal.com. CCO will notify Facility of any changes in the location of the Protocols.

CCO may change the Protocols from time to time. CCO will use reasonable commercial efforts to inform Facility at least 30 days in advance of any material changes to the Protocols. CCO may implement changes in the Protocols without Facility's consent if the change is applicable to all or substantially all facilities of the same type and in the same state as Facility (as used in this sentence, examples of a type of facility are an inpatient hospital, SNF, rehab hospital, or ambulatory surgery center). Otherwise, changes to the Protocols proposed by CCO to be applicable to Facility are subject to the terms of section 9.2 of this Agreement applicable to amendments.

4.5 Employees and subcontractors. Facility will assure that its employees, affiliates and any individuals or entities subcontracted by Facility to render services in connection with this Agreement adhere to the requirements of this Agreement. The use of employees, affiliates or subcontractors to render services in connection with this Agreement will not limit Facility's obligations and accountability under this Agreement with regard to these services. Facility affiliates are those entities that control, are controlled by or are under common control with Facility.

4.6 Licensure. Facility will maintain, without material restriction, such licensure, registration, and permits as are necessary to enable Facility to lawfully perform this Agreement.

4.7 Liability insurance. Facility will procure and maintain liability insurance. Except to the extent coverage is a state mandated placement, Facility's coverage must be placed with responsible, financially sound insurance carriers authorized or approved to write coverage in the state in which the Covered Services are provided. Facility's liability insurance must be, at a minimum, of the types and in the amounts set forth below. Facility's medical malpractice insurance must be either occurrence or claims made with an extended period reporting option. Prior to the Effective Date of this Agreement and within 10 days of each policy renewal thereafter, Facility will submit to CCO in writing evidence of insurance coverage.

TYPE OF INSURANCE	MINIMUM LIMITS
Medical malpractice and/or professional liability insurance	Five Million Dollars ($5,000,000.00) per occurrence and aggregate
Commercial general and/or umbrella liability insurance	Five Million Dollars ($5,000,000.00) per occurrence and aggregate

Substitute Table for SNF Contracts: **[**

TYPE OF INSURANCE	MINIMUM LIMITS
Medical malpractice and/or professional liability insurance	One Million Dollars ($1,000,000.00) per occurrence and Three Million Dollars ($3,000,000.00) aggregate
Commercial general and/or umbrella liability insurance	One Million Dollars ($1,000,000.00) per occurrence and aggregate

]

In lieu of purchasing the insurance coverage required in this section, Facility may, with the prior written approval of CCO, self-insure its medical malpractice and/or professional liability, as well as its commercial general liability. Facility will maintain a separate reserve for its self-insurance. Prior to the Effective Date, Facility will provide a statement, verified by an independent auditor or actuary, that its reserve funding levels and process of funding appears adequate to meet the requirements of this section and fairly represents the financial condition of the fund. Facility will provide a similar statement during the term of this Agreement upon CCO's request, which will be made no more frequently than annually. Facility will assure that its self-insurance fund will comply with applicable laws and regulations.

4.8 Notice by Facility. Facility will give notice to CCO within 10 days after any event that causes Facility to be out of compliance with section 4.6 or 4.7 of this Agreement, or of any change in Facility's name, ownership, control, or Taxpayer Identification Number.

In addition, Facility will give written notice to CCO 45 days prior to the effective date of changes in existing remit address(es) and other demographic information.

Lab Substitute:

[4.8 Notice by Facility. Facility will give notice to CCO within 10 days after any event that causes Facility to be out of compliance with section 4.6 or 4.7 of this Agreement, or of any change in Facility's name, ownership, control, or Taxpayer Identification Number.

In addition, Facility will give written notice to CCO 45 days prior to the effective date of changes in existing remit address(es) and other demographic information.

CCO shall have the right to terminate this Agreement upon ten (10) days written notice to Facility in the event there is any change in the controlling interest of Facility modifying the percentage ownership interest outlined in Exhibit [1][2] to this Agreement.]

4.9 Customer consent to release of medical record information. Facility will obtain any Customer consent required in order to authorize Facility to provide access to requested information or records as contemplated in section 4.10 of this Agreement, including copies of the Facility's medical records relating to the care provided to Customer.

LAB Substitute:
[4.9 This section is intentionally left blank.]

4.10 Maintenance of and access to records. Facility will maintain medical, financial and administrative records related to Covered Services rendered by Facility under this Agreement, including claims records, for at least 6 years following the end of the calendar year during which the Covered Services are provided, unless a longer retention period is required by applicable law.

Facility will provide access to these records as follows:

i) to CCO or its designees, in connection with CCO's utilization management, quality assurance and improvement and for claims payment, health care operations and other administrative obligations, including reviewing Facility's compliance with the terms and provisions of this Agreement and appropriate billing practice. Facility will provide access during ordinary business hours within fourteen days after a request is made, except in cases of a CCO billing audit involving an allegation of fraud or abuse or the health and safety of a Customer (in which case, access must be given within 48 hours after the request) or of an expedited Customer appeal or grievance (in which case, access will be given so as to enable CCO to reasonably meet the timelines for determining the appeal or grievance). If records are requested to adjudicate a claim or to make a decision regarding a request for correction under 6.10, or regarding an appeal, Facility will provide copies of the requested records within fourteen days after the request is made; and

ii) to agencies of the government, in accordance with applicable law, to the extent that access is necessary to comply with regulatory requirements applicable to Facility, CCO, or Payers.

Facility will cooperate with CCO on a timely basis in connection with any such record request including, among other things, in the scheduling of and participation in an interview to review findings, within 30 days after CCO's request.

If such information and records are requested by CCO, Facility will provide copies of the records free of charge**.**

4.11 Access to data. Facility represents that in conducting its operations, it collects and reviews certain quality data relating to care rendered by Facility that is reported in a manner which has been validated by a third party as having a clear, evidence-based link to quality or safety (e.g., AHRQ standards) or which has been created by employer coalitions as proxies for quality (e.g., Leapfrog standards).

CCO recognizes that Facility has the sole discretion to select the metrics which it will track from time to time and that Facility's primary goal in so tracking is to advance the quality of patient care. If the information that Facility chooses to report on is available in the public domain in a format that includes all data elements required by CCO, CCO will obtain quality information directly from the source to which Facility reported. If the Facility does not report metrics in the public domain, on a quarterly basis, Facility will share these metrics with CCO as tracked against a database of all discharged, patients (including patients who are not CCO customers). CCO may publish this data to entities to which CCO renders services or seeks to render services, and to Customers.

SNF substitute:

[4.11 Access to data. Facility will collect and provide to CCO aggregate, de-identified quality data relating to care rendered at the Facility for CCO's use in responding to requests for such data from recognized employer coalitions (e.g., Leapfrog) or other recognized organizations that focus on quality of care. Facility will also provide such data to CCO that Facility provides to other third parties, such as other insurers, employer coalitions, government agencies, and accrediting bodies.]

4.12 Compliance with law. Facility will comply with applicable regulatory requirements, including but not limited to those relating to confidentiality of Customer medical information.

4.13 Electronic connectivity. When made available by CCO, Facility will do business with CCO electronically. Facility will use portal.com to check eligibility status, claims status, and submit requests for claims adjustment for products supported by portal.com or other online resources as supported for additional products. Facility will use portal.com for additional functionalities (for instance, notification of admission) after CCO informs Facility that these functionalities have become available for the applicable Customer.

4.14 Implementation of patient safety programs. Facility will implement quality programs recommended by nationally recognized independent third parties on a reasonably prompt basis.

[SNF Substitute: *Delete section 4.14.]*

Ancillary Additional (medical device manufacturer only)*:*

[4.15 Warranty and liability. Facility will provide CCO with a copy of its manufacturer's warranty for any product provided under this Agreement which is listed in the

Manufacturer's Warranty Appendix to this Agreement. The warranty must state that the beneficiary of the warranty is CCO and the end user, i.e. Customer.

Facility will indemnify, defend and hold harmless CCO, and Payers, and each of their respective officers, directors, employees, and shareholders (each an "Indemnitee") from, against and in respect of all demands, claims, actions, assessments, losses, damages, liabilities, interest and penalties, costs and expenses (including, without limitation, reasonable legal fees and disbursements) resulting from, arising out of, or imposed upon or incurred by any Indemnitee hereunder by reason of (i) any breach of the manufacturer's warranty for a product provided under this Agreement, and (ii) any liability, claim or expense, including but not limited to reasonable attorneys' fees and medical expenses, arising in whole or in part out of claims of any and all third parties for personal injury or loss of or damage to property arising out of the design, materials or workmanship of the products provided under this Agreement, whether based on strict liability in tort, negligent manufacture of product, or any other allegation of liability arising from the design, testing, manufacture, packaging, or labeling (including instructions for use) of the products provided under this Agreement.]

Ancillary Additional Language:
[4.15][4.16] [Service Standards. Facility will comply with the additional requirements in the attached Service Standards Exhibit.]

Article V
Duties of CCO and Payers

5.1 Payment of claims. As described in further detail in Article VI of this Agreement, Payers will pay Facility for rendering Covered Services to Customers. CCO will make its Payment Policies available to Facility online or upon request. CCO may change its Payment Policies from time to time, and will make information available describing the change.

SNF Only Additional Language:
[CCO may amend this Agreement to add or modify contract rates for particular Benefit Plans ("Payment Terms Amendment"), upon 90 days prior written notice to Facility. Facility's signature is not required to make the Payment Terms Amendment effective. However, Facility may at that time elect not to participate in the impacted Benefit Plans, by sending written notice to CCO at the address set forth on the signature page of this Agreement, within 30 days after Facility's receipt of that Payment Terms Amendment.]

5.2 Liability insurance. CCO will procure and maintain professional and general liability insurance, as CCO reasonably determines may be necessary to protect CCO and CCO's employees against claims, liabilities, damages or judgments that arise out of services provided by CCO or CCO's employees under this Agreement.

5.3 Licensure. CCO will maintain, without material restriction, such licensure, registration, and permits as are necessary to enable CCO to lawfully perform this Agreement.

5.4 **Notice by CCO.** CCO will give written notice to Facility within 10 days after any event that causes CCO to be out of compliance with section 5.2 or 5.3 of this Agreement, or of any change in CCO's name, ownership, control, or Taxpayer Identification Number. This section does not apply to changes of ownership or control that result in CCO being owned or controlled by an entity with which it was already affiliated prior to the change.

5.5 **Compliance with law.** CCO will comply with applicable regulatory requirements, including but not limited to those relating to confidentiality of Customer medical information and those relating to prompt payment of claims, to the extent those requirements are applicable.

5.6 **Electronic connectivity.** CCO will do business with Facility electronically by providing eligibility status, claims status, and accepting requests for claim adjustments, for those Benefit Plans supported by portal.com. CCO will communicate enhancements in portal.com functionality as they become available, as described in section 4.13 of this Agreement, and will make information available as to which Benefit Plans are supported by portal.com.

5.7 **Employees and subcontractors.** CCO will assure that its employees, affiliates and any individuals or entities subcontracted by CCO to render services in connection with this Agreement adhere to the requirements of this Agreement. The use of employees, affiliates or subcontractors to render services in connection with this Agreement will not limit CCO's obligations and accountability under this Agreement with regard to those services.

Article VI
Submission, Processing, and Payment of Claims

6.1 **Form and content of claims.** Facility must submit claims for Covered Services as described in the Protocols, using current, correct and applicable coding.

6.2 **Electronic filing of claims.** Within six months after the Effective Date of this Agreement, Facility will use electronic submission for all of its claims under this Agreement that CCO is able to accept electronically.

6.3 **Time to file claims.** Unless a longer timeframe is required under applicable law, all information necessary to process a claim must be received by CCO no more than 90 days from the date of discharge or from the date outpatient Covered Services are rendered. If Payer is not the primary payer, and Facility is pursuing payment from the primary payer, the timely filing limit will begin on the date Facility receives the claim response from the primary payer.

In the event CCO requests additional information in order to process a claim, Facility will provide that additional information within 90 days of CCO's request, unless a longer timeframe is required under applicable law.

6.4 Payment of claims for Covered Services. Payer will pay claims for Covered Services as further described in the applicable Payment Appendix to this Agreement and in accordance with Payment Policies.

Claims for Covered Services subject to coordination of benefits will be paid in accordance with the Customer's Benefit Plan and applicable state and federal law.

The obligation for payment under this Agreement is solely that of Payer, and not that of CCO unless CCO is the Payer.

6.5 Denial of claims for not following Protocols, for not filing timely, for Services not Covered under the Customer's Benefit Plan, or for lack of medical necessity.

i) **Non-compliance with Protocol.** Payment may be denied in whole or in part if Facility does not comply with a Protocol or does not file a timely claim as required under section 6.3 of this Agreement.

In the event payment is denied under this subsection 6.5(i) for Facility's failure to file a timely claim or to comply with a Protocol regarding notification or regarding lack of coverage approval on file, Facility may request reconsideration of the denial, and the denial under this subsection (i) will be reversed if Facility can show that, at the time the Protocols required notification or prior authorization, or at the time the claim was due:

- Facility did not know and was unable to reasonably determine that the patient was a Customer, and
- Facility took reasonable steps to learn that the patient was a Customer, and
- Facility promptly submitted a claim after learning the patient was a Customer.

A claim denied under this subsection (i) is also subject to denial for other reasons permitted under the Agreement; reversal of a denial under this subsection (i) does not preclude CCO from upholding a denial for one of these other reasons.

ii) **Non-Covered Services.** Services not covered under the applicable Benefit Plan are not subject to the rates or discounts of this Agreement. Facility may seek and collect payment from a Customer for such services (provided that Facility obtained the Customer's written consent).

iii) **Denials for lack of medical necessity through the prior authorization process.** If a service would otherwise be a Covered Service, but is not a Covered Service under the applicable Benefit Plan because it is determined through the prior authorization process to not meet the Benefit Plan's requirement of medical necessity, as defined in the Benefit Plan or applicable law (or not meet a similar concept in the Benefit Plan, such as not being consistent with nationally recognized scientific evidence as available, or not being consistent with prevailing medical standards and clinical guidelines), Facility may seek or collect payment from the Customer but only if, prior to receiving the service, the Customer had knowledge

of the determination of non-coverage and specifically agreed in writing to be responsible for payment of those charges.

6.6 Retroactive correction of information regarding whether patient is a Customer. Prior to rendering services, Facility will ask the patient to present his or her Customer identification card. In addition, Facility may contact CCO to obtain the most current information available to CCO on the patient's status as a Customer.

However, such information provided by CCO is subject to change retroactively, under the following circumstances, (i) if CCO has not yet received information that an individual is no longer a Customer; (ii) if the individual's Benefit Plan is terminated retroactively for any reason including, but not limited to, non-payment of premium; (iii) as a result of the Customer's final decision regarding continuation of coverage pursuant to state and federal laws; or (iv) if eligibility information CCO receives is later proven to be false.

If Facility provides health care services to an individual, and it is determined that the individual was not a Customer at the time the health care services were provided, those services will not be eligible for payment under this Agreement and any claims payments made with regard to those services may be recovered as overpayments under the process described in section 6.10 of this Agreement. Facility may then directly bill the individual, or other responsible party, for those services.

6.7 Payment under this Agreement is payment in full. Payment as provided under section 6.4 of this Agreement, together with any co-payment, deductible or coinsurance for which the Customer is responsible under the Benefit Plan, is payment in full for a Covered Service. Facility will not seek to recover, and will not accept, any payment from Customer, CCO, Payer or anyone acting on their behalf, in excess of payment in full as provided in this section 6.7, regardless of whether that amount is less than Facility's billed charge or Customary Charge.

6.8 Customer hold harmless. Facility will not bill or collect payment from the Customer, or seek to impose a lien, for the difference between the amount paid under this Agreement and Facility's billed charge or Customary Charge, or for any amounts denied or not paid under this Agreement due to:

i) Facility's failure to comply with the Protocols,

ii) Facility's failure to file a timely claim,

iii) Payer's Payment Policies,

iv) inaccurate or incorrect claim processing,

v) insolvency or other failure by Payer to maintain its obligation to fund claims payments, if Payer is CCO, or is an entity required by applicable law to assure that its Customers not be billed in these circumstances, or

vi) a denial based on lack of medical necessity or based on consistency with nationally recognized scientific evidence as available, and prevailing medical standards and clinical guidelines, except as provided in section 6.5 of this Agreement.

This obligation to refrain from billing Customers applies even in those cases in which Facility believes that CCO or Payer has made an incorrect determination. In such cases, Facility may pursue remedies under this Agreement against CCO or Payer, as applicable, but must still hold the Customer harmless.

In the event of a default by a Payer other than those Payers covered by clause (v) of this section 6.8, Facility may seek payment directly from the Payer or from Customers covered by that Payer. However, Facility may do so only if it first inquires in writing to CCO as to whether the Payer has defaulted and, in the event that CCO confirms that Payer has defaulted (which confirmation will not be unreasonably withheld), Facility then gives CCO 15 days prior written notice of Facility's intent to seek payment from Payer or Customers. For purposes of this paragraph, a default is a systematic failure by a Payer to fund claims payments related to Customers covered through that Payer; a default does not occur in the case of a dispute as to whether certain claims should be paid or the amounts that should be paid for certain claims.

This section 6.8 and section 6.7 will survive the termination of this Agreement, with regard to Covered Services rendered prior to when the termination takes effect.

6.9 Consequences for failure to adhere to Customer protection requirements. If Facility collects payment from, brings a collection action against, or asserts a lien against a Customer for Covered Services rendered (other than for the applicable co-payment, deductible or coinsurance), contrary to section 6.7 or 6.8 of this Agreement, Facility will be in breach of this Agreement. This section 6.9 will apply regardless of whether Customer or anyone purporting to act on Customer's behalf has executed a waiver or other document of any kind purporting to allow Facility to collect such payment from Customer.

In the event of such a breach, Payer may deduct, from any amounts otherwise due Facility, the amount wrongfully collected from Customers, and may also deduct an amount equal to any costs or expenses incurred by the Customer, CCO or Payer in defending the Customer and otherwise enforcing sections 6.7 through 6.9 of this Agreement. Any amounts deducted by Payer in accordance with this provision will be used to reimburse the Customer and to satisfy any costs incurred. The remedy contained in this paragraph does not preclude CCO from invoking any other remedy for breach that may be available under this Agreement.

6.10 Correction of claims payments. If Facility does not seek correction of a given claim payment or denial by giving notice to CCO within 12 months after the claim was initially processed, it will have waived any right to subsequently seek such correction under this section 6.10, or through dispute resolution under Article VII of this Agreement or in any other forum.

Facility will repay overpayments within 30 days of written or electronic notice of the overpayment. Facility will promptly report any credit balance that it maintains with regard to any claim overpayment under this Agreement, and will return the overpayment to CCO within 30 days after posting it as a credit balance.

Recovery of overpayments may be accomplished by offsets against future payments.

Article VII
Dispute Resolution

The parties will work together in good faith to resolve any and all disputes between them ("Disputes") including but not limited to the existence, validity, scope or termination of this Agreement or any term thereof, and all questions of arbitrability, with the exception of any question regarding the availability of class arbitration or consolidated arbitration, which is expressly waived below. Disputes also include any dispute in which Facility is acting as the assignee of one or more Customer. In such cases, Facility agrees that the provisions of this Article VII will apply, including without limitation the requirement for arbitration.

If the Dispute pertains to a matter which is generally administered by certain CCO procedures, such as a credentialing or quality improvement plan, the policies and procedures set forth in that plan must be fully exhausted by Facility before Facility may invoke any right to arbitration under this Article VII. For Disputes regarding payment of claims, a party must have timely initiated, and completed, the claim reconsideration and appeal process as set forth in the Administrative Guide in order to initiate the Dispute process.

If the parties are unable to resolve any such Dispute within 60 days following the date one party sent written notice of the Dispute to the other party, and if either party wishes to pursue the Dispute, it may do so only by submitting the Dispute to binding arbitration conducted by the American Arbitration Association ("AAA") in accordance with the AAA Healthcare Payor Provider Arbitration Rules, as they may be amended from time to time (see http://www.adr.org), except that, in any case involving a Dispute in which a party seeks an award of $1,000,000 or greater or seeks termination of this Agreement, a panel of three arbitrators will be used; a single arbitrator cannot award $1,000,000 or more or order that this Agreement is terminated. The arbitrator(s) will be selected from the AAA National Healthcare Roster (as described in the AAA Healthcare Payor Provider Arbitration Rules) or the AAA's National Roster of Arbitrators. Unless otherwise agreed to in writing by the parties, if the party wishing to pursue the Dispute does not initiate the arbitration within one year after the date on which written notice of the Dispute was given, or, for Disputes subject to the procedures or processes described in the previous paragraph, within one year after the completion of the applicable procedure or process, it will have waived its right to pursue the Dispute in any forum.

Any arbitration proceeding under this Agreement will be conducted in [name of county] County, [state]. The arbitrator(s) may construe or interpret but must not vary or ignore the terms of this

Agreement and will be bound by controlling law. The arbitrator(s) have no authority to award punitive, exemplary, indirect or special damages, except in connection with a statutory claim that explicitly provides for that relief.

Except as may be required by law, neither a party, including without limitation, the parties' representatives, consultants and counsel of record in the arbitration, nor an arbitrator may disclose the existence, content, or results of any arbitration hereunder, or any Confidential Arbitration Information without the prior written consent of all parties. "Confidential Arbitration Information" means any written submissions in an arbitration by either party, discovery exchanged, evidence submitted, transcriptions or other records of hearings in the matter and any orders and awards issued, and any reference to whether either party won, lost, prevailed, or did not prevail against the other party in any arbitration proceeding, as well as any settlement agreement related to an arbitration. However, judgment on the award may be entered under seal in any court having jurisdiction thereof, by either party.

The parties expressly intend that any arbitration be conducted on an individual basis, so that no third parties may be consolidated or joined or allowed to proceed with class arbitration. The parties agree that any arbitration ruling allowing class arbitration, or requiring consolidated arbitration involving any third party(ies), would require immediate judicial review. Notwithstanding anything in this Agreement to the contrary, this paragraph may not be severed from Article VII of the Agreement under any circumstances, including but not limited to unlawfulness, invalidity or unenforceability.

The decision of the arbitrator(s) on the points in dispute will be binding. The parties acknowledge that because this Agreement affects interstate commerce the Federal Arbitration Act applies.

In the event any court determines that this arbitration procedure is not binding or otherwise allows litigation involving a Dispute to proceed, the parties hereby waive any and all right to trial by jury in, or with respect to, the litigation. The litigation would instead proceed with the judge as the finder of fact.

In the event a party wishes to terminate this Agreement based on an assertion of uncured material breach, and the other party disputes whether grounds for the termination exist, the matter will be resolved through arbitration under this Article VII. While the arbitration remains pending, the termination for breach will not take effect.

This Article VII will survive any termination of this Agreement.

Article VIII
Term and Termination

8.1 Term. This Agreement will take effect on the Effective Date. This Agreement has an initial term of [three years] and will renew automatically for renewal terms of one year, until terminated pursuant to section 8.2 of this Agreement.

SNF Substitute **[8.1**

Term. This Agreement will take effect on the Effective Date. This Agreement will continue for an initial term ending at the end of the day on December 31, [*year]*, and will renew automatically for renewal terms of one year, until terminated pursuant to section 8.2 of this Agreement.]

8.2 Termination. This Agreement may be terminated under any of the following circumstances:

i) by mutual written agreement of the parties;

ii) by either party, upon at least 180 days prior written notice, effective at the end of the initial term or effective at the end of any renewal term;

iii) by either party, upon 60 days prior written notice, in the event of a material breach of this Agreement by the other party; the notice must include a specific description of the alleged material breach; however, the termination will not take effect if the breach is cured within 60 days after notice of the termination; moreover, termination may be deferred as further described in Article VII of this Agreement;

iv) by either party, upon 10 days prior written notice, in the event the other party loses licensure or other governmental authorization necessary to perform this Agreement, or fails to have insurance as required under section 4.7 or section 5.2 of this Agreement;

v) by CCO, upon 10 days prior written notice, in the event Facility loses accreditation; or

vi) by CCO, upon 90 days prior written notice, in the event:

a) Facility loses approval for participation under CCO's credentialing plan, or

b) Facility does not successfully complete the CCO's re-credentialing process as required by the credentialing plan.

SNF Substitute: **[8.2 Termination.** This Agreement may be terminated under any of the following circumstances:

i) by mutual written agreement of the parties;

ii) by either party, upon at least 90 [180] days prior written notice, effective at the end of the initial term or effective at the end of any renewal term;

iii) by either party, upon 60 days prior written notice, in the event of a material breach of this Agreement by the other party; however, the termination will not take effect

if the breach is cured within 60 days after notice of the termination; moreover, such termination may be deferred as further described in Article VII of this Agreement;

iv) by either party, upon 10 days prior written notice, in the event the other party loses licensure or other governmental authorization necessary to perform this Agreement, or fails to have insurance as required under section 4.7 or section 5.2 of this Agreement;

v) by CCO, upon 10 days prior written notice, in the event Facility loses accreditation; or

vi) by CCO, upon 90 days prior written notice, in the event:

a) Facility loses approval for participation under CCO's credentialing plan, or

b) Facility does not successfully complete the CCO's re-credentialing process as required by the credentialing plan; or

vii) by CCO, upon 90 days prior written notice, if none of Facility's services locations set forth on Appendix 1 has CCO membership enrolled in a Specialized MA Plan for Special Needs Individuals who are Institutionalized (as those terms are defined by 42 CFR 422.2).]

SNF Additional:

[CCO may terminate a Facility service location, as set forth on Appendix 1, from CCO's network without terminating the entire Agreement as follows:

i) upon 60 days prior written notice in the event of a material breach by a Facility service location of this Agreement, except that such termination will not take effect if the breach is cured within 60 days after notice of the termination; moreover, such termination may be deferred as further described in Article VII of this Agreement;

ii) under the same circumstances and with the same notice period as specified in sections 8.2 (iv) through 8.2 (vi), above, but with respect to the Facility service location;

iii) upon 90 days prior written notice, if the Facility service location does not have any CCO membership enrolled in a Specialized MA Plan for Special Needs Individuals who are Institutionalized (as those terms are defined by 42 CFR 422.2).]

8.3 Ongoing Services to certain Customers after termination takes effect. In the event a Customer is receiving any of the Covered Services listed below, as of the date the termination of this Agreement takes effect, Facility will continue to render those Covered Services to that Customer, and this Agreement will continue to apply to those Covered Services, after the termination takes effect, for the length of time indicated below:

Pregnancy, Third Trimester – Low Risk	Through postpartum follow up visit
Pregnancy, First, Second or Third Trimester – Moderate Risk and High Risk	Through postpartum follow up visit
Non-Surgical Cancer Treatment	30 days or a complete cycle of radiation or chemotherapy, whichever is greater
End Stage Kidney Disease and Dialysis	30 days
Symptomatic AIDS undergoing active treatment	30 days
Circumstances where Payer is required by applicable law to provide transition coverage of services rendered by Facility after Facility leaves the provider network accessed by Payer.	As applicable

SNF Only Substitute :

[

Inpatient Covered Services	30 days or until discharge, whichever comes first
Pregnancy, Third Trimester – Low Risk	Through postpartum follow up visit
Pregnancy, First, Second or Third Trimester – Moderate Risk and High Risk	Through postpartum follow up visit
Non-Surgical Cancer Treatment	30 days or a complete cycle of radiation or chemotherapy, whichever is greater
End Stage Kidney Disease and Dialysis	30 days
Symptomatic AIDS undergoing active treatment	30 days
Circumstances where Payer is required by applicable law to provide transition coverage of services rendered by Facility after Facility leaves the provider network accessed by Payer.	As applicable

]

LAB Only Substitute:

8.3 Ongoing services to certain Customers after termination takes effect. In the event a Customer is receiving any Covered Services, as of the date the termination takes effect, Facility will continue to render those Covered Services to that Customer, and this Agreement will continue to apply to those Covered Services, after the termination takes effect, until the earlier of: the Covered Services are complete or 30 days after termination.

Article IX
Miscellaneous Provisions

9.1 **Entire Agreement**. In order for this Agreement to be binding, a hard copy must be signed by both parties. This Agreement is the entire agreement between the parties with regard to its subject matter, and supersedes any prior written or unwritten agreements between the parties or their affiliates with regard to the same subject matter, except that this Agreement does not supersede a national agreement between the parties or their affiliates.

9.2 **Amendment.** This Agreement may only be amended in a writing signed by both parties, except that this Agreement may be unilaterally amended by CCO upon written notice to Facility in order to comply with applicable regulatory requirements. CCO will provide at least 30 days notice of any such regulatory amendment, unless a shorter notice is necessary in order to accomplish regulatory compliance.

9.3 **Nonwaiver.** The waiver by either party of any breach of any provision of this Agreement is not a waiver of any subsequent breach of the same or any other provision.

9.4 **Assignment.** This Agreement may not be assigned by either party without the written consent of the other party, except that this Agreement may be assigned by CCO to any of CCO's Affiliates.

Additionally, if CCO transfers to a third party all of its business described in a given line item in Appendix 2, section 1, or other line of business, CCO may assign this Agreement, only as it relates to that transferred business, to that third party. Such an assignment will not impact the relationship of the parties under this Agreement with regard to the remainder of CCO's business.

9.5 **Relationship of the parties.** The sole relationship between the parties to this Agreement is that of independent contractors. This Agreement does not create a joint venture, partnership, agency, employment or other relationship between the parties.

9.6 **No third-party beneficiaries.** CCO and Facility are the only entities with rights and remedies under this Agreement.

9.7 **Calendar days.** Unless this Agreement specifically provides otherwise, all references in this Agreement to a period of days refers to calendar days.

9.8 **Notice procedures.** Any notice required to be given under this Agreement must be in writing, except in cases in which this Agreement specifically permits electronic notice, or as otherwise permitted or required in the Protocols. Acceptable forms of written notice include facsimile, first class mail, certified mail, or overnight delivery by a national, recognized delivery service. All notices of termination of this Agreement by either party must be sent by certified mail, return receipt requested, addressed to the appropriate party at the address set forth on the signature portion of this Agreement. Each party will provide the other with proper addresses, facsimile numbers and electronic mail addresses.

9.9 Confidentiality. Neither party may disclose to a Customer, other health care providers, or other third parties any of the following information (except as required by an agency of the government):

i) any proprietary business information, not available to the general public, obtained by the party from the other party;
ii) the specific reimbursement amounts provided for under this Agreement, except for purposes of administration of benefits, including informing Customers, Benefit Plan sponsors and/or referring providers about the cost of a particular Covered Service or set of Covered Services; or
iii) any customer list of the other party regardless of how such customer list was generated.

This section 9.9 does not preclude the disclosure of information by CCO to a third party as part of the process by which the third party is considering whether to purchase services from CCO.

At least 48 hours before either party issues a press release, advertisement, or other media statement about the business relationship between the parties, that party will give the other party a copy of the material the party intends to issue.

Except as otherwise required by applicable law or stock exchange rule, Facility will not, and will not permit any of its representative affiliates, representatives or advisors to, issue or cause the publication of any press release or make any other public announcement, including, without limitation, any advertisement, with respect to this Agreement without the consent of CCO.

9.10 Governing law. This Agreement will be governed by and construed in accordance with the laws of the state in which Facility renders Covered Services, and any other applicable law.

9.11 Regulatory appendices. One or more regulatory appendix may be attached to this Agreement, setting forth additional provisions included in this Agreement in order to satisfy regulatory requirements under applicable law. These regulatory appendices, and any attachments to them, are expressly incorporated into this Agreement and are binding on the parties to this Agreement. In the event of any inconsistent or contrary language between a regulatory appendix and any other part of this Agreement, including but not limited to appendices, amendments and exhibits, the regulatory appendix will control, to the extent it is applicable.

9.12 Severability. Except as otherwise set forth in this Agreement, any provision of this Agreement that is unlawful, invalid or unenforceable in any situation in any jurisdiction will not affect the validity or enforceability of the remaining provisions of this Agreement or the lawfulness, validity or enforceability of the offending provision in any other situation or jurisdiction.

9.13 **Survival**. Notwithstanding the termination of this Agreement, this Agreement will continue to apply to Covered Services rendered while this Agreement was in effect. Additionally, section 9.9 of this Agreement, (except for the last paragraph) will survive the termination of this Agreement.

THIS AGREEMENT CONTAINS A BINDING ARBITRATION PROVISION THAT MAY BE ENFORCED BY THE PARTIES.

[Name of Facility], as signed by its authorized representative:

Signature: _____

Print Name and Title: _____

Date: _____

Address to be used for giving notice to Facility under this Agreement:

Street: _____

City: _____

State: _____ Zip Code: _____

E-mail: _____

CCO, on behalf of itself, HMO and the other entities that are CCO's Affiliates, as signed by its authorized representative:

Signature: _____

Print Name: _____

Title: _____

Date: _____

Address to be used for giving notice to CCO under this Agreement:
*Street*_____
*City*_____
State _____ *Zip Code*_____

For office use only: [_____]
[_____]
Month, day and year in which Agreement is first effective: [_____]

Appendix 1
Facility Location and Service Listings

[Facility System Name]

IMPORTANT NOTES: Facility acknowledges its obligation under section 4.8 to promptly report any change in Facility's name, NPI or Taxpayer Identification Number. Failure to do so may result in denial of claims or incorrect payment.

The location where Covered Services will be rendered ("Service Location") MUST be listed in this Appendix.

FACILITY LOCATION - List BOTH the Service Location and the Billing Address for the Service Location	
Service Location	**Billing Address for the Service Location**
Facility Name	**Facility Name**
Street Address	**Street Address**
City	**City**
State and Zip Code	**State and Zip Code**
Phone Number	**Phone Number**
TIN	
National Provider ID (NPI)	

ADDITIONAL FACILITY LOCATIONS - List BOTH the Service Location and the Billing Address for the Service Location	
Service Location	**Billing Address for the Service Location**
Facility Name	**Facility Name**
Street Address	**Street Address**
City	**City**
State and Zip Code	**State and Zip Code**
Phone Number	**Phone Number**
TIN	

National Provider ID (NPI)	
Facility Name	**Facility Name**
Street Address	**Street Address**
City	**City**
State and Zip Code	**State and Zip Code**
Phone Number	**Phone Number**
TIN	
National Provider ID (NPI)	
Facility Name	**Facility Name**
Street Address	**Street Address**
City	**City**
State and Zip Code	**State and Zip Code**
Phone Number	**Phone Number**
TIN	
National Provider ID (NPI)	

Appendix 2
Benefit Plan Descriptions

Section 1. CCO may allow Payers to access Facility's services under this Agreement for the Benefit Plan types described in each line item below, unless otherwise specified in section 2 of this Appendix 2:

- [Mississippi Medicaid Benefit Plans.]

- [Mississippi CHIP Benefit Plans.]

Section 2. Notwithstanding the above section 1 of this Appendix 2, this Agreement will not apply to the Benefit Plan types described in the following line items:

- [Mississippi Medicaid Benefit Plans.]
- [Mississippi CHIP Benefit Plans.]
- Medicaid and CHIP Benefit Plans other than those separately addressed in this Appendix 2.

Note: Excluding certain Benefit Plans or programs from this Agreement does not preclude the parties or their affiliates from having or entering into a separate agreement providing for Facility's participation in a network for such Benefit Plans or programs.

Section 3. Definitions:

Note: CCO may adopt a different name for a particular Benefit Plan, and/or may modify information referenced in the definitions in this Appendix 2 regarding Customer identification cards. If that happens, section 1 or section 2 of this Appendix 2 will continue to apply to those Benefit Plans as it did previously, and CCO will provide Facility with the updated information. Additionally, CCO may revise the definitions in this Appendix 2 to reflect changes in the names or roles of CCO's business units, provided that doing so does not change Facility's participation status in Benefit Plans impacted by that change, and further provided that CCO provides Facility with the updated information.

MEDICAID, CHIP AND OTHER STATE PROGRAMS:

- **Medicaid Benefit Plans** means Benefit Plans that offer coverage to beneficiaries of a program that is authorized by Title XIX of the federal Social Security Act, and jointly financed by the federal and state governments and administered by the state.

- **Mississippi Medicaid Benefit Plans** means Medicaid Benefit Plans issued in Mississippi that have a reference to "CCO" on the valid identification card of any Customer eligible for and enrolled in that Benefit Plan.

- **Children's Health Insurance Program ("CHIP") Benefit Plans** means Benefit Plans under the program authorized by Title XXI of the federal Social Security Act that is jointly financed by the federal and state governments and administered by the state.

- **Mississippi CHIP Benefit Plans** means CHIP Benefit Plans issued in Mississippi that include a reference to "CCO" and MSCHIP" on the face of the valid identification card of any Customer eligible for and enrolled in that Benefit Plan.

- **Other Governmental Benefit Plans** means Benefit Plans that are funded wholly or substantially by a state or district government or a subdivision of a state (such as a city or county), but do not include Benefit Plans for:
  i) employees of a state government or a subdivision of a state and their dependents;
  ii) students at a public university, college or school;
  iii) employer-based coverage of private sector employees, even if the employer receives a government subsidy to help fund the coverage;
  iv) Medicaid beneficiaries;
  v) Children's Health Insurance Program (CHIP) beneficiaries; and
  vi) Medicare and Medicaid Enrollees (MME).

Page intentionally left blank.

Additional Manuals Appendix

For some of the Benefit Plans for which Facility may provide Covered Services under this Agreement, Facility is subject to additional requirements of one or more additional provider manuals ("Additional Manuals"). When this Agreement refers to Protocols or Payment Policies, it is also referring to the Additional Manuals. An Additional Manual may be a separate document or it may be a supplement to the CCO Administrative Guide ("CCO Administrative Guide").

For Benefit Plans subject to an Additional Manual, the Additional Manual controls if it conflicts with any of the following: (1) a provision of this Agreement or of the CCO Administrative Guide; or (2) a CCO Protocol or Payment Policy. However, the Additional Manual does not control where it conflicts with applicable statutes or regulations.

The Additional Manuals will be made available to Facility on a designated website and upon request. The names of the Additional Manuals, the websites to view and download them, and the Benefit Plans to which they apply, are listed in Table 1 below. CCO may change the location of a website or the Customer identification card identifier used to identify Customers subject to a given Additional Manual; if CCO does so, CCO will inform Facility.

CCO may make changes to the Additional Manuals subject to this Appendix in accordance with the provisions of this Agreement relating to Protocol and Payment Policy changes.

Table 1

Benefit Plan(s)	**Description of Applicable Additional Manual**	**Website**
[No Additional Manuals Apply]		
[Mississippi CHIP Benefit Plans	CCO Administrative Guide for Mississippi Children's Health Insurance Program (CHIP)	portal.com]
[Mississippi Medicaid Benefit Plans	CCO Administrative Guide for Mississippi Medicaid	portal.com]

[Payment Appendix – Mississippi Medicaid

Applicability

This Payment Appendix applies to Covered Services rendered by Facility to Customers covered under the following types of Benefit Plans, as described in this Agreement:

- Mississippi Medicaid Benefit Plans.

Section 1
Payment for Covered Services

1.1 Payment. Facility's contract rates for Covered Services are the lesser of (i) Facility's Customary Charges or (ii) the following, in order of applicability:

(a) {X}% of the Mississippi Medicaid conversion factor published by the applicable state agency for anesthesia services;

(b) {Y}% of the Mississippi Medicaid fee schedule published by the applicable state agency;

(c) 100% of the Mississippi Division of Medicaid reimbursement for durable medical equipment and medical supplies, currently delineated under Title 23 Part 209;

(d) In the event a fee source listed above in clause (a) (b) or (c) does not publish a specific fee amount, then CCO will pay {Z} % of Facility's Customary Charges for Covered Services.

(e) For certain CPT/HCPC codes, CCO may pay an amount higher than the amount listed in this section 1.1clauses, and in the future, CCO may reduce the higher amount paid for those CPT/HCPCS codes, but not less than the amount payable in clauses (a), (b), (c) and (d) above.

The actual payment amount is also subject to matters described in this Agreement, such as Payment Policies.

Facility will submit claims using a CMS 1500, its successor form or its electronic equivalent. All claims submitted under this Payment Appendix must use CPT Codes, HCPCS Codes, ICD-10 Codes or its successor and other codes in compliance with HIPAA standard data set requirements. Claims submitted without HIPAA standard data set requirements may be denied.

If an applicable state or federal program is available to provide items or payment directly to Facility for specific Covered Services for Customers subject to this Payment Appendix that would otherwise be payable under this Payment Appendix, the applicable program will apply and not this Payment Appendix. (For example, the Vaccines For Children program currently provides vaccines free of charge, and therefore no amount will be payable under this Payment Appendix for vaccines within the Vaccines For Children program. However, the administration of such vaccine may be

payable under this Payment Appendix if payment is not provided under the Vaccines For Children program for vaccine administration.)

The contract rates established by this Payment Appendix are all-inclusive, including without limitation any applicable taxes, for all Covered Services provided to the Customer. Unless specifically indicated otherwise, amounts listed in this fee schedule represent global fees and may be subject to reductions based on appropriate modifiers (for example, professional and technical modifiers).

1.2 Routine Maintenance. CCO routinely updates this fee schedule in response to changes published by the primary fee source, such as fee amount changes. Provided that the state does not change its methodology, CCO will implement fee schedule changes in its systems within from the date the change is published in the Medicaid agency's official correspondence to CCO or is otherwise formally communicated by the Medicaid agency to CCO. CCO will make the changes effective in its system on the effective date of the change by the primary fee source. However, claims already processed prior to the change being implemented by CCO will not be reprocessed unless otherwise required by law.

CCO also routinely updates this fee schedule in response to coding changes as described in this Agreement. When implementing coding updates, CCO will apply the same percentages as set forth above in section 1.1 and the then current value of the published code to determine the contract rate. CCO will use reasonable commercial efforts to implement such changes within from the date of publication. However, claims already processed prior to the change being implemented by CCO will not be reprocessed unless otherwise required by law.

1.3 Medicaid Agency Payment Changes. If the Medicaid agency changes the manner in which it reimburses or changes the Medicaid primary fee source such that CCO is required to make significant programming or platform changes in order to implement the Medicaid agency changes, CCO will implement the Medicaid agency changes, within 45 days, from the date the change is published in the Medicaid agency's official correspondence to CCO or is otherwise formally communicated by the Medicaid agency to CCO. Facility agrees that, in such case, it shall accept the current payment as set forth in this Payment Appendix until such a time as CCO can implement the Medicaid agency change. At such time as CCO is able to implement the change, CCO will communicate the change and the effective date of the change via a copy of a new payment appendix. The changes will be incorporated into this Appendix for all dates of service on or after those changes are effective in the Medicaid program.

If CCO is unable, through commercially reasonable efforts, to incorporate the Medicaid agency payment changes in their entirety, CCO will so notify Facility within 90 days from the date the change is published in the Medicaid agency's official correspondence to CCO, or otherwise formally communicated by the Medicaid agency. The parties shall then negotiate in good faith for a period of up to 60 days to amend the Agreement to replace this Payment Appendix with a new Payment Appendix and stated effective date for the new contract rates. If the parties have not reached an agreement upon such an amendment within the aforementioned 60 day period, either party may initiate Dispute Resolution according to this Agreement.

1.4 Service Standards. Facility will meet and be bound by the service expectations set forth in the Service Standards Exhibit attached to the Agreement to the extent applicable.

[Payment Appendix – Mississippi CHIP

Mississippi CHIP Fee Information Document: [Fee Schedule ID]

This Payment Appendix applies to Covered Services rendered by Facility to Customers covered under the following types of Benefit Plans, as described in this Agreement:

Mississippi CHIP Benefit Plans.

]

For use with Lab agreements only

Exhibit [1][2]
ATTESTATION OF [NAME OF LAB]

State of _____

County of [ ]

Before me the undersigned Notary appeared _____, who being either known personally to me and/or presenting proper identification, was duly sworn by me and testified as follows:

(1) "My name is _____. I am over the age of 18, fully competent to give this Attestation and have personal knowledge of the facts stated in it."

(2) "I hereby certify that [ENTITY NAME or NAME OF LAB] has XX% ownership of the [NAME OF THE LAB]."

(3) "I hereby certify that the following entities have the following percentage ownership of the [NAME OF THE LAB]: [List all entities and percentage ownership]."

(4) "I hereby certify that at no time will there be any change in the controlling interest modifying the current percentage ownership as set forth herein of the [NAME OF THE LAB]."

(5) "I hereby certify that at no time will the [NAME OF THE LAB] assets, liabilities, revenues and expenses be consolidated from [NAME OF THE LAB] to any other laboratory or its affiliates such that all or some of the Covered Services subject to this Agreement will be rendered by such other laboratory or its affiliates."

Signed this _____ day of ____, 20___.

_____
[Affiant signature]

Notary Stamp/Certification

_____
Notary Signature

_____
Date of Notary's Signature

_____
Expiration date of Notary authority

Ancillary Additional (medical device manufacturer only)

Manufacturer's Warranty Appendix

[Provider Name, Inc.] ("[Provider Name]") warrants the [Provider Name] [equipment item] against defects in materials and workmanship for a period of four (4) years from the date of purchase. In addition, [Provider Name] warrants the [equipment item] motor against defects in materials and workmanship for the lifetime of the [equipment item]. This warranty does not include supplies and accessories, including but not limited to, cartridges, batteries, or infusion sets.

This warranty is valid only upon the receipt by [Provider Name] of a completed warranty registration form. During the warranty period, [Provider Name] will repair or replace, at its discretion, any defective [equipment item] or [equipment item] motor, subject to the conditions and exclusions stated herein. In the event the [equipment item] is repaired or replaced, the warranty period will not be extended beyond the remaining warranty period of the original [equipment item].

Exclusions: This warranty is valid only if the [Provider Name] [equipment item] is used in accordance with the manufacturer's instructions and it does not include wear and tear nor maintenance items. This warranty will not apply;

- If damage results from changes or modifications made to the [equipment item] by the user or third persons after the date of manufacture;
- If damage results from service or repairs performed by any person or entity other than the manufacturer;
- If damage results from a force majeure or other event beyond the control of the manufacturer; or
- If damage results from negligence or improper use, including but not limited to improper storage, submersion in water, physical abuse such as dropping, or otherwise.

Parties covered: This warranty shall be personal to the original user. Any sale, rental, or other transfer or use of this product covered by this warranty to or by a user other than the original user shall cause this warranty to immediately terminate.

Warranty performance procedure: Notice of the claimed defect must be made in writing and sent to: Technical Product Support, [Provider Name, Inc., street, city, state, zip,] USA. The notice must include the date of purchase, model and serial number, and a description of the claimed defect to allow for repair or replacement.

The remedies provided for in this warranty are the exclusive remedies available for any breach hereof and no person has any authority to bind [Provider Name] to any representation, condition, or warranty except this warranty policy. Neither [Provider Name] nor its suppliers or distributors shall be liable for any incidental, consequential, or special damage of any nature or kind caused by or arising out of a defect in the product.

All other warranties express or implied, are excluded, including the warranties of merchantability and fitness for a particular purpose.

Mississippi Medicaid Program
Regulatory Requirements Appendix

MISSISSIPPI MEDICAID PROGRAM

REGULATORY REQUIREMENTS APPENDIX

PROVIDER

THIS MISSISSIPPI MEDICAID PROGRAM REGULATORY REQUIREMENTS APPENDIX (this "Appendix") supplements and is made part of the provider agreement (the "Agreement") between HMO ("HMO") or one of its Affiliates and the party named in the Agreement ("Provider").

SECTION 1
APPLICABILITY

The requirements of this Appendix apply to Medicaid benefit plans sponsored, issued or administered by HMO under the Mississippi Coordinated Access Network Program (the "MississippiCAN Program") governed by the State's designated regulatory agencies. In the event of a conflict between this Appendix and other appendices or any provision of the Agreement, the provisions of this Appendix shall control except with regard to benefit plans outside the scope of this Appendix or unless otherwise required by law. In the event HMO is required to amend or supplement this Appendix as required or requested by the State to comply with federal or State regulations, HMO will unilaterally initiate such additions, deletions or modifications. All provider agreements must be in writing and must include all specific activities and report responsibilities delegated to the Provider by HMO.

SECTION 2
DEFINITIONS

Unless otherwise defined in this Appendix, all capitalized terms shall be as defined in the Agreement. For purposes of this Appendix, the following terms shall have the meanings set forth below; provided, however, in the event any definition set forth in this Appendix or the Agreement is inconsistent with any definitions under the MississippiCAN Program, the definitions shall have the meaning set forth under the MississippiCAN Program.

2.1 Adverse Benefit Determination: The denial or limited authorization of a requested service, including determinations on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit; the reduction, suspension, or termination of previously authorized services; the denial, in whole or in part, of payment for a service; HMO's failure to provide services in a timely manner; HMO's failure to resolve Complaints, Grievances, or Appeals within the specified time frames; for residents in a rural area with only one MCO, the denial of a Covered Person's request to exercise his or her right, under 42 C.F.R. §438.52(b)(2)(ii); the denial of a Covered Person's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other enrollee financial liabilities; and determinations by skilled nursing facilities and nursing facilities to transfer or discharge residents and adverse determinations made by a State with regard to the preadmission screening and annual resident review requirements of Section 1919(e)(7) of the Act, if applicable.

2.2 **Affiliate:** Those entities controlling, controlled by, or under common control with HMO.

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

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

2.5 **CMS:** Center for Medicare and Medicaid Services is an agency within the U.S. Department of Health & Human Services responsible for administration of several key federal health care programs.

2.6 **Complaint:** An expression of dissatisfaction received orally or in writing that is of a less serious or formal nature that is resolved within one (1) business day of receipt.

2.7 **Covered Person:** An individual who meets all of the eligibility requirements for Mississippi Medicaid and is currently enrolled with HMO for the provision of services under a MississippiCAN Program. A Covered Person may also be referred to as an Enrollee, Member or Customer under the Agreement.

2.8 **Covered Services:** Health care services or products for which a Covered Person is enrolled with HMO to receive coverage under the State Contract, including all services required by the State Contract and State and federal law.

2.9 **DOM:** Division of Medicaid, Office of the Governor, State of Mississippi.

2.10 **Early, Periodic, Screening, Diagnosis, and Treatment (EPSDT) Services:** Defined by DOM to include:

i) Age appropriate, comprehensive health and development history that includes physician and mental health assessments along with counseling and anticipatory guidance and risk factor reduction interventions;
ii) Calculation of Body Mass Index;
iii) Growth measurements and head circumference;
iv) Nutritional counseling;
v) Developmental surveillance and Developmental and autism Spectrum Disorders Screenings as appropriate;
vi) Comprehensive unclothed exam;
vii) Appropriate laboratory tests (including blood level assessment appropriate to age and risk);

viii) Appropriate immunizations in accordance with Recommended Childhood and Adolescent Immunization Schedule adopted by DOM;
ix) A vision assessment;
x) A hearing assessment;
xi) A dental screening and/or referral to dental care;
xii) Health education; and
xiii) Referrals for identified abnormalities.

2.11 Fraud and Abuse: Fraud is any type of intentional deception or misrepresentation made by an entity or person with the knowledge that the deception could result in some unauthorized benefit to the entity, him or herself, or some other person. The Fraud can be committed by many entities, including a vendor, a subcontractor, a provider, a State employee, or a Covered Person, among others. Abuse is any practice that is inconsistent with sound fiscal, business, or medical practices, and results in an unnecessary cost to the Medicaid program, a vendor, a subcontractor or Provider or in reimbursement for services that are not Medically Necessary or that fail to meet professionally recognized standards for health care.

2.12 Grievance: An expression of dissatisfaction about any matter or aspect of HMO or its operation, other than an Adverse Benefit Determination as defined herein. Grievances may include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the Covered Person's rights regardless of whether remedial action is requested. Grievance includes a Covered Person's right to dispute an extension of time proposed by HMO to make an authorization decision.

2.13 Marketing: The activities that promote visibility and awareness for the MississippiCAN Program and HMO's participation in the program. All marketing activities are subject to prior review and approval by DOM and may not contain misleading information.

2.14 Medical Record: A single complete record, which documents the entire treatment plan developed for, and medical services received by, the Covered Person including inpatient, outpatient, referral services and emergency medical services whether provided by contracted Providers or non-contracted providers.

2.15 Mississippi Coordinated Access Network (MississippiCAN) Program: Mississippi Medicaid's coordinated care program for select Medicaid Beneficiaries.

2.16 Primary Care Provider (PCP): Any physician or health care practitioner or group operating within the scope of his or her licensure who is responsible for supervising, prescribing and providing primary care and primary case management services in the MississippiCAN Program, whose practice is limited to the general practice of medicine or who is an Internist, Pediatrician, Obstetrician, Gynecologist, Family Practitioner, General Practitioner, Certified Nurse Practitioners whose specialty is pediatrics, adult, family, certified nurse midwife, obstetrics/gynecology, or a physician assistant.

2.17 Prior Authorization: A determination to approve a Provider's request, pursuant to services covered in the MississippiCAN Program, to provide a service or course of

treatment of a specific duration and scope to a Member prior to the initiation or continuation of the service.

2.18 Provider Network: The Panel of health service Providers with which HMO contracts for the provision of covered services to Covered Persons and Non-Contracted Providers administering services to Covered Persons.

2.19 State: The State of Mississippi or its designated regulatory agencies.

2.20 State Contract: HMO's contract with the State for the purpose of providing and paying for Covered Services to Covered Persons enrolled in the MississippiCAN Program.

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

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

SECTION 3
PROVIDER REQUIREMENTS

The MississippiCAN Program, through the State Contract and federal and State statutes and regulations, requires the Agreement to contain certain conditions that HMO and Provider agree to undertake, which include the following:

3.1 Definitions Related to the Provision of Covered Services. Provider shall follow the applicable State Contract's requirements for the provision of Covered Services. Provider's decisions affecting the delivery of acute or chronic care services to Covered Persons shall be made on an individualized basis and in accordance with the following definitions:

i) Emergency Medical Condition: A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in any of the following: (a) 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; (b) serious impairment to body functions; or (c) serious dysfunction of any body organ or part.

ii) Emergency Services: Covered inpatient and outpatient services, inclusive of dialysis services, furnished by a provider who is qualified to furnish those health

services and that are needed to evaluate or stabilize an Emergency Medical Condition in accordance with 42 CFR 438.114.

iii) Medically Necessary Services: As set forth in the Social Security Act, Section 1905 (42 USC 1396d(a)), Medically Necessary Services are defined as services, supplies, or equipment provided by a licensed health care professional that are:

a) Appropriate and consistent with the diagnosis or treatment of the Covered Person's condition, illness, or injury;

b) In accordance with the standards of good medical practice consistent with the individual Covered Person's condition(s);

c) Not primarily for the personal comfort or convenience of the Member, family, or Provider;

d) The most appropriate services, supplies, equipment, or levels of care that can be safely and efficiently provided to the Covered Person;

e) Furnished in a setting appropriate to the Covered Person's medical need and condition and, when applied to the care of an inpatient, further mean that the Covered Person's medical symptoms or conditions require that the services cannot be safely provided to the Covered Person as an outpatient;

f) Not experimental or investigational or for research or education;

g) Provided by an appropriately licensed practitioner; and

h) Documented in the patient's record in a reasonable manner, including the relationship of the diagnosis to the service.

Medically Necessary Services may also be those services for children that are necessary to correct or ameliorate defects and physical and mental illnesses and conditions discovered during an interperiodic or periodic EPSDT screen, whether such services are covered or exceed the benefit limits in the Medicaid State Plan and Title 23 of Mississippi Administrative Code.

iv) Urgent Care: Urgent care services are utilized because the Covered Person's primary care physician is not available. An urgent condition is not life threatening but may need prompt attention. Urgent care services are for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe it requires emergency room care.

3.2 Provider Eligibility. Provider must be enrolled in the Mississippi Medicaid program and must use the same National Provider Identifier (NPI) number to participate in HMO's Network. Upon notification from the State that Provider's enrollment has been denied or terminated, HMO must terminate Provider immediately and will notify affected Covered Persons that Provider is no longer participating in the network. HMO will exclude from its

network any provider who has been terminated or suspended from the Medicare or Medicaid program in any state.

3.3 Accessibility Standards. Provider shall provide for timely access for Covered Person appointments in accordance with the appointment availability requirements established under the State Contract, as further described in the applicable provider manual.

Type	Appointment Scheduling Time Frames
PCP (well care visit)	Not to exceed thirty (30) calendar days
PCP (routine sick visit)	Not to exceed seven (7) calendar days
PCP (urgent care visit)	Not to exceed twenty-four (24) hours
Specialists	Not to exceed forty-five (45) calendar days
Dental Providers (routine visits)	Not to exceed forty-five (45) calendar days
Dental Providers (urgent Care)	Not to exceed forty-eight (48) hours
Behavioral Health Providers (routine visit)	Not to exceed fourteen (14) calendar days
Behavioral Health Providers (urgent visit)	Not to exceed twenty-four (24) hours
Behavioral Health Providers (post-discharge from an acute psychiatric hospital when the Contractor is aware of the Member's discharge)	Not to exceed seven (7) calendar days
Urgent Care Providers	Not to exceed twenty-four (24) hours
Emergency Providers	Immediately (twenty-four (24) hours a day, seven (7) days a week) and without Prior Authorization

3.4 Hours of Operation; Appointments. Provider shall offer hours of operation that are no less than the hours of operation offered to commercial beneficiaries or comparable to Medicaid fee-for-service if Provider serves only Medicaid beneficiaries. As applicable, Provider will make Covered Services available 24 hours a day, 7 days a week when medically necessary.

3.5 Hold Harmless. Except for any applicable cost-sharing requirements under the State Contract, Provider shall look solely to HMO for payment of Covered Services provided to Covered Persons pursuant to the Agreement and the State Contract and hold the State, DOM, the U.S. Department of Health and Human Services and Covered Persons harmless in the event that HMO cannot or will not pay for such Covered Services. In accordance with 42 CFR 447.15, as may be amended from time to time, the Covered Person is not liable to Provider for any services for which HMO is liable and as specified under the State's relevant health insurance or managed care statutes, rules or administrative agency guidance. Provider shall not require any copayment or cost sharing for Covered Services provided under the Agreement unless expressly permitted under the State Contract.

Provider shall also be prohibited from charging Covered Persons for missed appointments if such practice is prohibited under the State Contract or applicable law. Neither the State, DOM nor Covered Persons shall be in any manner liable for the debts and obligations of HMO and under no circumstances shall HMO, or any providers used to deliver services covered under the terms of the State Contract, charge Covered Persons for Covered Services.

Covered Person may be responsible for non-covered item(s) and/or service(s), only if the Provider ensures that written documentation in compliance with the Advance Beneficiary Notification (ABN) is received from the Covered Person that an item(s) or service(s) rendered is a non-covered item and/or service(s) and that the Covered Person will be financially responsible for the item(s) and/or service(s). If HMO determines a Covered Person was charged for Covered Services inappropriately, such payment may be recovered, as applicable.

This provision shall survive any termination of the Agreement, including breach of the Agreement due to insolvency.

3.6 Indemnification. To the extent applicable to Provider in performance of the Agreement, Provider shall indemnify, defend, protect, save and hold DOM and its employees and Covered Persons harmless from and against all injuries, deaths, losses, damages, claims, suits, liabilities, judgments, costs and expenses, including, without limitation, court costs, investigative fees and expenses and attorney fees, to the extent proximately caused by any negligent act or other intentional misconduct or omission of Provider, its agents, officers, employees or contractors arising from the Agreement. DOM may waive this requirement for public entities if Provider is a state agency or sub-unit as defined by the State or a public health entity with statutory immunity. This clause shall survive the termination of the Agreement for any reason, including breach due to insolvency.

3.7 Provider Selection. To the extent applicable to Provider in performance of the Agreement, Provider shall comply with 42 CFR 438.214, as may be amended from time to time, which includes, but is not limited to the selection and retention of providers, credentialing and recredentialing requirements and nondiscrimination. If HMO delegates credentialing to Provider, HMO will provide monitoring and oversight and Provider shall ensure that all licensed medical professionals are credentialed in accordance with HMO's and the State Contract's credentialing requirements.

3.8 Restrictions on Referrals. Provider shall not make inappropriate referrals for designated health services to health care entities with which Provider or a member of Provider's family has a financial relationship, pursuant to federal anti-kickback and physician self-referral laws that prohibit such referrals.

3.9 Records Retention. As required under State or federal law or the State Contract, Provider shall maintain an adequate record keeping system for recording services, charges, dates and all other commonly accepted information elements sufficient to disclose the quality, quantity, appropriateness and timeliness of services rendered to Covered Persons. All financial records shall follow generally accepted accounting principles. Medical records and supporting management systems shall include all pertinent information related to the

medical management of each Covered Person. Other records shall be maintained as necessary to clearly reflect all actions taken by Provider related to services provided under the State Contract. Such records, including, as applicable, grievance and appeal records shall be maintained for a period of not less than ten (10) years from the close of the Agreement, or such other period as required by law. If records are under review or audit, they must be retained for a minimum of ten (10) years following resolution of such action. Prior approval for the disposal of records must be requested and approved by HMO if the Agreement is continuous.

3.10 Records Access. Provider agrees to cooperate with HMO to maintain and share a health record of all services provided to a Covered Person, as appropriate and in accordance with applicable laws, regulations and professional standards. Provider acknowledges and agrees that the State, DOM, the U.S. Department of Health and Human Services and other authorized federal and state personnel shall have complete access to all records pertaining to services provided to Covered Persons. Provider shall provide immediate access to facilities, records and supportive materials pertinent to the State Contract for State or Federal fraud investigators. Copies of requested documents shall be provided to the State, DOM, the U.S. Department of Health and Human Services and other authorized federal and state personnel or their designees free of charge.

3.11 Government Audit; Investigations. Provider acknowledges and agrees that the State and the U.S. Department of Health and Human Services, the Centers for Medicare & Medicaid Services, the Office of Inspector General, the General Accounting Office, or any other auditing agency and their designees or their authorized representatives, with prior approval by DOM, shall, at all reasonable time, with or without notice, have the right to inspect, audit or otherwise evaluate the quality, appropriateness, and timeliness of services provided under the terms of the State Contract and any other applicable rules, including the right to inspect and audit any records or documents of Provider and its subcontractors, and the right to inspect the premises, physical facilities, and equipment where Medicaid-related activities or work is conducted. The right to audit under this section exists for 10 years from the end date of the State Contract or from the date of completion of any audit, whichever is later. There shall be no restrictions on the right of the State or federal government to conduct whatever inspections and audits are necessary to assure quality, appropriateness or timeliness of services provided pursuant to the State Contract and the reasonableness of their costs.

3.12 Privacy; HIPAA. Provider shall comply with all applicable privacy rule and security rule provisions of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), and associated implementing regulations, as may be amended from time to time, and shall safeguard information about Covered Persons in accordance with applicable federal and State privacy laws and rules including 42 CFR 438.224 and 42 CFR Part 431, Subpart F, as may be amended from time to time. HMO agrees and shall require Provider to agree that confidential information, including but not limited to medical and other pertinent information relative to Covered Persons, shall not be disclosed to any person or organization for any purpose without the expressed, written authority of DOM or as otherwise required by law and that all such disclosures shall fully comply with HIPAA privacy and security standards.

3.13 Compliance with Law. Provider shall comply with all applicable federal and State laws and regulations, and all provisions of the State Contract, that pertain to a Covered Person's rights, including but not limited to the following to the extent applicable to Provider in performance of the Agreement:

i) Title VI of the Civil Rights Act of 1964; Title XIX of the Social Security Act; 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 Genetic Information Non-Discrimination Act of 2008 (GINA); the Americans with Disabilities Act; section 1557 of the Patient Protection and Affordable Care Act, and their implementing regulations, as may be amended from time to time.

ii) All relevant federal and State statutes, regulations and orders related to equal opportunity in employment, including but not limited to compliance with E.O. 11246, "Equal Employment Opportunity," as amended by E.O. 11375, "Amending Executive Order 11246 Relating to Equal Employment Opportunity," and as supplemented by regulations at 41 CFR part 60, "Office of Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor."

iii) All federal and State professional and facility licensing and accreditation requirements/standards that apply to the services HMO and Provider perform pursuant to the Agreement, including but not limited to:

a) All applicable standards, orders or requirements issued under Section 306 of the Clean Air Act (42 USC 1857 (h)). Section 508 of the Clean Water Act (33 USC 1368), Executive Order 11738, and Environmental Protection Agency (EPA) regulations (40) CFR Part 15), which prohibit the use of facilities included on the EPA list of violating facilities. Any violations must be reported to DSHS, DHHS, and the EPA;

b) Any applicable mandatory standards and policies relating to energy efficiency that are contained in the State Energy Conservation Plan, including the Energy Policy & conservation Act (Pub. L. 94-165), and issued in compliance with the Federal Energy Policy & Conservation Act.

c) Those specified for laboratory services in the Clinical Laboratory Improvement Amendments (CLIA). All laboratory service sites must have a CLIA certificate of registration or waiver, and a CLIA identification number.

d) Section 1128B(d)(1) of the Balanced Budget Act of 1997; and,

e) Any other requirements associated with the receipt of federal funds.

iv) All Medicaid laws, regulations and program instructions to the extent applicable to Provider in Provider's performance of the Agreement. Provider understands that payment of a claim by HMO or the State is conditioned upon the claim and the underlying transaction complying with such laws, regulations, and program

instructions (including, but not limited to, federal requirements on fraud, waste and abuse, disclosure, debarment, termination and exclusion screening), and is conditioned on the Provider's compliance with all applicable conditions of participation in Medicaid. Provider understands and agrees that each claim the Provider submits to HMO constitutes a certification that the Provider has complied with all applicable Medicaid laws, regulations and program instructions in connection with such claims and the services provided therein. Provider's payment of a claim will be denied if Provider is terminated or excluded from participation in federal healthcare programs. Provider's payment of a claim may be temporarily suspended if the State or HMO provides notice that a credible allegation of fraud exists and there is a pending investigation. Provider's payment of a claim may also be temporarily suspended or adjusted if the Provider bills a claim with a code that does not match the service provided. HMO performs coding edit procedures based primarily on National Correct Coding Initiative (NCCI) policies and other nationally recognized and validated policies. Provider agrees that it will provide medical records to HMO upon its request in order to determine appropriateness of coding. Provider may dispute any temporarily suspended or adjusted payment consistent with the terms of the Agreement.

3.14 Physician Incentive Plans. In the event Provider participates in a physician incentive plan ("PIP") under the Agreement, Provider agrees that such PIPs must comply with 42 CFR 417.479, 42 CFR 438.3(i), 42 CFR 422.208, and 42 CFR 422.210, as may be amended from time to time. Neither HMO nor Provider may make a specific payment directly or indirectly under a PIP to a physician or physician group as an inducement to reduce or limit Medically Necessary services furnished to an individual Covered Person. PIPs must not contain provisions that provide incentives, monetary or otherwise, for the withholding of services that meet the definition of Medical Necessity.

3.15 Lobbying. Provider agrees to comply with the following requirements related to lobbying:

i) Prohibition on Use of Federal Funds for Lobbying: By signing the Agreement, Provider certifies to the best of Provider's knowledge and belief, pursuant to 31 U.S.C. Section 1352 and 45 CFR Part 93, as may be amended from time to time, that no federally appropriated funds have been paid or will be paid to any person by or on Provider's behalf for the purpose of influencing or attempting to influence an officer or employee of any agency, a member of Congress, an officer or employee of Congress, or an employee of a member of Congress in connection with the award of any federal contract, the making of any federal grant, the making of any federal loan, the entering into of any cooperative agreement, or the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan, or cooperative agreement.

ii) Disclosure Form to Report Lobbying: If any funds other than federally appropriated funds have been paid or will be paid to any person for the purpose of influencing or attempting to influence an officer or employee of any agency, a member of Congress, an officer or employee of Congress, or an employee of a member of Congress in connection with the award of any federal contract, the making of any federal grant, the

making of any federal loan, the entering into of any cooperative agreement, or the extension, continuation, renewal, amendment or modification of any federal contract, grant, loan, or cooperative agreement and the value of the Agreement exceeds $100,000, Provider shall complete and submit Standard Form-LLL, "Disclosure Form to Report Lobbying," in accordance with its instructions.

3.16 Excluded Individuals and Entities. Provider certifies that neither it nor any of its employees, principals, nor any providers, subcontractors or consultants or persons with an ownership or controlling interest in the Provider (an owner including the Provider himself or herself), or an agent or managing employee of the Provider, with whom Provider contracts and who are providing items or services that are significant and material to Provider's obligations under the Agreement is:

i) excluded from participation in federal health care programs under either Section 1128 or section 1128A of the Social Security Act; or

ii) debarred, suspended or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in nonprocurement activities under regulations issued under Executive Order no. 12549 or under guidelines implementing Executive Order No. 12549; or an affiliate, as defined in the Federal Acquisition Regulation, of such a person.

Provider acknowledges and agrees that payment will not be made for any items or Covered Services provided by an excluded individual pursuant to 42 CFR 1001.1901(b) and is obligated to screen all employees, contractors, and subcontractors for exclusion as required under applicable State and Federal laws. Additionally, Provider acknowledges that pursuant to 42 CFR 1003.102(a)(2) civil monetary penalties may be imposed against Provider if he or she employs or enters into contracts with excluded individuals or entities to provide items or Covered Services to Covered Persons under this Agreement. Provider agrees not to employ or subcontract with individuals or entities whose owner, those with a controlling interest, or managing employees are on a State or Federal exclusion list to provide items or Covered Services under this Agreement. Provider shall immediately report to HMO any exclusion information discovered. Provider can search the HHS-OIG website, at no cost, by the names of any individuals or entities. The database is called LEIE and can be accessed at http://www.oig.hhs.gov/fraud/exclusions.asp. The GSA EPLS/SAM database can be accessed at https://www.sam.gov. Federal and State exclusion databases must be reviewed monthly to ensure that no employee or contractor has been excluded. Applicable state exclusion databases can be accessed through the State's Medicaid website. HMO will terminate the Agreement immediately and exclude from its network any provider who has been excluded from federal health care programs or terminated from the Medicare or the Medicaid program in any state. HMO may also terminate the Agreement if Provider or Provider's owners, agents, or managing employees are found to be excluded on a State or Federal exclusion list.

3.17 Disclosure. Provider must be screened and enrolled in the State's Medicaid program and submit disclosures to the DOM related to ownership and control, significant business transactions, and persons convicted of crimes in accordance with 42 CFR Part 455 .Provider must submit information related to ownership and control of subcontractors or

wholly owned suppliers within thirty-five (35) calendar days of a request for such information in accordance with 42 CFR 455.105. Additionally, Provider must cooperate with DOM for submission of fingerprints upon a request from DOM or CMS in accordance with 42 CFR 455.434.

By executing this Agreement, Provider certifies that neither Provider nor any of its principals is presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in any State or federal health care program or from participating in transactions by any State or federal department or agency. HMO will terminate the Agreement upon becoming aware or receiving notice from DOM, whichever is earlier, that Provider is or has been excluded from participation in any State or federal health care program or by any State or federal agency.

3.18 Cultural Competency and Access. Provider shall participate in HMO's and the State's efforts to promote the delivery of services in a culturally competent manner to all Covered Persons, including those with limited English proficiency, physical or mental disabilities, diverse cultural and ethnic backgrounds and regardless of gender, sexual orientation or gender identity, and shall provide interpreter services in a Covered Person's primary language and for the hearing impaired for all appointments and emergency services. Provider shall provide information to Covered Persons regarding treatment options and alternatives, as well as information on complaints and appeals, in a manner appropriate to the Covered Person's condition and ability to understand. Provider shall provide physical access, reasonable accommodations, and accessible equipment for Covered Persons with physical or mental disabilities.

3.19 Marketing. As required under State or federal law or the applicable State Contract, any marketing materials developed and distributed by Provider as related to the performance of the Agreement must be submitted to HMO at least sixty (60) days prior to planned distribution for timely submission to DOM for prior approval. Provider agrees it will not proceed with the statement or communication until the required approval is obtained.

3.20 Fraud, Waste and Abuse Prevention. Provider shall cooperate fully with HMO's policies and procedures designed to protect program integrity and prevent and detect potential or suspected fraud, waste, and abuse in the administration and delivery of services under the State Contract and shall cooperate and assist DOM and any other State or federal agency charged with the duty of preventing, identifying, investigating, sanctioning or prosecuting suspected fraud, waste, and abuse in state and/or federal health care programs.

In accordance with HMO's policies and the Deficit Reduction Act of 2005 (DRA), Provider shall have written policies for its employees, contractors or agents that: (a) provide detailed information about the federal False Claims Act (established under sections 3729 through 3733 of title 31, United States Code), including if any entity makes or receives annual payments under the State Program of at least $5,000,000, such entity must establish certain minimum written policies and information communicated through an employee handbook relating to the Federal False Claims Act in accordance with 42 CFR 438.600; (b) cite administrative remedies for false claims and statements (established under chapter 38 of title 31, United States Code) and whistleblower protections under federal and state laws; (c) reference state laws pertaining to civil or criminal penalties for false claims

and statements; and (d) with respect to the role of such laws in preventing and detecting fraud, waste, and abuse in federal health care programs (as defined in section 1128B(f)), include as part of such written policies, detailed provisions regarding Provider's policies and procedures for detecting and preventing fraud, waste, and abuse. Provider agrees to train its staff on the aforesaid policies and procedures.

3.21 Data; Reports. Provider shall cooperate with and release to HMO any information necessary for HMO to perform its obligations under the State Contract to the extent applicable to Provider in performance of the Agreement, including the timely submission of reports and information required by HMO, in the format specified by HMO and the State. Such reports shall include child health check-up reporting, if applicable, as well as complete and accurate encounter data in accordance with the requirements of HMO and the State. Data must be provided at the frequency and level of detail specified by HMO or the State. By submitting data to HMO, Provider represents and attests to HMO and the State that the data is accurate, complete and truthful, and upon HMO's request Provider shall certify in writing, that the data is accurate, complete, and truthful, based on Provider's best knowledge, information and belief.

Provider shall be able to receive, maintain and utilize applicable data extracts from HMO or DOM and systematically update its database within five (5) calendar days of receipt of the files. Data extract files include but are not limited to the following, as applicable: 1. Daily Active Provider Extract; 2. Weekly Provider Affiliation Details Extract; 3. 834 Enrollment Files; 4. 835 Claims Payment Remittance Advice Transaction; 5. 277 Claims Acknowledgement; 6. NCPDP Formulary; 7. NCPDP Response File; 8. TPL Resource/Policy Information File, etc.; 9. Claims History Extracts; and 10. Prior Authorization Extracts.

3.22 Encounter Data. Provider agrees to cooperate with HMO to comply with HMO's obligation to prepare encounter data submissions, reports, and clinical information including, without limitation, child and adolescent health check-up reporting, EPSDT encounters, and cancer screening encounters, as applicable, and such other reporting regarding Covered Services as may be required under the State Contract. Encounter data must be accurate and include all services furnished to a Covered Person, including capitated provider's data and rendering provider information. Encounter data must be provided within the timeframes specified and in a form that meets HMO and State requirements. By submitting encounter data to HMO, Provider represents to HMO that the data is accurate, complete and truthful, and upon HMO's request Provider shall certify in writing, that the data is accurate, complete, and truthful, based on Provider's best knowledge, information and belief.

3.23 Claims Information. Provider shall promptly submit to HMO the information needed to make payment and shall identify third party liability coverage, including Medicare and other insurance, and if applicable seek such third party liability payment before submitting claims to HMO. Provider understands and agrees that each claim Provider submits to HMO constitutes a certification that the claim is true and accurate to the best of Provider's knowledge and belief and that the Covered Services are 1) Medically Necessary and 2) have been provided to the Covered Person prior to submitting the claim.

Effective July 1, 2014, Provider must submit claims within six (6) months from the date of service. Claims filed within the appropriate time frame but denied may be resubmitted to the Contractor within ninety (90) calendar days from the date of denial

3.24. Electronic Visit Verification. Provider shall cooperate with State requirements for electronic visit verification for personal care services and home health services, as applicable.

3.25 Licensure. Provider represents that it is currently licensed and/or certified under applicable State and federal statutes and regulations and by the appropriate State licensing body or standard-setting agency, as applicable. Provider represents that it is in compliance with all applicable State and federal statutory and regulatory requirements of the Medicaid program and that it is eligible to participate in the Medicaid program. Provider represents that it does not have a Medicaid provider agreement with DOM that is terminated, suspended, denied, or not renewed as a result of any action of DOM, CMS, HHS, or the Medicaid Fraud Control Unit of the State's Attorney General. Provider shall maintain at all times throughout the term of the Agreement all necessary licenses, certifications, registrations and permits as are required to provide the health care services and/or other related activities delegated to Provider by HMO under the Agreement. If at any time during the term of the Agreement, Provider is not properly licensed as described in this Section, Provider shall discontinue providing services to Covered Persons. As applicable, if Provider performs any laboratory tests on human specimens for the purpose of diagnosis and/or treatment, Provider agrees to acquire and maintain the appropriate CLIA certification or waiver for the type of laboratory testing performed. Provider further agrees to provide a copy of the certification if requested by HMO. A State authorized license or permit that meets the CLIA requirements may be substituted for the CLIA certificate pursuant to State law. Medicare and Medicaid programs require the applicable CLIA certification or waiver for the type of services performed as a condition of payment. Provider must include the appropriate CLIA certificate or waiver number on claims submitted for payment for laboratory services.

3.26 Quality; Utilization Management. Pursuant to any applicable provider manuals and related protocols, or as elsewhere specified under the Agreement, Provider agrees to cooperate with HMO's quality improvement and utilization review and management activities. This shall include, but not be limited to, participation in any internal and external quality assurance, utilization review, peer review, and grievance procedures established by HMO or as required under the State Contract to ensure that Covered Persons have due process for their complaints, grievances, appeals, fair hearings or requests for external review of adverse decisions made by HMO or Provider. Provider shall adhere to the quality assurance and utilization review standards of the MississippiCAN Program and shall monitor quality and initiate corrective action to improve quality consistent with the generally accepted level of care.

3.27 Non-Discrimination. Provider will not discriminate against, nor use any policy or practice that has the effect of discriminating against, Covered Persons on the basis of race, color, creed, sex, religion, age, national origin, ancestry, marital status, sexual orientation, gender identity, language, health status, disease or pre-existing condition (including genetic

information), anticipated need for health care or physical or mental handicap, except where medically indicated. Examples of prohibited practices include, but are not limited to, the following:

i) Denying or not providing a Covered Person any Medicaid Covered Service. Health care and treatment necessary to preserve life must be provided to all Covered Persons who are not terminally ill or permanently unconscious, except where a competent Covered Person objects to such care on his/her own behalf.

ii) Subjecting a Covered Person to segregated, separate, or different treatment, including a different place or time from that provided to other Covered Persons or public or private patients, in any manner related to the receipt of any Medicaid Covered Service, except where Medically Necessary.

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

3.28 Advance Directives. Provider shall comply with the advance directives requirements set forth in the Uniform Health-Care Decisions Act, Section 41-41-215 of the Mississippi Code. When applicable, Provider shall comply with the advance directives requirements for hospitals, nursing facilities, providers of home and health care and personal care services, hospices, and HMOs as specified in 42 CFR Part 49, subpart I, 42 CFR § 417.436(d), 42 CFR § 422.128, and 42 CFR 438.3(i).

3.29 National Provider ID (NPI). Provider shall obtain a National Provider Identification Number (NPI) and when filing claims with HMO, the NPI used is the same NPI used when filing claims with DOM.

3.30 Termination. In the event of termination of the Agreement, Provider shall promptly supply to HMO all information necessary for the reimbursement of any outstanding Medicaid claims.

3.31 Complaints; Grievances and Appeals. Information on how Provider or Provider's authorized representative can submit complaints and file grievances and appeals, and the resolution process, is contained in the applicable provider manual.

3.32 Health Care Acquired/Preventable Conditions. Provider agrees that no payment shall be made for the provision of medical assistance for health care acquired conditions and other provider preventable conditions as may be identified by the State. As a condition of payment, Provider shall identify and report to HMO any provider preventable conditions in accordance with 42 CFR §§ 434.6(a)(12), 438 including but not limited to 438.3(g), and 447.26.

3.33 Quality and Utilization Management Program. Provider shall cooperate with HMO in meeting the Quality Management and Utilization Management Program standards outlined

in the State Contract including, without limitation, any external evaluations and assessments of HMO's performance authorized by DOM under the State Contract and conducted by DOM's contracted External Quality Review Organization (EQRO) or other designee.

3.34 Referrals. Provider shall make referrals for social, vocational, education or human services when a need for such service is identified.

3.35 Insolvency. In the event HMO becomes insolvent or unable to pay Provider, Provider shall not seek compensation for services rendered from the State, DOM, their officers, Agents, or employees, or the Covered Persons or their eligible dependents.

3.36 Third Party Resources. Provider will report all third party resources to HMO identified through the provision of medical services.

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

3.38 Capitated Providers. If Provider is capitated and terminates its agreement with HMO, for any reason, Provider will provide services to Covered Persons assigned to Provider up to the end of the month in which the effective date of termination falls.

3.39 Certification on Relationship to State, DOM and CMS. Provider certifies that no officer, director, employee, subcontractor or agent of Provider, or person with an ownership or control interest in Provider, is also employed by, or is a public official of, the State of Mississippi or any of its agencies, DOM or CMS.

3.40 Funding. Provider recognizes that the obligation of DOM to proceed under its Contract with HMO is conditioned upon the appropriation of funds by the Mississippi State

Legislature and the receipt of State and/or Federal funds. If the funds anticipated for the continuing fulfillment of the agreement are, at any time, not forthcoming or insufficient, either through the failure of the Federal government to provide or the State of Mississippi to appropriate funds, or the discontinuance, or material alteration of the program under which the funds were provided or if funds are not otherwise available to DOM, DOM has the right upon ten (10) working days written notice to HMO to terminate the Contract.

3.41 Gratuities. Provider represents that it has not violated, is not violating, and promises that it will not violate the prohibitions against gratuities set forth in Section 6-204 (Gratuities) of the Mississippi Personal Service Contract Procurement Regulations.

3.42 Assignment/Delegation. Provider shall not assign or delegate the Agreement without the express written consent of HMO or DOM. If Provider subcontracts or delegates any functions of the Agreement, in accordance with the terms of the Agreement and with the express written consent of HMO or DOM, the subcontract or delegation must be in writing and include all of the requirements of this Appendix, and applicable requirements of the State Contract, and applicable laws and regulations. The transfer of five percent (5%) or more of the beneficial ownership in Provider at any time during the term of this Agreement shall be deemed an assignment under this Agreement.

3.43 Notice of Legal Action. Immediately upon obtaining knowledge or receiving notice of any legal action or notice listed below, Provider shall provide to HMO written notice of such legal action or notice and, upon request by HMO, a complete copy of all filings and other documents generated in connection with any such legal action:

i. Any action, suit or counterclaim filed against Provider;

ii. Any regulatory action, or proposed action, respecting Provider's business or operations;

iii. Any notice received by Provider from the Department of Insurance or the State Health Officer;

iv. The filing of a petition in bankruptcy by or against Provider, or the insolvency of Provider;

v. The conviction of any person who has an ownership or control interest in Provider, or who is an agent or managing employee of Provider, of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or Title XX of the Social Security Act; or

vi. A malpractice action against any Provider delivering service under an agreement.

3.44 Federal and State Funds Liability. Providers acknowledges and agrees that payments made to Provider for services provided under the Agreement are derived from federal and State funds and that any false claim or statement in documents or any concealment of material fact related to such services may be a cause for sanctions and prosecution under applicable federal and State laws. Provider shall be subject to all laws applicable to

individuals and entities receiving State and federal funds and may be held civilly or criminally liable to both HMO and DOM in the event of nonperformance, misrepresentation, fraud, or abuse related to services provided pursuant to the State Contract. Provider recognizes that payments made to the Provider are derived from federal and State funds, and are contingent upon and subject to availability and receipt of funds.

3.45 Insurance Requirements. As applicable, Provider shall secure and maintain during the term of the Agreement insurance appropriate to the services to be performed under the Agreement. Provider shall require that its providers secure and maintain during the term of the Agreement general liability insurance, professional liability insurance, and workers' compensation insurance for all employees connected with the provision of services under the Agreement. Such workers compensation insurance shall comply with Mississippi Workers' Compensation Laws. Such comprehensive general liability insurance and professional liability insurance shall provide coverage in an amount established by HMO pursuant to the Agreement or as required under the State Contract.

3.46 Overpayment. Provider shall to report to HMO when it has received an overpayment and will return the overpayment to HMO within 60 calendar days after the date on which the overpayment was identified. Provider will notify HMO in writing of the reason for the overpayment.

SECTION 4
ADDITIONAL PROVIDER REQUIREMENTS FOR SPECIFIC ACTIVITIES

4.1 Behavioral Health Providers. Behavioral Health Providers shall ensure that all Covered Persons receiving inpatient psychiatric services are scheduled for outpatient follow-up and/or continuing treatment prior to discharge from the inpatient psychiatric hospital if the Provider is aware of the Covered Person's inpatient hospitalization status. Behavioral Health Providers will be provided daily reports identifying Covered Persons known to be admitted to an inpatient facility. Behavioral Health Services will be delivered in compliance with the requirements of 42 CFR 438 subpart K insofar as those requirements are applicable.

4.2 PCP Responsibilities. Providers acting as PCPs shall meet the following requirements:

i) PCPs who serve Covered Persons under the age of twenty-one (21) are responsible for conducting all EPSDT screens for individuals on their Panel under the age of twenty-one (21). Should the PCP be unable to conduct the necessary EPSDT screens, the PCP is responsible for arranging to have the necessary EPSDT screens conducted by another network Provider and ensure that all relevant medical information, including the results of the EPSDT screens, are incorporated into the Covered Person's PCP Medical Record.

ii) PCPs who serve Members under the age of twenty-one (21) report encounter data associated with EPSDT screens, using a format approved by DOM, to the Contractor within ninety (90) calendar days from the date of service.

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

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

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

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

4.3 Specialists as PCPs. Covered Persons with disabling conditions, chronic illnesses, or child(ren) with special health care needs may request that their PCP be a specialist. The designation of a specialist as a PCP must be pursuant to a treatment plan approved by HMO, in consultation with the PCP to which the Covered Person is currently assigned, the Covered Person and, as appropriate, the specialist.

The specialist as a PCP shall provide or arrange for all primary care, including routine preventive care, and to provide those specialty medical services consistent with the Covered Person's disabling condition, chronic illness, or special health care need in accordance with HMO's standards and within the scope of the specialty training and clinical expertise.

The specialist as a PCP shall have admitting privileges at a hospital in HMO's network.

4.4 Long-Term Services and Supports (LTSS) Providers. Any LTSS Covered Services under the State Contract that could be authorized through a waiver under section 1915(c) of the Social Security Act (the "Act") or a State Program amendment authorized through sections 1915(i) or 1915(k) of the Act must be delivered in settings consistent with 42 CFR 441.301(c)(4).

SECTION 5
HMO REQUIREMENTS

5.1 Prompt Payment. HMO shall pay Provider pursuant to the State Contract and applicable State and federal law and regulations, including but not limited to Mississippi Code Section 83-9-5, 42 CFR 447.46, 42 CFR 447.45(d)(2), 42 CFR 447.45(d)(3), 42 CFR 447.45(d)(5) and 42 CFR 447.45(d)(6), as applicable and as may be amended from time to time. If a third party liability exists, payment of claims shall be determined in accordance with federal and/or State third party liability law and the terms of the State Contract. Unless HMO otherwise requests assistance from Provider, HMO will be responsible for third party collections in accordance with the terms of the State Contract.

5.2 No Incentives to Limit Medically Necessary Services. HMO shall not structure compensation provided to individuals or entities that conduct utilization management and concurrent review activities so as to provide incentives for the individual or entity to deny, limit, or discontinue Medically Necessary services to any Covered Person.

5.3 Provider Discrimination Prohibition. HMO shall not discriminate with respect to participation, reimbursement, or indemnification of a provider who is acting within the scope of the provider's license or certification under applicable State law, solely on the basis of such license or certification. HMO shall not discriminate against Provider for serving high-risk Covered Persons or if Provider specializes in conditions requiring costly treatments. This provision shall not be construed as prohibiting HMO from limiting a provider's participation to the extent necessary to meet the needs of Covered Persons. This provision also is not intended and shall not interfere with measures established by HMO that are designed to maintain quality of care practice standards and control costs.

5.4 Communications with Covered Persons. Covered Persons are entitled to the full range of their Providers' opinions and counsel about the availability of Medically Necessary Services under the provisions of the State Contract. Any contractual provisions, including gag clauses or rules, that restrict a Provider's ability to advise Covered Persons about Medically Necessary treatment options violate federal law and regulations.

HMO shall not prohibit or otherwise restrict Provider, when acting within the lawful scope of practice, from advising or advocating on behalf of a Covered Person for the following:

i) The Covered Person's health status, medical care, or treatment options, including any alternative treatment that may be self-administered;

ii) Any information the Covered Person needs in order to decide among all relevant treatment options;

iii) The risks, benefits, and consequences of treatment or non-treatment;

iv) The Covered Person's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions; or

v) Information regarding the nature of treatment options including those that may not reflect HMO's position or may not be covered by HMO.

HMO also shall not prohibit a Provider from advocating on behalf of a Covered Person in any grievance system, utilization review process, or individual authorization process to obtain necessary health care services.

5.5 Termination, Revocation and Sanctions. In addition to its termination rights under the Agreement, HMO shall have the right to revoke any functions or activities HMO delegates to Provider under the Agreement or impose other sanctions consistent with the State Contract if in HMO's reasonable judgment Provider's performance under the Agreement is inadequate. HMO shall also have the right to suspend, deny, refuse to renew or terminate

Provider in accordance with the terms of the State Contract and applicable law and regulation. However, HMO shall not exclude or terminate a Provider from participation in HMO's Provider Network due to the fact that the Provider has a practice that includes a substantial number of patients with expensive medical conditions, and shall not terminate a Provider for filing a Complaint, Grievance, or Appeal on a Covered Person's behalf.

5.6 Rights of DOM. DOM shall have the right to invoke against Provider any remedy set forth in the State Contract, including the right to require the termination of the Agreement, for each and every reason for which it may invoke such a remedy against HMO or require termination of the State Contract. Suspected Fraud and Abuse by Provider will be investigated by DOM.

SECTION 6
OTHER REQUIREMENTS

6.1 Compliance with State Contract. All tasks performed under the Agreement shall be performed in accordance with the requirements of the applicable State Contract, as set forth in this Appendix, applicable provider manuals, and protocols, policies and procedures that HMO has provided or delivered to Provider. The applicable provisions of the State Contract are incorporated into the Agreement by reference. Nothing in the Agreement relieves HMO of its responsibility under the State Contract. If any provision of the Agreement is in conflict with provisions of the State Contract, the terms of the State Contract shall control and the terms of the Agreement in conflict with those of the State Contract will be considered waived.

6.2 Monitoring. HMO shall perform ongoing monitoring (announced or unannounced) of services rendered by Provider under the Agreement and shall perform periodic formal reviews of Provider according to a schedule established by the State, consistent with industry standards or State managed care organization laws and regulations or requirements under the State Contract. As a result of such monitoring activities, HMO shall identify to Provider any deficiencies or areas for improvement mandated under the State Contract and Provider and HMO shall take appropriate corrective action. Provider shall comply with any corrective action plan initiated by HMO and/or required by the MississippiCAN Program. In addition, Provider shall monitor and report the quality of services delivered under the Agreement and initiate a plan of correction where necessary to improve quality of care, in accordance with that level of care which is recognized as acceptable professional practice in the respective community in which HMO and Provider practice and/or the performance standards established under the State Contract.

6.3 Enrollment. The parties acknowledge and agree that DOM is responsible for enrollment, reenrollment and disenrollment of Covered Persons.

6.4 No Exclusivity. Nothing in the Agreement or this Appendix shall be construed as prohibiting or penalizing Provider for contracting with a managed care organization other than HMO or as prohibiting or penalizing HMO for contracting with other providers. HMO may not require Providers who agree to participate in the MississippiCAN Program to contract with HMO's other lines of business.

6.5 **Delegation.** The parties agree that, prior to execution of the Agreement, HMO evaluated Provider's ability to perform any duties delegated to Provider under the Agreement. Any delegated duties and reporting responsibilities shall be set forth in the Agreement or other written delegation agreement or addendum between the parties. HMO shall have the right to revoke any functions or activities HMO delegates to Provider under the Agreement if in HMO's reasonable judgment Provider's performance under the Agreement is inadequate.

MississippiCHIP
Regulatory Requirements Appendix

MississipiCHIP

REGULATORY REQUIREMENTS APPENDIX

PROVIDER

THIS MISSISSIPPICHIP PROGRAM REGULATORY REQUIREMENTS APPENDIX (this "Appendix") supplements and is made part of the provider agreement (the "Agreement") between HMO contracting on behalf of itself and the other entities that are its affiliates (collectively, "CCO") and the party named in the Agreement ("Provider").

SECTION 1
APPLICABILITY

This Appendix applies with respect to the provision of direct or health care related services provided by Provider under the Mississippi Children's Health Insurance Program (the "MississippiCHIP Program") as governed by the State's designated regulatory agencies. In the event of a conflict between this Appendix and other appendices or any provision of the Agreement, the provisions of this Appendix shall control except with regard to benefit plans outside the scope of this Appendix or unless otherwise required by law. In the event CCO is required to amend or supplement this Appendix as required or requested by the State to comply with federal or State regulations, CCO will unilaterally initiate such additions, deletions or modifications. All provider agreements must be in writing and must include all specific activities and report responsibilities delegated to the Provider by CCO.

SECTION 2
DEFINITIONS

Unless otherwise defined in this Appendix, all capitalized terms shall be as defined in the Agreement. For purposes of this Appendix, the following terms shall have the meanings set forth below; provided, however, in the event any definition set forth in this Appendix or the Agreement is inconsistent with any definition under the MississippiCHIP Program Contract, the definition shall have the meaning set forth under the MississippiCHIP Program Contract.

2.1 **Abuse:** Any practice that is inconsistent with sound fiscal, business, or medical practices, and results in an unnecessary cost to CHIP, CCO, a subcontractor, or a provider or in reimbursement for services that are not Medically Necessary or that fail to meet professionally recognized standards for healthcare.

2.2 **Adverse Benefit Determination:** The denial or limited authorization of a requested service, including determinations on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit; the reduction, suspension, or termination of previously authorized services; the denial, in whole or in part, of payment for a service; CCO's failure to provide services in a timely manner; CCO's failure to resolve Complaints, Grievances, or Appeals within the specified time frames; for residents in a rural area with only one MCO, the denial of a Covered Person's request to exercise his or her right, under 42 C.F.R. §438.52(b)(2)(ii); the denial of a Covered Person's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other enrollee financial liabilities; and determinations by skilled nursing facilities and nursing facilities to transfer or discharge residents and adverse determinations made by a State with regard to the preadmission

screening and annual resident review requirements of Section 1919(e)(7) of the Act, if applicable.

2.3 **Agreement:** An agreement between the CCO and an individual, business, university, government entity, affiliate, or nonprofit organization to perform part or all of CCO's responsibilities under the MississippiCHIP Program Contract. Agreements must be approved in writing by DOM prior to the start date of the Agreement.

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

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

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

2.7 **Benchmark Plan:** The State School Employee's Health Insurance Plan.

2.8 **Child:** An individual who is under nineteen (19) years of age who is not eligible for Medicaid benefits and is not covered by other health insurance. Child is also referred to as Member.

2.9 **CHIP:** The Children's Health Insurance Program as defined in Title XXI of the Social Security Act.

2.10 **Complaint:** An expression of dissatisfaction received orally or in writing that is of a less serious or formal nature that is resolved within one (1) business day of receipt.

2.11 **Coordinated Care Organization (CCO):** An organization that meets the requirements for participation as a Contractor in CHIP and manages the purchase and provision of health care services under CHIP. For purposes of this Appendix, CCO is a CCO.

2.12 **Co-Payment:** The fixed amount certain CHIP Members pay for a covered health care service. The amount may vary based on healthcare service being provided.

2.13 **Cost Sharing:** In accordance with 42 C.F.R. §457.10, premium charges, enrollment fees, deductibles, coinsurance, Co-Payments, or other similar fees that the Member has responsibility for paying.

2.14 **Covered Services:** Health care services or products for which a Member is enrolled with CCO to receive coverage under the MississippiCHIP Program Contract, including all services required by the State Contract and State and federal law.

2.15 Disenrollment: Action taken by DOM, or its Agent, to remove a Member's name from the monthly Member Listing Report following DOM's receipt and approval of a request for Disenrollment or a determination that the Member is no longer eligible for Enrollment in Contractor.

2.16 DOM: The Division of Medicaid, Office of the Governor, State of Mississippi.

2.17 Fraud: Fraud is any type of intentional deception or misrepresentation made by an entity or person with the knowledge that the deception could result in some unauthorized benefit to the entity, him or herself, or some other person. The Fraud can be committed by many entities, including a vendor, a subcontractor, a provider, a State employee, or a Member among others.

2.18 Grievance: An expression of dissatisfaction about any matter or aspect of CCO or its operation, other than an Adverse Benefit Determination as defined herein. Grievances may include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the Covered Person's rights regardless of whether remedial action is requested. Grievance includes a Covered Person's right to dispute an extension of time proposed by CCO to make an authorization decision.

2.19 Marketing: The activities that promote visibility and awareness for the MississippiCHIP Program and the CCOs participating in the program. All marketing activities are subject to prior review and approval by DOM and may not contain misleading information.

2.20 Medical Record: A single complete record, which documents the entire treatment plan developed for, and medical services received by, the Member including inpatient, outpatient, referral services and emergency medical services whether provided by Contracted Providers or Non-Contracted Providers.

2.21 Member: An individual who meets all of the eligibility requirements for CHIP, enrolls in a CCO under CHIP, and receives health benefits coverage through CHIP.

2.22 MississippiCHIP Program: The Mississippi Medicaid child health program for select individuals under the age of nineteen (19) years of age who are not eligible for Medicaid benefits and are not covered by other health insurances.

2.23 MississippiCHIP Program Contract: The DOM contract with CCO, for the purpose of providing and paying for Covered Services to Members enrolled in the MississippiCHIP Program.

2.24 Primary Care Provider (PCP): Any physician or health care practitioner or group operating within the scope of his or her licensure who is responsible for supervising, prescribing and providing primary care and primary case management services in the MississippiCHIP Program, whose practice is limited to the general practice of medicine or who is an Internist, Pediatrician, Obstetrician/Gynecologist, Family and General Practitioner, Nurse Practitioners (who meet requirements of Section 4.B, Choice of a Health Care Professional), Physician Assistants, specialists who perform primary care functions upon request, and other providers approved by DOM.

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

2.26 Provider Network: The Panel of health service Providers with which the CCO contracts for the provision of covered services to Members and Non-Contracted Providers administering services to Member.

2.27 State: The State of Mississippi or its designated regulatory agencies.

2.28 State Child Health Plan: The State of Mississippi's plan submitted to HHS for the administration of CHIP.

2.29 Third Party Liability/Resource: Any resource available to a Member for the payment of medical expenses associated with the provision of covered services, including but not limited to, insurers and workers' compensation plan.

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

2.31 Well-Baby and Well-Child Care Services: Regular or preventive diagnostic and treatment services necessary to ensure the health of babies, children, and adolescents as defined by DOM in the State Child Health Plan. For the purposes of Cost Sharing, the term has the meaning assigned at 42 C.F.R. § 457.520.

SECTION 3
PROVIDER REQUIREMENTS

The MississippiCHIP Program, through contractual requirements and federal and State statutes and regulations, requires that providers who provide services to Members enrolled in the MississippiCHIP Program comply with certain requirements as set forth below and elsewhere in this Appendix.

3.1 Definitions Related to the Provision of Covered Services. Provider shall follow the applicable MississippiCHIP Program Contract's requirements for the provision of Covered Services. Provider's decisions affecting the delivery of acute or chronic care services to Members shall be made on an individualized basis and in accordance with the following definitions:

i) Emergency Medical Condition: In accordance with Section 1932(b) of the Act and 42 CFR §457.10, a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in any of the following: (1) 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; (2) serious impairment to body functions; or (3) serious dysfunction of any body organ or part.

ii) Emergency Services: Covered inpatient and outpatient services, inclusive of dialysis services, furnished by a provider who is qualified to furnish those health services and that

are needed to evaluate or stabilize an Emergency Medical Condition in accordance with 42 CFR 438.114.

iii) Medically Necessary Services: As set forth in the Social Security Act, Section 1905 (42 U.S.C. 1396d(a)), Medically Necessary Services are defined as services, supplies, or equipment provided by a licensed health care professional that are:

a) Appropriate and consistent with the diagnosis or treatment of the patient's condition, illness, or injury;

b) In accordance with the standards of good medical practice consistent with the individual patient's condition(s);

c) Not primarily for the personal comfort or convenience of the Member, family, or Provider;

d) The most appropriate services, supplies, equipment, or levels of care that can be safely and efficiently provided to the Member;

e) Furnished in a setting appropriate to the patient's medical need and condition and, when applied to the care of an inpatient, further mean that the Member's medical symptoms or conditions require that the services cannot be safely provided to the Member as an outpatient;

f) Not experimental or investigational or for research or education;

g) Provided by an appropriatelylicensed practitioner; and

h) Documented in the patient's record in a reasonable manner, including the relationship of the diagnosis to the service.

Medically Necessary Services may also be those services for children that are necessary to correct or ameliorate defects and physical and mental illnesses and conditions discovered during an interperiodic or Well-Baby and Well-Child Care Services, whether such services are covered or exceed the benefit limits in the Medicaid State Plan and Title 23 of Mississippi Administrative Code.

3.2 Accessibility Standards. Provider shall provide for timely access for Member appointments in accordance with the appointment availability requirements established under the MississippiCHIP Program Contract, as further described in the applicable provider manual.

Type	Appointment Scheduling Time Frames
PCP (well care visit)	Not to exceed thirty (30) calendar days
PCP (routine sick visit)	Not to exceed seven (7) calendar days
PCP (urgent care visit)	Not to exceed twenty-four (24) hours
Specialists	Not to exceed forty-five (45) calendar days

Dental Providers (routine visits)	Not to exceed forty-five (45) calendar days
Dental Providers (urgent Care)	Not to exceed forty-eight (48) hours
Behavioral Health Providers (routine visit)	Not to exceed fourteen (14) calendar days
Behavioral Health Providers (urgent visit)	Not to exceed twenty-four (24) hours
Behavioral Health Providers (post-discharge from an acute psychiatric hospital when the Contractor is aware of the	Not to exceed seven (7) calendar days
Urgent Care Providers	Not to exceed twenty-four (24) hours
Emergency Providers	Immediately (twenty-four (24) hours a day, seven (7) days a week) and without Prior

3.3 Hours of Operation; Appointments. Provider shall offer hours of operation that are no less than the hours of operation offered to commercial beneficiaries. As applicable, Provider will make Covered Services available 24 hours a day, 7 days a week when medically necessary.

3.4 PCP Responsibilities. If applicable, and Provider is a PCP, Provider shall comply with the following:

i) PCPs who serve Members under the age of nineteen (19) are responsible for conducting all Well-Baby and Well-Child Care services. Should the PCP be unable to conduct the necessary Well-Baby and Well-Child Care services screens, the PCP is responsible for arranging to have the necessary Well-Baby and Well-Child Care services screens conducted by another network provider and ensure that all relevant medical information, including the results of the Well-Baby and Well-Child Care services screens, are incorporated into the Member's PCP Medical Record.

ii) PCPs who serve Members under the age of nineteen (19) report encounter data associated with Well-Baby and Well-Child Care services, using a format approved by DOM, to Contractor within one hundred and eighty (180) calendar days from the date of service.

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

a) Contact Members identified in the quarterly Encounter lists as not complying with Well-Baby, Well-Child Care, and immunization schedules for Children;

b) Identify to Contractor any such Members who have not come into compliance with Well-Baby, Well-Child Care, and immunization schedules within one (1) month of such notification to the site by Contractor; and

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

iv) PCP shall provide Well-Baby and Well-Child Care Services, including vision screening, laboratory

tests and hearing screenings, according to recommendations of the U.S. Preventive Services Task Force. Vision and hearing screenings shall be included as part of periodic Well-Child assessments. PCP shall have written policies and procedures related to the provision of the full-range of Well-Baby Care, Well-Child Care, and childhood and adolescent immunization services as defined in, and in accordance with, the State Child Health Plan, 42 C.F.R. §457.495, and this provisions of the MississippiCHIP Program Contract. Services shall include, without limitation, 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). PCP shall make all reasonable efforts to identify all Members whose Medical Records do not indicate up-to-date immunizations and shall ensure that these Members receive necessary immunizations. Immunizations are purchased and distributed through the Mississippi State Department of Health. CCO shall reimburse PCP for the administration of the immunizations.

CCO requires that PCP cooperate to the maximum extent possible with the efforts to improve the health status of Mississippi citizens, and to actively work to improve the percentage of Members receiving appropriate screenings, and meet or exceed DOM's targets.

a) The following minimum elements must be included in the periodic health screening assessment of children:

i. Comprehensive health and development history (including assessment of both physical and mental development);

ii. Measurements (e.g. head circumference for infants, height, weight, body mass index);

iii. Comprehensive unclothed physical examination;

iv. Immunizations appropriate to age and health history;

v. Assessment of nutritional status;

vi. Laboratory tests (including tuberculosis screening and Federally required blood lead screenings);

vii. Vision screening;

viii. Hearing screening;

ix. Dental and oral health assessment; and

x. Developmental and behavioral assessment.

v) If a suspected problem is detected by a screening examination, the child must be evaluated as necessary for further diagnosis. This diagnosis is used to determine treatment needs. PCP must establish a tracking system that provides information on compliance with Well-Baby and Well-Child Care services and immunization services provision requirements in the following areas:

a) Initial visit for newborns;

b) Well-Baby and Well-Child Care services and reporting of all assessment results; and

c) Diagnosis and/or treatment for Children.

vi) PCP must have an established process for reminders, follow-ups and outreach to Members that includes:

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

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

c) Protocols for conducting outreach with non-compliant Members, including home visits, as appropriate; and

d) A process for outreach and follow-up to Members with special health care needs.

vii) PCP may develop an alternate process for follow-up and outreach subject to prior written approval from CCO and DOM.

viii) **Specialists as PCPs**. Members with disabling conditions, chronic conditions, or with special health care needs may request that their PCP be a specialist. The designation of a specialist as a PCP must be pursuant to a treatment plan approved by Contractor; in consultation with the PCP to which the Member is currently assigned, the Member and, as appropriate, the specialist. When possible, the specialist must be a provider participating in Contractor's network. The specialist as a PCP must agree to provide or arrange for all primary care, including routine preventive care, and to provide those specialty medical services consistent with the Member's disabling condition, chronic illness, or special health care need in accordance with Contractor's standards and within the scope of the specialty training and clinical expertise. To accommodate the full spectrum of care, the specialist as a PCP must also have admitting privileges at a hospital in Contractor's network.

3.5 Provider Selection. To the extent applicable to Provider in performance under the Agreement, Provider shall comply with 42 CFR §438.214, as may be amended from time to time, which includes, but is not limited to the selection and retention of providers, credentialing and re-credentialing requirements and nondiscrimination. If CCO delegates credentialing to Provider, CCO will provide monitoring and oversight and Provider shall ensure that all licensed medical professionals are credentialed in accordance with CCO's and the MississippiCHIP Program Contract's credentialing requirements.

3.6 Records Retention. As required under State or federal law or the MississippiCHIP Program Contract, Provider shall maintain a record keeping system of current, detailed, and organized records for recording services, charges, dates and all other commonly accepted information elements sufficient to disclose the quality, quantity, appropriateness and timeliness of services rendered to Members. All financial records shall follow generally accepted accounting principles. Medical records and supporting management systems shall include all pertinent information related to the medical management of each Member. Other records shall be maintained as necessary to clearly reflect all actions taken by Provider related to services provided under the MississippiCHIP Program Contract. Such records, including, as applicable, grievance and appeals records shall be maintained for a period of not less than ten (10) years from the close of the Agreement, or such other period as required by law. If records are under review or audit or are the subject of litigation they must be retained for a minimum of ten (10) years following resolution of such action. Prior approval for the disposal of records must be requested and approved by CCO if the Agreement is continuous. Provider shall have written records retention policies and procedures and will make such policies and procedures available to CCO or DOM upon request. DOM requires ready access to any and all documents and records of transactions pertaining to the provisions of services provided by Provider and those copies of requested documents/records will be provided to DOM or its designee free of charge.

3.7 **Records Access.** Provider agrees to cooperate with CCO to maintain and share a health record of all services provided to a Covered Person, as appropriate and in accordance with applicable laws, regulations and professional standards. Provider acknowledges and agrees and shall require Provider to acknowledge and agree that DOM, the U.S. Department of Health and Human Services and other authorized federal and state personnel shall have complete access to all records pertaining to services provided to Members. Provider shall provide immediate access to facilities, records and supportive materials pertinent to the MississippiCHIP Program Contract for State or Federal fraud investigators.

3.8 **Government Audit; Investigations.** Provider acknowledges and agrees and shall require Provider to acknowledge and agree that the State or any of its duly authorized representatives, DOM, the U.S. Department of Health and Human Services, the Centers for Medicare & Medicaid Services, the Office of Inspector General, the General Accounting Office, or any other auditing agency or their authorized representatives and their designees, with prior approval by DOM, at any time during the term of the Agreement, shall, at all reasonable time and within regular business hours, with or without notice, have the right to inspect, audit or otherwise evaluate the quality, appropriateness, and timeliness of services provided under the terms of the MississippiCHIP Program Contract and any other applicable federal and State law and regulation.

This shall include, but not be limited to, the right to enter onto Provider's premises, access to and the right to audit, inspect, monitor, and examine any pertinent books, documents, papers, medical records, financial records, surveys and computer databases and/or to otherwise evaluate the performance of Provider related to Provider's performance under the Agreement. Such monitoring activities may also include, without limitation, on-site inspections of all service locations and facilities; auditing and/or review of all records developed under the MississippiCHIP Program Contract or the Agreement; reviewing management systems and procedures developed under the MississippiCHIP Program Contract or the Agreement; and review of any other areas of materials relevant or pertaining to the MississippiCHIP Program Contract or the Agreement. All reviews and audits shall be performed in such a manner as will not unduly delay the work of Provider. There will be no restrictions on the right of the State or federal authorities to conduct inspections and audits as necessary.

The Provider must fully cooperate with any and all reviews and/or audits by state or federal agencies, such as the Department of Audit, Department of Health and Human Services, Centers for Medicare and Medicaid Services, Office of Inspector General, General Accounting Office, or any other auditing agency approved by DOM, by assuring that appropriate employees and involved parties are available for interviews relating to the reviews or audits.

All records shall be maintained and available for review by authorized federal and state agencies during the entire term of the MississippiCHIP Program Contract and for a period of ten (10) years thereafter, unless an audit, litigation, or other legal action is in progress. When an audit or litigation is in progress or audit findings are unresolved, records shall be kept for a period of ten (10) years or until all issues are finally resolved, whichever is later. The Provider must have written policies and procedures for storing this information. Records must be kept in an original paper state or preserved on micro media or electronic format.

3.9 **Data; Reports.** Provider shall and shall require that Provider cooperate with and release to CCO any information necessary for CCO to perform its obligations under the MississippiCHIP Program Contract to the extent applicable to Provider in performance of the Agreement, including the timely submission of reports and information required by CCO, in the format specified by CCO and the State. Such reports shall include well-baby/well-child reporting, as well as complete and accurate encounter and utilization management data in accordance with the requirements of CCO and DOM. Data must be provided at the frequency and level of detail specified by CCO or the State. By submitting data to CCO, Provider represents and attests to CCO and the State that the data is accurate, complete and truthful, and upon

CCO's request Provider shall certify in writing, that the data is accurate, complete, and truthful, based on Provider's best knowledge, information and belief.

Provider shall be able to receive, maintain and utilize applicable data extracts from CCO or DOM and systematically update its database within five (5) calendar days of receipt of the files. Data extract files include but are not limited to the following, as applicable: 1. Daily Active Provider Extract; 2. Weekly Provider Affiliation Details Extract; 3. 834 Enrollment Files; 4. 835 Claims Payment Remittance Advice Transaction; 5. 277 Claims Acknowledgement; 6. NCPDP Formulary; 7. NCPDP Response File; 8. TPL Resource/Policy Information File, etc.; 9. Claims History Extracts; and 10. Prior Authorization Extracts.

3.10 Encounter Data. Provider shall agree to cooperate with CCO to comply with CCO's obligation to prepare encounter data submissions, reports, and clinical information including, without limitation, and well-baby/well-child reporting and encounters, as applicable, and such other reporting regarding Covered Services as may be required under the MississippiCHIP Program Contract. Encounter data must be accurate and include all services furnished to a Covered Person, including capitated provider's data and rendering provider information. Encounter data must be provided within the timeframes specified and in a form that meets CCO and State requirements. By submitting encounter data to CCO, Provider represents to CCO that the data is accurate, complete and truthful, and upon CCO's request Provider shall certify in writing, that the data is accurate, complete, and truthful, based on Provider's best knowledge, information and belief.

3.11 Claims Information. Provider shall promptly submit to CCO the information needed to make payment and shall identify third party liability coverage, including Medicare and other insurance, and if applicable seek such third party liability payment before submitting claims to CCO. Provider understands and agrees that each claim Provider submits to CCO constitutes a certification that the claim is true and accurate to the best of Provider's knowledge and belief and that the Covered Services are 1) Medically Necessary and 2) have been provided to the Member prior to submitting the claim.

Provider must submit claims within six (6) months from the date of service. Claims filed within the appropriate time frame but denied may be resubmitted to CCO within ninety (90) calendar days from the date of denial.

3.12 Third Party Resources. Provider shall report all Third Party Resources to CCO identified through the provision of medical services.

3.13 Privacy; HIPAA. Provider shall comply with all applicable privacy rule and security rule provisions of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), and associated implementing regulations, as may be amended from time to time, and shall safeguard information about Members in accordance with applicable federal and State privacy laws and rules including 42 CFR §438.224 and 42 CFR Part 431, Subpart F, as may be amended from time to time. Provider agrees that confidential information, including but not limited to, medical and other pertinent information relative to Members, shall not be disclosed to any person or organization for any purpose without the expressed, written authority of DOM or as otherwise required by law and that all such disclosures shall fully comply with HIPAA privacy and security standards.

3.14 Cultural Competency and Access. Provider shall participate in CCO's and DOM's efforts to

promote the delivery of services in a culturally competent manner to all Members, including those with limited English proficiency, physical or mental disabilities, diverse cultural and ethnic backgrounds and regardless of gender, sexual orientation or gender identity, and shall provide interpreter services in a Member's primary language and for the hearing impaired for all appointments and emergency services. Provider shall provide information to Members regarding treatment options and alternatives, as well as information on complaints and appeals, in a manner appropriate to the Member's condition and ability to understand. Provider shall provide physical access, reasonable accommodations, and accessible equipment for Covered Persons with physical or mental disabilities.

3.15 Approval of Marketing Materials. As required under State or federal law or the applicable MississippiCHIP Program Contract, any marketing materials developed and distributed by Provider as related to the performance of the Agreement must be submitted to CCO at least sixty (60) days prior to planned distribution for timely submission to DOM for prior approval. Provider agrees it will not proceed with the statement or communication until the required approval is obtained.

3.16 Independent Contractor Relationship. Provider expressly agrees that Provider is acting in an independent capacity in the performance of the Agreement and not as an officer, agent or employee of DOM, CMS or the State. Provider further expressly agrees that the Agreement shall not be construed as a partnership or joint venture between Provider and DOM, CMS or the State. Nothing in the Agreement shall be construed, nor shall it be deemed to create, any right or remedy in any third party.

3.17 Certification on Relationship to State, DOM and CMS. Provider certifies that no officer, director, employee, subcontractor or agent of Provider, or person with an ownership or control interest in Provider, is also employed by, or is a public official of, the State of Mississippi or any of its agencies, DOM or CMS.

3.18 Ownership and Control Information. If applicable, Provider shall cooperate with CCO in obtaining and providing information to DOM related to ownership and control, significant business transactions, and persons convicted of a criminal offense in compliance with§1128 of the Social Security Act, 42 USC §1320a-7 and 42 CFR Part 455, as amended and shall provide information upon request. Provider shall submit information related to ownership and control of subcontractors or wholly owned supplier within thirty-five (35) calendar days of a request for such information.

By executing the Agreement, Provider certifies that neither Provider nor any of its principals is presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in any State or federal health care program or from participating in transactions by any State or federal department or agency. CCO will terminate the Agreement upon becoming aware or receiving notice from DOM, whichever is earlier, that Provider is or has been excluded from participation in any State or federal health care program or by any State or federal agency.

3.19 Excluded Individuals and Entities. Provider certifies that neither it nor any of its employees, principals, nor any providers, subcontractors or consultants or persons with an ownership or controlling interest in the Provider (an owner including the Provider himself or herself), or an agent or managing employee of the Provider, with whom Provider contracts and who are providing items or services that are significant and material to Provider's obligations under the

Agreement is:

i) excluded from participation in federal health care programs under either Section 1128 or section 1128A of the Social Security Act; or

ii) debarred, suspended, proposed for debarment, declared ineligible, or otherwise voluntarily excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549; or an affiliate, as defined in the Federal Acquisition Regulation, of such a person.

Provider acknowledges and agrees and shall require that Provider acknowledge and agree that payment will not be made for any items or Covered Services provided by an excluded individual pursuant to 42 CFR §1001.1901(b) and is obligated to screen all employees, contractors, and subcontractors for exclusion as required under applicable State and Federal laws. Additionally, Provider acknowledges that pursuant to 42 CFR §1003.102(a)(2) civil monetary penalties may be imposed against Provider if he or she employs or enters into contracts with excluded individuals or entities to provide items or Covered Services to Member under the Agreement. Provider agrees not to employ or subcontract with individuals or entities whose owner, those with a controlling interest, or managing employees are on a State or Federal exclusion list to provide items or Covered Services under the Agreement. Provider shall immediately report to CCO any exclusion information discovered. Provider can search the HHS-OIG website, at no cost, by the names of any individuals or entities. The database is called LEIE and can be accessed at http://www.oig.hhs.gov/fraud/exclusions.asp. The GSA EPLS/SAM database can be accessed at https://www.sam.gov. Federal and State exclusion databases must be reviewed monthly to ensure that no employee or contractor has been excluded. Applicable state exclusion databases can be accessed through the State's Medicaid website. CCO will terminate the Agreement immediately upon becoming aware or receiving notice from DOM, whichever is earlier, that Provider's owners, agents, managing employees, or any provider is or has been excluded from federal health care programs or terminated from the Medicare or the Medicaid program in any state.

3.20 Licensure. Provider represents that it is currently licensed and/or certified under applicable State and federal statutes and regulations and by the appropriate State licensing body or standard-setting agency, as applicable. Provider represents that it does not have a Medicaid provider agreement with DOM that is terminated, suspended, denied, or not renewed as a result of any action of DOM, CMS, HHS, or the Medicaid Fraud Control Unit of the State's Attorney General. Provider shall maintain at all times throughout the term of the Agreement all necessary licenses, certifications, registrations and permits as are required to provide the health care services and/or other related activities delegated to Provider by CCO under the Agreement. If at any time during the term of the Agreement, Provider is not properly licensed as described in this Section, Provider shall discontinue providing services to Members.

3.21 National Provider ID (NPI). If applicable, Provider shall and shall require that Providers obtain a National Provider Identification Number (NPI) and when filing claims with Provider, the NPI number used is the same NPI number used when filing claims with DOM.

3.22 Funding. Provider recognizes that the obligation of DOM to proceed under its MississippiCHIP Program Contract with CCO is conditioned upon the appropriation of funds by the Mississippi

State Legislature and the receipt of State and/or Federal funds. If the funds anticipated for the continuing fulfillment of the agreement are, at any time, not forthcoming or insufficient, either through the failure of the Federal government to provide or the State of Mississippi to appropriate funds, or the discontinuance, or material alteration of the program under which the funds were provided or if funds are not otherwise available to DOM, DOM has the right upon ten (10) working days written notice to CCO to terminate the MississippiCHIP Program Contract.

3.23 Federal and State Funds Liability. Providers acknowledges and agrees that payments made to Provider for services provided under the Agreement are derived from federal and State funds and that any false claim or statement in documents or any concealment of material fact related to such services may be a cause for sanctions and prosecution under applicable federal and State laws. Provider shall be subject to all laws applicable to individuals and entities receiving State and federal funds and may be held civilly or criminally liable to both CCO and DOM in the event of nonperformance, misrepresentation, fraud, or abuse related to services provided pursuant to the MississippiCHIP Program Contract. Provider recognizes that payments made to the Provider are derived from federal and State funds, and are contingent upon and subject to availability and receipt of funds.

3.24 Insolvency. In the event CCO becomes insolvent or unable to pay Provider, Provider shall not seek compensation for services rendered from DOM, its officers, Agents, or employees, or the Members or their eligible dependents.

3.25 Termination. In the event of termination of the Agreement, Provider shall promptly supply to CCO all information necessary for the reimbursement of any outstanding MississippiCHIP Program claims.

3.26 Capitated Providers. If a Provider that is capitated terminates its agreement with CCO, for any reason, Provider will provide services to Members assigned to Provider up to the end of the month in which the effective date of termination falls.

3.27 Fraud, Waste, and Abuse Prevention. Provider shall cooperate fully with the CCO's policies and procedures designed to protect program integrity and prevent and detect potential or suspected fraud, waste, and abuse in the administration and delivery of services under the MississippiCHIP Program Contract and shall cooperate and assist DOM and any other State or federal agency charged with the duty of preventing, identifying, investigating, sanctioning or prosecuting suspected fraud, waste, and abuse in state and/or federal health care programs. Provider and CCO are responsible for reporting suspected fraud and abuse by participating and non-participating providers, as well as Members, when detected.

In accordance with CCO's policies and the Deficit Reduction Act of 2005 (DRA), Provider shall have written policies for its employees, contractors or agents that: (a) provide detailed information about the federal False Claims Act (established under sections 3729 through 3733 of title 31, United States Code), including if any entity makes or receives annual payments under the State Program of at least $5,000,000, such entity must establish certain minimum written policies and information communicated through an employee handbook relating to the Federal False Claims Act in accordance with 42 CFR 438.600; (b) cite administrative remedies for false claims and statements (established under chapter 38 of title 31, United States Code) and whistleblower protections under federal and state laws; (c) reference state laws pertaining to civil or criminal penalties for false

claims and statements; and (d) with respect to the role of such laws in preventing and detecting fraud, waste, and abuse in federal health care programs (as defined in section 1128B(f)), include as part of such written policies, detailed provisions regarding Provider's policies and procedures for detecting and preventing fraud, waste, and abuse. Provider agrees to train its staff on the aforesaid policies and procedures.

3.28 Quality Utilization Management. Pursuant to any applicable provider manuals and related protocols, or as elsewhere specified under the Agreement, Provider agrees to cooperate with CCO's quality improvement and utilization review and management activities. This shall include, but not be limited to, participation in any internal and external quality assurance, utilization review, peer review, and grievance procedures established by CCO or as required under the MississippiCHIP Program Contract to ensure that Members have due process for their complaints, grievances, appeals, fair hearings or requests for external review of adverse decisions made by CCO or Provider. Provider shall adhere to the quality assurance and utilization review standards of the MississippiCHIP Program and shall monitor quality and initiate corrective action to improve quality consistent with the generally accepted level of care.

3.29 Quality and Utilization Management Program. Provider shall cooperate with CCO in meeting the Quality Management and Utilization Management Program standards outlined in the MississippiCHIP Program Contract.

3.30 Referrals. Provider shall make referrals for social, vocational, education or human services when a need for such service is identified.

3.31 Restrictions on Referrals. Provider shall not make inappropriate referrals for designated health services to health care entities with which Provider or a member of Provider's family has a financial relationship, pursuant to federal anti-kickback and physician self-referral laws that prohibit such referrals.

3.32 Complaints, Grievances and Appeals. Information on how Provider or Provider's authorized representative shall submit complaints and file grievances and appeals, and the resolution process, is contained in the CCO MississippiCHIP Provider Manual.

3.33 Health Care Acquired/Preventable Conditions. Provider agrees that no payment shall be made for the provision of medical assistance for health care acquired conditions and other provider preventable conditions as may be identified by the State. As a condition of payment, Provider shall identify and report to CCO any provider preventable conditions in accordance with 42 CFR §§ 434.6(a)(12), 438 including but not limited to 438.3(g), and 447.26.

3.34 Compliance with Laws. Provider shall comply with all applicable federal and State laws and regulations and all provisions of the MississippiCHIP Program Contract that pertain to a Member's rights, including but not limited to the following, to the extent applicable to Provider in performance of the Agreement:

i) Title VI of the Civil Rights Act of 1964; (b) Title XIX of the Social Security Act; Title IX of the Education Amendments of1972 (regarding education programs and activities); the Age Discrimination Act of 1975; the Rehabilitation Act of 1973; and The Genetic Information Non-Discrimination Act of 2008 (GINA); the Americans with Disabilities Act;

section 1557 of the Patient Protection and Affordable Care Act, and their implementing regulations, as may be amended from time to time.

ii) All federal and State professional and facility licensing and accreditation requirements/standards that apply to the services Provider perform pursuant to the Agreement, including but not limited to:

a) All applicable standards, orders or requirements issued under Section 306 of the Clean Air Act (42 USC 1857 (h)). Section 508 of the Clean Water Act (33 USC 1368), Executive Order 11738, and Environmental Protection Agency (EPA) regulations (40) CFR Part 15), which prohibit the use of facilities included on the EPA list of violating facilities. Any violations must be reported to DSHS, DHHS, and the EPA;

b) Any applicable mandatory standards and policies relating to energy efficiency that are contained in the State Energy Conservation Plan, including the Energy Policy & conservation Act (Pub. L. 94-165), and issued in compliance with the Federal Energy Policy & Conservation Act.

iii) All relevant federal and State statutes, regulations and orders related to equal opportunity in employment, including but not limited to compliance with E.O. 11246, "Equal Employment Opportunity," as amended by E.O. 11375, "Amending Executive Order 11246 Relating to Equal Employment Opportunity," and as supplemented by regulations at 41 CFR Part 60, "Office of Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor."

iv) If the Agreement is for an amount in excess of $100,000, Provider shall comply with all applicable standards, orders or regulations issued pursuant to the Clean Air Act, 42 U.S.C. 7401 et seq., and the Federal Water Pollution Control Act, as amended, 33 U.S.C. 1251 et seq. Any violations shall be reported to DHHS and the appropriate Regional Office of the Environmental Protection Agency.

v) Those specified for laboratory services in the Clinical Laboratory Improvement Amendments (CLIA). All laboratory service sites must have a CLIA certificate of registration or waiver, and a CLIA identification number.

vi) The American with Disabilities Act (ADA). Provider shall make reasonable accommodation for Members with disabilities in accord with the ADA for all Covered Services and shall assure physical and communication barriers do not inhibit Members with disabilities from obtaining Covered Services;

vii) Section 1128B(d)(1) of the Balanced Budget Act of 1997; and,

viii) Any other requirements associated with the receipt of federal funds.

ix) All Medicaid laws, regulations and program instructions to the extent applicable to Provider in Provider's performance of the Agreement. Provider understands that payment of a claim by CCO or the State is conditioned upon the claim and the underlying transaction complying with such laws, regulations, and program instructions (including, but not limited

to, federal requirements on fraud, waste and abuse, disclosure, debarment, termination and exclusion screening), and is conditioned on the Provider's compliance with all applicable conditions of participation in Medicaid. Provider understands and agrees that each claim the Provider submits to CCO constitutes a certification that the Provider has complied with all applicable Medicaid laws, regulations and program instructions in connection with such claims and the services provided therein. Provider's payment of a claim will be denied if Provider is terminated or excluded from participation in federal healthcare programs. Provider's payment of a claim may be temporarily suspended if the State or CCO provides notice that a credible allegation of fraud exists and there is a pending investigation. Provider's payment of a claim may also be temporarily suspended or adjusted if the Provider bills a claim with a code that does not match the service provided. CCO performs coding edit procedures based primarily on National Correct Coding Initiative (NCCI) policies and other nationally recognized and validated policies. Provider agrees that it will provide medical records to CCO upon its request in order to determine appropriateness of coding. Provider may dispute any temporarily suspended or adjusted payment consistent with the terms of the Agreement.

3.35 Non-Discrimination. Provider will not discriminate against, nor use any policy or practice that has the effect of discriminating against, Covered Persons on the basis of race, color, creed, sex, religion, age, national origin, ancestry, marital status, sexual orientation, gender identity, language, health status, disease or pre-existing condition (including genetic information), anticipated need for health care or physical or mental handicap, except where medically indicated. Examples of prohibited practices include, but are not limited to, the following:

i) Denying or not providing a Member any MississippiCHIP Covered Service. Health care and treatment necessary to preserve life must be provided to all Members who are not terminally ill or permanently unconscious, except where a competent Member objects to such care on his/her own behalf.

ii) Subjecting a Member to segregated, separate, or different treatment, including a different place or time from that provided to other Members or public or private patients, in any manner related to the receipt of any MississippiCHIP Covered Service, except where Medically Necessary.

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

3.36 Advance Directives. Provider shall comply with the advance directives requirements with 42 C.F.R §422.128 and with the Uniform Health-Care Decisions Act (Miss. Code Ann. § 41-41-201, *et. seq*.). When applicable, Provider shall comply with the advance directives requirements for hospitals, nursing facilities, providers of home and health care and personal care services, hospices, and HMOs as specified in 42 CFR Part 49, subpart I, 42 CFR § 417.436(d), 42 CFR § 422.128, and 42 CFR 438.3(i).

3.37 Physician Incentive Plans. In the event Provider participates in a physician incentive plan

("PIP") under the Agreement, Provider agrees that such PIPs must comply with 42 CFR § 417.479, 42 CFR § 438.3, 42 CFR § 422.208, and 42 CFR § 422.210, as may be amended from time to time. CCO or Provider may not make a specific payment directly or indirectly under a PIP to a physician or physician group as an inducement to reduce or limit Medically Necessary services furnished to an individual Member. PIPs must not contain provisions that provide incentives, monetary or otherwise, for the withholding of services that meet the definition of Medical Necessity. Provider shall disclose annually to CCO any PIP arrangement Provider may have with any physicians even if there is not substantial financial risk between CCO and such physicians.

3.38 Lobbying. Provider agrees to comply with the following requirements related to lobbying:

i) Prohibition on Use of Federal Funds for Lobbying: By signing the Agreement, Provider certifies to the best of Provider's knowledge and belief, pursuant to 31 U.S.C. § 1352 and 45 CFR Part 93, as may be amended from time to time, that no federally appropriated funds have been paid or will be paid to any person by or on Provider's behalf for the purpose of influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the award of any federal contract, the making of any federal grant, the making of any federal loan, the entering into of any cooperative agreement, or the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan, or cooperative agreement.

ii) Disclosure Form to Report Lobbying: If any funds other than federally appropriated funds have been paid or will be paid to any person for the purpose of influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the award of any federal contract, the making of any federal grant, the making of any federal loan, the entering into of any cooperative agreement, or the extension, continuation, renewal, amendment or modification of any federal contract, grant, loan, or cooperative agreement and the value of the Agreement exceeds $100,000, Provider shall complete and submit Standard Form-LLL, "Disclosure Form to Report Lobbying," in accordance with its instructions.

iii) Contractor shall abide by lobbying laws of the State of Mississippi.

3.39 Gratuities. Provider represents that it has not violated, is not violating, and promises that it will not violate the prohibitions against gratuities set forth in Section 6-204 (Gratuities) of the Mississippi Personal Service Contract Procurement Regulations.

3.40 Compliance with Mississippi Employment Protection Act (MEPA). Represents and warrants and shall require that Provider represent and warrant that it will ensure its compliance with the Mississippi Employment Protection Act, Section 71-11-1 et set of the Mississippi Code Annotated (Supp. 2008), and will register and participate in the status verification system for all newly hired employees. The term "employee" as used herein means any person that is hired to perform work within the State of Mississippi. As used herein, "status verification system" means the Illegal Immigration Reform and Immigration Responsibility Act of 1996 that is operated by the United States Department of Homeland Security, also known as the E-Verify Program, or any other

successor electronic verification system replacing the E-Verify Program. Provider agrees and shall require that Provider agree to maintain records of such compliance and, upon request of the State and approval of the Social Security Administration or Department of Homeland Security, where required, to provide a copy of each such verification to the State. Provider represents and warrants that any person assigned to perform services hereunder meets the employment eligibility requirements of all immigration laws of the State of Mississippi. Provider acknowledges and agrees that any breach of these warranties may subject Provider to the following: (a) termination of the Agreement and ineligibility for any state or public contract in Mississippi for up to three (3) years, with notice of such cancellation/termination being made public, or (b) the loss of any license, permit, certification or other document granted to Provider by an agency, department or governmental entity for the right to do business in Mississippi for up to one (1) year, or (c) both.

3.41 Insurance Requirements. As applicable, Provider shall and shall require that Provider secure and maintain during the term of the Agreement general liability insurance, professional liability insurance, and workers' compensation insurance for all employees connected with the provision of services under the Agreement. Such workers compensation insurance shall comply with Mississippi Workers' Compensation Laws. Such comprehensive general liability insurance and professional liability insurance shall provide coverage in an amount established by CCO pursuant to the Agreement or as required under the MississippiCHIP Program Contract.

3.42 Indemnification. To the extent applicable to Provider in performance under the Agreement, Provider shall indemnify, defend, protect, save and hold DOM and its employees and Members harmless from and against all injuries, deaths, losses, damages, claims, suits, demands, actions, recovery, liabilities, judgments, costs and expenses, including without limitation, court costs, investigative fees and expenses, and attorney fees, to the extent proximately caused by any negligent act or other intentional misconduct or omission of Provider, its agents, officers, employees or contractors arising from the Agreement. DOM may waive this requirement for public entities if Provider is a state agency or sub-unit as defined by the State or a public health entity with statutory immunity. This clause shall survive the termination of the Agreement for any reason, including breach due to insolvency.

3.43 Notice of Legal Action. Immediately upon obtaining knowledge or receiving notice of any legal action or notice listed below, Provider shall provide to CCO written notice of such legal action or notice and, upon request by CCO, a complete copy of all filings and other documents generated in connection with any such legal action:

i) Any action, suit or counterclaim filed against Provider;

ii) Any regulatory action, or proposed action, respecting Provider's business or operations;

iii) Any notice received by Provider from the Department of Insurance or the State Health Officer;

iv) The filing of a petition in bankruptcy by or against Provider, or the insolvency of Provider;

v) The conviction of any person who has an ownership or control interest in Provider, or who is an agent or managing employee of Provider, of a criminal offense related to that person's

involvement in any program under Medicare, Medicaid, or Title XX of the Social Security Act; or

vi) A malpractice action against any Provider delivering service under an agreement.

3.44 Hold Harmless. Except for any applicable cost-sharing requirements under the MississippiCHIP Program Contract, Provider shall look solely to CCO for payment of Covered Services provided to Members pursuant to the Agreement and the MississippiCHIP Program Contract and hold DOM, the State, the U.S. Department of Health and Human Services and Members harmless in the event that CCO cannot or will not pay for such Covered Services. In accordance with 42 CFR § 447.15, as may be amended from time to time, the Member is not liable to Provider for any services for which CCO is liable and as specified under the State's relevant health insurance or managed care statutes, rules or administrative agency guidance. Provider shall not require any copayment or cost sharing for Covered Services provided under the Agreement unless expressly permitted under the MississippiCHIP Program Contract. Provider shall also be prohibited from charging Members for missed appointments if such practice is prohibited under the MississippiCHIP Program Contract or applicable law. Neither the State, DOM, nor Member shall be in any manner liable for the debts and obligations of CCO and under no circumstances shall CCO, or any providers used to deliver services covered under the terms of the MississippiCHIP Program Contract, charge Members for Covered Services.

3.45 Assignment/Delegation. Provider shall not assign or delegate the Agreement without the express written consent of CCO or DOM. If Provider subcontracts or delegates any functions of the Agreement, in accordance with the terms of the Agreement and with the express written consent of CCO or DOM, the subcontract or delegation must be in writing and include all of the requirements of this Appendix, and applicable requirements of the State Contract, and applicable laws and regulations. The transfer of five percent (5%) or more of the beneficial ownership in Provider at any time during the term of this Agreement shall be deemed an assignment under this Agreement.

3.46 Behavioral Health Providers. Behavioral Health Providers shall ensure that all Covered Persons receiving inpatient psychiatric services are scheduled for outpatient follow-up and/or continuing treatment prior to discharge from the inpatient psychiatric hospital if the Provider is aware of the Covered Person's inpatient hospitalization status. Behavioral Health Providers will be provided daily reports identifying Covered Persons known to be admitted to an inpatient facility. Behavioral Health Services will be delivered in compliance with the requirements of 42 CFR 438 subpart K insofar as those requirements are applicable.

3.47 Provider Eligibility. Provider must be enrolled in the Mississippi CHIP program and must use the same National Provider Identifier (NPI) number to participate in CCO's Network. Upon notification from the State that Provider's enrollment has been denied or terminated, CCO must terminate Provider immediately and will notify affected Covered Persons that Provider is no longer participating in the network. CCO will exclude from its network any provider who has been terminated or suspended from the Medicare, Medicaid or CHIP program in any state.

3.48 Disclosure. Provider must be screened and enrolled in the State's CHIP program and submit disclosures to the DOM related to ownership and control, significant business transactions, and persons convicted of crimes in accordance with 42 CFR Part 455 .Provider must submit information related to ownership and control of subcontractors or wholly owned suppliers within thirty-five (35)

calendar days of a request for such information in accordance with 42 CFR 455.105. Additionally, Provider must cooperate with DOM for submission of fingerprints upon a request from DOM or CMS in accordance with 42 CFR 455.434.

3.49 Electronic Visit Verification. Provider shall cooperate with State requirements for electronic visit verification for personal care services and home health services, as applicable.

3.50 Clinical Laboratory Improvements Act (CLIA) Certification or Waiver. As applicable, if Provider performs any laboratory tests on human specimens for the purpose of diagnosis and/or treatment, Provider agrees to acquire and maintain the appropriate CLIA certification or waiver for the type of laboratory testing performed. Provider further agrees to provide a copy of the certification if requested by CCO. A State authorized license or permit that meets the CLIA requirements may be substituted for the CLIA certificate pursuant to State law. Medicare and Medicaid programs require the applicable CLIA certification or waiver for the type of services performed as a condition of payment. Provider must include the appropriate CLIA certificate or waiver number on claims submitted for payment for laboratory services.

3.51 Overpayment. Provider shall to report to CCO when it has received an overpayment and will return the overpayment to CCO within 60 calendar days after the date on which the overpayment was identified. Provider will notify CCO in writing of the reason for the overpayment.

SECTION 4
CCO REQUIREMENTS

4.1 Communications with Members. Members are entitled to the full range of their Providers' opinions and counsel about the availability of Medically Necessary Services under the provisions of the MississippiCHIP Program Contract. Any contractual provisions, including gag clauses or rules, that restrict a Provider's ability to advise Members about Medically Necessary treatment options violate federal law and regulations. CCO shall not prohibit or otherwise restrict Provider, when acting within the lawful scope of practice, from advising or advocating on behalf of a Member for the following:

i) The Member’s health status, medical care, or treatment options, including any alternative treatment that may be self-administered;

ii) Any information the Member needs in order to decide among all relevant treatment options;

iii) The risks, benefits, and consequences of treatment or non-treatment;

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

v) Information regarding the nature of treatment options including those that may not reflect CCO’s position or may not be covered by CCO.

CCO shall not prohibit a Provider from advocating on behalf of a Member in any grievance system,

utilization review process, or individual authorization process to obtain necessary health care services.

4.2 Prompt Payment. CCO shall pay Provider pursuant to the MississippiCHIP Program Contract and applicable State and federal law and regulations, including but not limited to Miss. Code Ann. §83-9-5, 42 CFR §447.46, 42 CFR §447.45(d)(2), 42 CFR §447.45(d)(3), 42 CFR §447.45(d)(5) and 42 CFR §447.45(d)(6), as applicable and as may be amended from time to time. If a third party liability exists, payment of claims shall be determined in accordance with federal and/or State third party liability law and the terms of the MississippiCHIP Program Contract. Unless CCO otherwise requests assistance from Provider, CCO will be responsible for third party collections in accordance with the terms of the MississippiCHIP Program Contract.

4.3 No Incentives to Limit Medically Necessary Services. CCO shall not structure compensation provided to individuals or entities that conduct utilization management and concurrent review activities so as to provide incentives for the individual or entity to deny, limit, or discontinue Medically Necessary services to any Member.

4.4 Provider Discrimination Prohibition. CCO shall not discriminate with respect to participation, reimbursement, or indemnification of a provider who is acting within the scope of the provider's license or certification under applicable State law, solely on the basis of such license or certification. CCO shall not discriminate against Provider for serving high-risk Members or if Provider specializes in conditions requiring costly treatments. This provision shall not be construed as prohibiting CCO from limiting a provider's participation to the extent necessary to meet the needs of Members. This provision also is not intended and shall not interfere with measures established by CCO that are designed to maintain quality of care practice standards and control costs. CCO shall not provide false or misleading information to any person or entity in an attempt to recruit Providers for CCO's network.

4.5 Termination, Revocation and Sanctions. In addition to its termination rights under the Agreement, CCO shall have the right to revoke any functions or activities CCO delegates to Provider under the Agreement or impose other sanctions consistent with the MississippiCHIP Program Contract if in CCO's reasonable judgment Provider's performance under the Agreement is inadequate. CCO shall also have the right to suspend, deny, refuse to renew or terminate the subcontract in accordance with the terms of the MississippiCHIP Program Contract and applicable law and regulation. However, CCO shall not exclude or terminate a Provider from participation in CCO's Provider Network due to the fact that the Provider has a practice that includes a substantial number of patients with expensive medical conditions, and shall not terminate a Provider for filing a Complaint, Grievance, or Appeal on a Member's behalf.

SECTION 5
OTHER REQUIREMENTS

5.1 Compliance with MississippiCHIP Program Contract. All tasks performed under the Agreement shall be performed in accordance with the requirements of the MississippiCHIP Program Contract, as applicable, as set forth in this Appendix, applicable provider manuals, and protocols, policies and procedures that CCO has provided or delivered to Provider. The applicable provisions of the MississippiCHIP Program Contract are incorporated into the Agreement by reference. Nothing in the Agreement or this Appendix relieves CCO of its responsibility under the

MississippiCHIP Program Contract. If any provision of the Agreement is in conflict with provisions of the MississippiCHIP Program Contract, the terms of the MississippiCHIP Program Contract shall control and the terms of the Agreement in conflict with those of the MississippiCHIP Program Contract will be considered waived.

5.2 Monitoring. In accordance with 42CFR § 457.950, CCO shall perform ongoing monitoring (announced or unannounced) of services rendered by Provider under the Agreement and shall perform periodic formal reviews of Provider according to a schedule established by the State, consistent with industry standards or State managed care organization laws and regulations or requirements under the MississippiCHIP Program Contract. As a result of such monitoring activities, and/or as a result of the inspecting, auditing and monitoring activities of DOM or other authorities pursuant to section 4.4 above, CCO shall identify to Provider any deficiencies or areas for improvement mandated under the MississippiCHIP Program Contract and Provider and CCO shall take appropriate corrective action within the relevant timeframe permitted, as applicable. Provider shall comply with any corrective action plan initiated by CCO and/or required by the MississippiCHIP Program. In addition, Provider shall monitor and report the quality of services delivered under the Agreement and initiate a plan of correction where necessary to improve quality of care, in accordance with that level of care which is recognized as acceptable professional practice in the respective community in which CCO and Provider practice and/or the performance standards established under the MississippiCHIP Program Contract.

5.3 Enrollment. The parties acknowledge and agree that DOM is responsible for enrollment, reenrollment and disenrollment of Members.

5.4 No Exclusivity. Nothing in the Agreement or this Appendix shall be construed as prohibiting or penalizing Provider for contracting with a managed care organization other than CCO or as prohibiting or penalizing CCO for contracting with other providers. The CCO may not require Providers who agree to participate in the MississippiCHIP Program to contract with the Contractor's other lines of business.

5.5 Revoking Delegation. The parties agree that, prior to execution of the Agreement, CCO evaluated Provider's ability to perform any duties delegated to Provider under the Agreement. Any delegated duties and reporting responsibilities shall be set forth in the Agreement or other written delegation agreement or addendum between the parties. In addition to its termination rights under the Agreement, CCO shall have the right to revoke any functions, assignment authority, or activities CCO delegates to Provider under the Agreement or impose other sanctions if in CCO's reasonable judgment Provider's performance under the Agreement is inadequate or untimely.

5.6 Rights of DOM. DOM shall have the right to invoke against Provider any remedy set forth in the MississippiCHIP Program Contract, including the right to require the termination of the Agreement, for each and every reason for which it may invoke such a remedy against CCO or require termination of the MississippiCHIP Program Contract. Suspected Fraud and Abuse by Provider will be investigated by DOM.

Mississippi
Regulatory Requirements Appendix

Mississippi Regulatory Requirements Appendix

This Mississippi Regulatory Requirements Appendix (the "Appendix") is made part of the agreement ("Agreement") entered into between **CCO,** contracting on behalf of itself, **HMO**, and the other entities that are CCO's Affiliates (collectively referred to as "CCO") and the health care professional or entity named in the Agreement ("Provider").

This Appendix applies to all products or benefit plans sponsored, issued or administered by or accessed through CCO to the extent such products are regulated under Mississippi laws; provided, however, that the requirements in this Appendix will not apply to the extent they are preempted by the Medicare Modernization Act or other applicable law.

CCO and Provider each agree to be bound by the terms and conditions contained in this Appendix. In the event of a conflict or inconsistency between this Appendix and any term or condition contained in the Agreement, this Appendix shall control, except with regard to Benefit Plans outside the scope of this Appendix.

If any of the capitalized terms in this Appendix are used or defined (or the equivalent terms are used or defined) in the Agreement, then the terms used in this Appendix will have the same meaning as the terms (or equivalent terms) used or defined in the Agreement. For example, "Benefit Plans," as used in this Appendix, will have the same meaning as "benefit contracts"; "Customer," as used in this Appendix, will have the same meaning as "member," "enrollee," or "covered person"; "Payer," as used in this Appendix, will have the same meaning as "participating entity"; "Provider," as used in this Appendix, will have the same meaning as "Facility," "Medical Group," "Ancillary Provider," "Physician," or "Practitioner." Additionally, if the Agreement uses pronouns to refer to the contracted entities, then "CCO" will have the same meaning as "we" or "us," and "Provider" will have the same meaning as "you" or "your."

This Appendix will be deemed to be updated to incorporate any changes to the laws and regulations referenced herein, including any changes to definitions referenced herein, effective as of the date of such changes.

1. Customer Hold Harmless and Continuation of Services. Provider agrees that in no event, including but not limited to nonpayment by CCO, Payer or intermediary, insolvency of CCO, Payer or intermediary, or breach of this Agreement, shall Provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against a Customer or a person (other than CCO, Payer or intermediary) acting on behalf of the Customer for services provided pursuant to this Agreement. This Agreement does not prohibit Provider from collecting coinsurance, deductibles or copayments, as specifically provided in the evidence of coverage, or fees for uncovered services delivered on a fee-for-service basis to Customers. Nor does this Agreement prohibit Provider (except for a health care professional who is employed full-time on the staff of CCO and has agreed to provide services exclusively to CCO's Customers and no others) and a Customer from agreeing to continue services solely at the expense of the Customer, as long as the provider has clearly informed the Customer that CCO or Payer

may not cover or continue to cover a specific service or services. Except as provided herein, this Agreement does not prohibit Provider from pursuing any available legal remedy.

In the event of CCO, Payer or intermediary insolvency or other cessation of operations, Covered Services to Customers will continue through the period for which a premium has been paid to CCO or Payer on behalf of the Customer or until the Customer's discharge from an inpatient facility, whichever time is greater. Covered Services to Customers confined in an inpatient facility on the date of insolvency or other cessation of operations will continue until their continued confinement in an inpatient facility is no longer medically necessary.

The provisions in this section 1 shall be construed in favor of the Customer, shall survive the termination of the Agreement regardless of the reason for termination, including the insolvency of CCO or Payer, and shall supersede any oral or written contrary agreement between Provider and a Customer or the representative of a Customer if the contrary agreement is inconsistent with the hold harmless and continuation of Covered Services provisions required by this section 1.

In no event shall Provider collect or attempt to collect from a Customer any money owed to Provider by CCO or Payer.

2. CCO Programs. As applicable, Provider shall comply with CCO's administrative policies and programs, including but not limited to terms, including payment, utilization review, quality assessment and improvement programs, credentialing, grievance procedures, data reporting requirements, confidentiality requirements and any applicable federal or state programs.

3. Treatment Options. CCO shall not prohibit Provider from discussing treatment options with Customers irrespective of CCO's position on the treatment options, or from advocating on behalf of Customers within the utilization review or grievance processes established by CCO or a person contracting with CCO.

4. Records. Provider shall make health records available to appropriate state and federal authorities involved in assessing the quality of care or investigating the grievances or complaints of Customers, and to comply with the applicable state and federal laws related to the confidentiality of medical or health records.

5. Termination. CCO and Provider shall provide advance written notice to each other in the form and for the length of time as provided in the Agreement but in no case less than sixty (60) before terminating the Agreement without cause. CCO shall make a good faith effort to provide written notice of a termination within thirty (30) days of receipt or issuance of a notice of termination to all Customers who are patients seen on a regular basis by Provider whose Agreement is terminating, irrespective of whether the termination was for cause or without cause. Where a contract termination involves a primary care professional, all Customers who are patients of that primary care professional shall also be notified. Within five (5) working days of the date that Provider either gives or receives notice of termination, Provider shall supply CCO with a list of those patients of Provider that are covered by a Benefit Plan subject to this Appendix.

6. Assignment. The rights and responsibilities under this Agreement shall not be assigned or delegated by Provider without the prior written consent of CCO.

7. Provision of Covered Services. Provider shall furnish Covered Services to all Customers without regard to the Customer's enrollment in the plan as a private purchaser of the plan or as a participant in publicly financed programs of health care services. This requirement does not apply to circumstances when Provider should not render services due to limitations arising from lack of training, experience, skill or licensing restrictions.

8. Coinsurance, Copayments and Deductibles. Provider shall collect applicable coinsurance, copayments or deductibles from Customers pursuant to the Benefit Plan and, as applicable, Provider shall notify Customers of their personal financial obligations for non-covered services.

9. No Penalty for Reporting to Authorities. CCO shall not penalize Provider because Provider, in good faith, reports to state or federal authorities any act or practice by CCO that jeopardizes patient health or welfare.

10. Definitions. To the extent a definition or other provision in the Agreement conflicts with the Benefit Plan or the Managed Care Plan Network Adequacy Regulation (the "Regulation"), the Benefit Plan or the Regulation will control.

11. Prompt Pay. Provider and CCO shall comply with the prompt payment requirements set forth in the Mississippi Code Section 83-9-5(1)(h). Claims will be paid within twenty-five (25) days after receipt where claims are submitted electronically, and within thirty-five (35) days after receipt where claims are submitted in paper format.

12. Reciprocal Time Limitations. If the Agreement includes a time limit in which Provider is required to submit a claim for payment, CCO or Payer shall have the same time limit following payment of the claim to perform any review or audit for reconsidering the validity of the claim and requesting reimbursement for payment of an invalid claim or overpayment of a claim. If CCO or Payer does not limit the time in which Provider is required to submit a claim for payment, CCO may not request reimbursement or offset another claim payment for reimbursement of an invalid claim or overpayment of a claim more than twelve (12) months after the payment of an invalid or overpaid claim. This provision does not apply to claims submitted in the context of misrepresentation, omission, concealment, or fraud by Provider.

13. Intermediaries. The following provisions apply to intermediaries as defined in the Regulation.

a) Intermediaries and participating providers with whom they contract shall comply with all the applicable requirements of sections 1-10 of this Appendix (section 14.06 of the Regulation).
b) CCO's statutory responsibility to monitor the offering of Covered Services to Customers shall not be delegated or assigned to the intermediary.

c) CCO shall have the right to approve or disapprove participation status of a subcontracted provider in its own or a contracted network for the purpose of delivering Covered Services to the carrier's Customers.
d) CCO shall maintain copies of all intermediary health care subcontracts at its principal place of business in the state, or ensure that it has access to all intermediary subcontracts, including the right to make copies to facilitate regulatory review, upon twenty (20) days prior written notice from CCO.
e) If applicable, an intermediary shall transmit utilization documentation and claims paid documentation to CCO. CCO shall monitor the timeliness and appropriateness of payments made to providers and health care services received by Customers.
f) If applicable, an intermediary shall maintain the books, records, financial information and documentation of services provided to Customers at its principal place of business in the state and preserve them in a manner that facilitates regulatory review.
g) An intermediary shall allow the commissioner access to the intermediary's books, records, financial information and any documentation of services provided to Customers, as necessary to determine compliance with the Regulation.
h) CCO shall have the right, in the event of the intermediary's insolvency, to require the assignment to CCO of the provisions of a provider's contract addressing the provider's obligation to furnish covered services.

Dialysis Mississippi Medicaid State Specific Payment Appendix

Dialysis Mississippi Medicaid State Specific Payment Appendix

APPLICABILITY

Facility or Facilities subject to this Appendix as of this Appendix Effective Date: _____
Tax ID: _____
Provider ID: _____
This Appendix applies to the following types of Benefit Plans as described in the Agreement: • [Mississippi Medicaid Benefit Plans] • [Mississippi CHIP Benefit Plans] This Appendix does not apply, to the extent another agreement or appendix between the parties or their affiliates specifically applies to a given Benefit Plan that would otherwise be subject to this Appendix.
This Appendix is effective for dates of service on or after: _____ Any prior Appendix applicable to the same Benefit Plan(s) are superseded by this Appendix.

Unless another appendix to the Agreement applies specifically to a particular Benefit Plan as it covers a particular Customer, the provisions of this Appendix apply to Covered Services rendered by or at Facility when it is acting as a Dialysis provider to Customers with regard to Benefit Plans subject to this Appendix.

SECTION 1
Definitions

Unless otherwise defined in this Section, capitalized terms used in this Appendix have the meanings assigned to them in the Agreement. If any definition in this Appendix conflicts with another definition in the Agreement, the definition in this Appendix controls, with regard to Benefit Plans subject to this Appendix.

Agency: Mississippi Medicaid agency, responsible for sponsoring the Benefit Plans subject to this Appendix.

Agency Rates: The rates set by the Agency for Covered Services for the Payment Methods in this Appendix.

CMS: Centers for Medicare and Medicaid Services.

Customer Expenses: Copayments, deductibles, or coinsurance that are the financial responsibility of the Customer according to the Customer's Benefit Plan.

Eligible Charges: The Customary Charge for Covered Services.

Institutional Claim: Any UB04 or electronic version or successor form.

Outpatient Encounter: Covered Services rendered to a Customer by Facility on an outpatient basis from the time of registration for outpatient services until discharge.

Payment Method: A methodology for determining contract rates under this Appendix. Unless otherwise specified in this Appendix, payment under this Appendix, less any applicable Customer Expenses, is considered payment in full for all Covered Services rendered to the Customer including (as applicable), but not limited to:

- Ancillary services
- Diagnostic and therapeutic services (including but not limited to diagnostic imaging)
- Durable medical equipment
- Laboratory or pathology services (regardless of whether provided directly by Facility)
- Medications (including, calcimimetic medications)
- Nursing care
- Physician and other professional fees billed by Facility on an Institutional Claim
- Services rendered by non-Physician personnel (regardless of whether those personnel are employed by Facility and regardless of whether those services are characterized as professional services)
- Supplies (including, but not limited to, anesthesia supplies)

Per Unit via Facility Fee Schedule: The Payment Method designated "Per Unit via Facility Fee Schedule" in this Appendix, based on the CPT/HCPCS specific fee listed in the applicable fee schedule for each unit of service and applicable to Covered Services rendered to a Customer for which a Per Unit via Facility Fee Schedule Payment Method is indicated in this Appendix. Facility is required to identify procedures by revenue code and CPT/HCPCS code to receive payment. The number of units for each procedure or service rendered will be billed in accordance with the guidelines in the latest edition of the Current Procedural Terminology (CPT) manual as published by the American Medical Association or the latest edition of the HCPCS manual as published by CMS. Unless otherwise specified in this Appendix, payment under the Per Unit via Facility Fee Schedule Payment Method, less any applicable Customer Expenses, is payment in full for all Covered Services rendered to the Customer including, but not limited to, Physician and other professional fees billed by Facility on an Institutional Claim, services rendered by non-Physician personnel (regardless of whether those personnel are employed by Facility and regardless of whether those services are characterized as professional services), nursing care, diagnostic and therapeutic services, durable medical equipment, supplies (including, but not limited to anesthesia supplies), medications, and facility and ancillary services. The units reported for Covered Services for which the contract rate is a Per Unit via Facility Fee Schedule must always equal the number of times a procedure or service is performed.

Per Visit: The Payment Method applicable to Covered Services rendered to a Customer during one-calendar day period for each Service Category. Facility is required to identify each date of service when submitting claims spanning multiple dates of service.

Physician: A Doctor of Medicine ("M.D."), a Doctor of Osteopathy ("D.O.") or another health care professional as authorized under applicable law and Facility bylaws to admit or refer patients for Covered Services.

SECTION 2
Contract Rate for Covered Services

2.1 Contract Rate. For Covered Services rendered by Facility to a Customer, the contract rate will be the lesser of (1) Facility's Eligible Charges, or (2) the applicable contract rate determined in accordance with Sections 2.2

and/or 3 of this Appendix. Payment by Payer of the contract rate under this Appendix will be less any applicable Customer Expenses, and is subject to the requirements set forth in the Agreement.

2.2 Outpatient Dialysis Covered Services. For the provision of Outpatient Dialysis Covered Services during an Outpatient Encounter, the contract rate will be determined according to Sections 2.1 and 2.2, and the applicable table included therein. Unless otherwise specified in this Appendix, the negotiated percentage identified in this Section for an entire Outpatient Encounter is the percentage in effect on the date the Outpatient Encounter begins.

For Outpatient Covered Services, appropriate CPT/HCPCS codes, as described by the National Uniform Billing Committee and CPT/HCPCS code guidelines, must be submitted on the Institutional Claim in order to be eligible for reimbursement. Revenue codes and CPT/HCPCS codes that are used by Agency outside of the National Uniform Billing Committee guidelines and CPT/HCPCS code guidelines are not considered valid and are not eligible for reimbursement.

Table 1: Outpatient Dialysis Services Category Table

SERVICE CATEGORY	PAYMENT METHOD	CONTRACT RATE AS OF THE EFFECTIVE DATE OF THIS APPENDIX	NEGOTIATED PERCENTAGE OF AGENCY RATE
Hemodialysis/Composite (In-center/In-clinic only)* (Revenue Code 0821)	**Per Visit**	**$_____**	**[XX]% of Agency Rate**
Peritoneal Dialysis (Outpatient or Home) (Revenue Code 0831)	**Per Visit**	**$_____**	**[XX]% of Agency Rate**
Continuous Ambulatory Peritoneal Dialysis (CAPD) (Outpatient or Home) (Revenue Code 0841)	**Per Visit**	**$_____**	**[XX]% of Agency Rate**
Continuous Cycling Peritoneal Dialysis (CCPD) (Outpatient or Home) (Revenue Code 0851)	**Per Visit**	**$_____**	**[XX]% of Agency Rate**

SERVICE CATEGORY	PAYMENT METHOD	CONTRACT RATE AS OF THE EFFECTIVE DATE OF THIS APPENDIX	NEGOTIATED PERCENTAGE OF AGENCY RATE
Separately Reimbursed Services (Revenue Codes 0250, 0300-03079, 0320-0329, 0340-0349, 0390, 0634-0636, 0730, 0920-0929, or 0933) with applicable CPT/HCPCS codes	**Per Unit via Facility Fee Schedule #** _____	**As calculated**	**[XX]% of the "Source Fee" as described in the Dialysis Separately Reimbursed FS Exhibit**

*Hemodialysis is reimbursable for 3 visits per week, unless the patient's need for hemodialysis in excess of the standard 3 hemodialysis treatments per week supported by the medical documentation and subject to the review of medical records by CCO in accordance with the Agreement. Medical documentation supporting Hemodialysis treatments in excess of 3 per week is not required to be submitted with the claim, but such records are to be maintained on file and made available, upon CCO's request within the timeframe specified in the Agreement.

Fee Schedule Notes

Calculation of the contract rate is based on the following:

1. Facility is required to identify procedures by revenue code-and CPT/HCPCS code, and modifier code as applicable, to receive payment.
2. The Dialysis Separately Reimbursed FS Exhibit was created based on Agency except as noted below.
3. CPT/HCPCS Codes listed on the Dialysis Separately Reimbursed FS Exhibit are priced using fee sources, where a source rate exists, according to the following hierarchy:
    1. Mississippi State Lab
    2. Mississippi State Radiology
    3. Mississippi State Injectable Drug
    4. MS Comprehensive Fee source
4. There will be a monthly update to the Dialysis Separately Reimbursed FS Exhibit to set fixed rates for new Separately Reimbursed codes and any rate adjustments that are made to previously established codes, in either case published throughout the previous month. The contract rates will be set based on the same methodology used to establish the contract rates for the existing codes and will change due to a retroactive correction to the amount provided by the fee source. These changes will be effective on the same date the Agency rates become effective and any claims affected will be addressed.

5. Unless otherwise specified, appropriately billed codes for a valid Covered Services that are not listed on the current Dialysis Separately Reimbursed Fee Schedule Exhibit will not be considered for reimbursement.

SECTION 3
Miscellaneous Provisions

3.1 Inclusive Rates. The contract rates established by this Appendix for the service categories listed in Table 1 and Table 2 are all-inclusive, including without limitation applicable taxes, and represent the entire payment for the provision to the Customer of all Covered Services that are in the given service category, including but not limited to those Covered Services that are generally provided as a part of the service in the given service category. All items and non-Physician services provided to Customers at Facility must be directly furnished by Facility or billed by Facility when services are provided by another entity. No additional payments will be made for any services or items covered under the Customer's Benefit Plan and billed for separately by Facility.

Notwithstanding the foregoing, Facility will only bill for dialysis laboratory services provided by Facility. Facility will not bill, nor be reimbursed for laboratory/pathology services performed by another provider entity and not by Facility.

3.2 Payment Code Updates. CCO will update CPT codes, HCPCS codes, ICD-10-CM codes, or successor version, and/or revenue codes, according to Health Insurance Portability and Accountability Act requirements based on (a) the latest edition of the Current Procedural Terminology (CPT) manual which is revised by the American Medical Association, (b) the latest edition of the HCPCS manual which is revised by CMS, (c) the latest edition of the ICD-10-CM manual, or successor version, which is issued by the U.S. Department of Health and Human Services, and (d) the latest revenue code guidelines from the National Uniform Billing Committee. Unless specified elsewhere in this Appendix, the contract rate for a new, replacement, or modified code(s) will be at the existing contract rate for the appropriate code(s) it replaced or modified.

3.3 Facility Reimbursement for No Cost Items. If an applicable program is available to provide items or payment directly to Facility for specific Covered Services for Customers subject to this Appendix that would otherwise be payable under this Appendix, the applicable program will apply and not this Appendix. However, related items for services not provided or paid under the program may be payable under this Appendix. (For example, the Campath Distribution program currently provides Campath (alemtuzumab) free of charge, and therefore no amount will be payable under this Appendix for Campath (alemtuzumab). However, the administration of Campath (alemtuzumab) may be payable under this Appendix, because payment is not provided to facilities under the Campath Distribution program.)

3.4 Changes to Agency Rates. Unless otherwise specified in this Appendix, contract rates based on Agency Rates (including a contract rate that is a fixed percentage of the Agency Rate) will be automatically updated within 45 days, or as specified by the Agency, ("Update Period") following publication of new Agency Rates with an effective date as published by the Agency. CCO will reprocess any claims at the updated contract rate.

3.5 Changes to Agency Payment Method. If the Agency changes the Payment Method set forth in this Appendix, CCO will make commercially reasonable efforts to implement new Payment Method within a reasonable time frame. Facility agrees it will accept the current methodologies as set forth in this Appendix,

until CCO can implement the change in Payment Method. CCO will communicate the change and the effective date of the change.

If CCO is unable to incorporate all of the Agency Payment Method changes, CCO will notify Facility within 90 days after the Agency published the Payment Method change. The parties will negotiate an amendment to replace this Appendix with an appendix with Payment Methods CCO can administer. If the parties have not reached an agreement within 90 days, either party may initiate dispute resolution according to the Agreement.

Dialysis Separately Reimbursed Fee Schedule Exhibit

As described on Table 1 of this Appendix, Dialysis Separately Reimbursed Services, the contract rate is [XX]% of the "Source Fee" as described in the Dialysis Separately Reimbursed FS Exhibit, as noted under the column header "Negotiated Percentage of Agency Rate".

Mississippi State Specific Home Health Services Payment Appendix

Mississippi State Specific Home Health Services Payment Appendix

APPLICABILITY

Facility or Facilities subject to this Appendix as of this Appendix Effective Date: _____
Tax ID: _____
Provider ID: _____
This Appendix applies to the following types of Benefit Plans as described in the Agreement: • [Mississippi Medicaid Benefit Plans] • [Mississippi CHIP Benefit Plans] This Appendix does not apply, to the extent another agreement or appendix between the parties or their affiliates specifically applies to a given Benefit Plan that would otherwise be subject to this Appendix.
This Appendix is effective for dates of service on or after: _____ Any prior Appendix applicable to the same Benefit Plan(s) are superseded by this Appendix.

Unless another appendix to the Agreement applies specifically to a particular Benefit Plan as it covers a particular Customer, the provisions of this Appendix apply to Covered Services rendered by or at Facility when it is acting as a Home Health Service provider to Customers covered by Benefit Plans subject to this Appendix.

SECTION 1
Definitions

Unless otherwise defined in this Section, capitalized terms used in this Appendix have the meanings assigned to them in the Agreement. If any definition in this Appendix conflicts with another definition in the Agreement, the definition in this Appendix controls, with regard to Benefit Plans subject to this Appendix.

Agency: Mississippi Medicaid agency, responsible for sponsoring the Benefit Plans subject to this Appendix.

Agency Rates: The rates set by the Agency for Covered Services for the Payment Methods in this Appendix.

CMS: Centers for Medicare and Medicaid Services.

Customer Expenses: Copayments, deductibles, or coinsurance that are the financial responsibility of the Customer according to the Customer's Benefit Plan.

Eligible Charges: The Customary Charge for Covered Services.

Institutional Claim: Any UB-04 or electronic version or successor form.

Payment Method: A methodology for determining contract rates under this Appendix. Unless otherwise specified in this Appendix, payment under this Appendix, less any applicable Customer Expenses, is considered payment in full for all Covered Services rendered to the Customer including (as applicable), but not limited to:

• Professional and non-professional services billed by Facility on an Institutional Claim

Additionally, includes
• All ancillary medical supplies
• Customer education
• Clinical management (i.e. monitoring, on call, record keeping, etc.)
• Educational materials
• Mileage associated with the care rendered

Per Unit: The Payment Method applicable to Covered Services rendered to a Customer for each unit of service. The units reported for Covered Services for which the contract rate is a Per Unit must always equal the number of times a procedure or service is performed.

Physician: A Doctor of Medicine ("M.D."), a Doctor of Osteopathy ("D.O.") or another health care professional as authorized under applicable law and Facility bylaws to admit or refer patients for Covered Services.

SECTION 2
Contract Rate for Covered Services

2.1 Contract Rate. For Covered Services rendered by Facility to a Customer, the contract rate will be the lesser of (1) Facility's Eligible Charges, or (2) the applicable contract rate determined in accordance with Sections 2.2 and/or 3 of this Appendix, less any Customer Expenses. Payment by CCO of the contract rate under this Appendix will be less any applicable Customer Expenses, and is subject to the requirements set forth in the Agreement.

2.2 Home Health Covered Services. For the provision of Covered Services to a Customer, the contract rate will be determined according to Sections 2.1 and 2.2, and the applicable table included therein. Unless otherwise specified in this Appendix, the negotiated percentage identified in this Section is the percentage in effect on the date the service begins.

For Outpatient Covered Services, appropriate CPT/HCPCS codes, as described by the National Uniform Billing Committee and CPT/HCPCS code guidelines, must be submitted on the Institutional Claim in order to be eligible for reimbursement. Revenue codes and CPT/HCPCS codes that are used by Agency outside of the National Uniform Billing Committee guidelines and CPT/HCPCS code guidelines are not considered valid and are not eligible for reimbursement.

Table 1: Home Health Services Category Table

SERVICE CATEGORY	PAYMENT METHOD	CONTRACT RATE AS OF THE EFFECTIVE DATE OF THIS APPENDIX	NEGOTIATED PERCENTAGE OF AGENCY RATE

Physical Therapy (Revenue Code 0421)	**Per Unit**	**$_____**	**[XX]% of Agency Rate**
Speech Therapy (Revenue Code 0441)	**Per Unit**	**$_____**	**[XX]% of Agency Rate**
Nursing Services - Skilled Nursing (Revenue Code 0551)	**Per Unit**	**$_____**	**[XX]% of Agency Rate**
Home Health Aide (Revenue Code 0571)	**Per Unit**	**$_____**	**[XX]% of Agency Rate**

SECTION 3
Miscellaneous Provisions

3.1 Inclusive Rates. The contract rates established by this Appendix for the service categories listed in Table 1 are all-inclusive, including without limitation applicable taxes, and represent the entire payment for the provision to the Customer of all Covered Services that are in the given service category, including but not limited to those Covered Services that are generally provided as a part of the service in the given service category. All items and non-Physician services provided to Customers at Facility must be directly furnished by Facility or billed by Facility when services are provided by another entity. No additional payments will be made for any services or items covered under the Customer's Benefit Plan and billed for separately by Facility.

Services in the service categories listed in Table 1 that are not rendered in accordance with the treatment plan requested or recommended by the Customer's Physician are not subject to reimbursement under this Appendix. When these services are Covered Services, per the Customer's Benefit Plan, Facility will not bill and collect from the Customer for the services, as prohibited under the Agreement. However, when these services are not Covered Services, per the Customer's Benefit Plan, Facility may bill and collect from the Customer for the services, to the extent permitted under the Agreement.

3.2 Payment Code Updates. CCO will update CPT codes, HCPCS codes ICD-10-CM codes, and/or revenue codes according to Health Insurance Portability and Accountability Act requirements based on (a) the latest edition of the Current Procedural Terminology (CPT) manual which is revised by the American Medical Association, (b) the latest edition of the HCPCS manual, or successor version, which is revised by CMS (c) the latest edition of the ICD-10-CM manual which is issued by the U.S. Department of Health and Human Services and (d) the latest revenue code guidelines from the National Uniform Billing Committee.

3.3 Facility Reimbursement for No Cost Items. If an applicable program is available to provide items or payment directly to Facility for specific Covered Services for Customers subject to this Appendix that would otherwise be payable under this Appendix, the applicable program will apply and not this Appendix. However, related items for services not provided or paid under the program may be payable under this Appendix (For example, the Campath Distribution program currently provides Campath (alemtuzumab) free of charge, and therefore no amount will be payable under this Appendix for Campath (alemtuzumab). However, the

administration of Campath (alemtuzumab) may be payable under this Appendix, because payment is not provided to facilities under the Campath Distribution program.)

3.4 Changes to Agency Rates. Unless otherwise specified in this Appendix, contract rates based on Agency Rates (including a contract rate that is a fixed percentage of the Agency Rate), will be automatically updated within 28 days, or as specified by the Agency, ("Update Period") following publication of new Agency Rates with an effective date as published by the Agency. CCO will reprocess any claims at the updated contract rate.

3.5 Changes to Agency Payment Method. If the Agency changes the Payment Method set forth in this Appendix, CCO will make commercially reasonable efforts to implement new Payment Method within a reasonable time frame. Facility agrees it will accept the current methodologies as set forth in this Appendix, until CCO can implement the change in Payment Method. CCO will communicate the change and the effective date of the change.

If CCO is unable to incorporate all of the Agency Payment Method changes, CCO will notify Facility within 90 days after the Agency published the Payment Method change. The parties will negotiate an amendment to replace this Appendix with an appendix with Payment Methods CCO can administer. If the parties have not reached an agreement within 90 days, either party may initiate dispute resolution according to the Agreement.

Mississippi State Specific Medicaid Hospice Payment Appendix

Mississippi State Specific Medicaid Hospice Payment Appendix

APPLICABILITY

Facility or Facilities subject to this Appendix as of this Appendix Effective Date: _____
Tax ID: _____
Provider ID: _____
This Appendix applies to the following types of Benefit Plans as described in the Agreement: • [Mississippi Medicaid Benefit Plans] • [Mississippi CHIP Benefit Plans] This Appendix does not apply, to the extent another agreement or appendix between the parties or their affiliates specifically applies to a given Benefit Plan that would otherwise be subject to this Appendix.
This Appendix is effective for dates of service on or after: _____ Any prior Appendix applicable to the same Benefit Plan(s) are superseded by this Appendix.

Unless another appendix to the Agreement applies specifically to a particular Benefit Plan as it covers a particular Customer, the provisions of this Appendix apply to Covered Services rendered by Facility when it is acting as a Hospice Agency provider to Customers covered by Benefit Plans sponsored, with regard to Benefit Plans subject to this Appendix.

SECTION 1
Definitions

Unless otherwise defined in this Section, capitalized terms used in this Appendix have the meanings assigned to them in the Agreement. If any definition in this Appendix conflicts with another definition in the Agreement, the definition in this Appendix controls, with regard to Benefit Plans subject to this Appendix.

Admission: The admittance of a Customer to a licensed hospice bed. Admission applies only to those services provided by order of a Physician.

Agency: Mississippi Medicaid agency, responsible for sponsoring the Benefit Plans subject to this Appendix.

Agency Rates: The rates set by the Agency for Covered Services for the Payment Methods in this Appendix.

CMS: Centers for Medicare and Medicaid Services.

Customer Expenses: Copayments, deductibles, or coinsurance that are the financial responsibility of the Customer according to the Customer's Benefit Plan.

Eligible Charges: The Customary Charge for Covered Services.

Institutional Claim: Any UB-04 or electronic version or successor form.

Payment Method: A methodology for determining contract rates under this Appendix. Unless otherwise specified in this Appendix, payment under this Appendix, less any applicable Customer Expenses, is considered payment in full for all Covered Services rendered to the Customer including (as applicable), but not limited to:

• Ancillary services
• Diagnostic and therapeutic services (including but not limited to diagnostic imaging)
• Durable medical equipment
• Medications
• Nursing care
• Physician and other professional fees billed by Facility on an Institutional Claim
• Room and board
• Services rendered by non-Physician personnel (regardless of whether those personnel are employed by Facility and regardless of whether those services are characterized as professional services)
• Supplies (including, but not limited to, anesthesia supplies)

Additionally, includes
• IV hydration
• Palliative chemotherapy
• Palliative radiation

Per Diem: The Payment Method applicable to Covered Services rendered to a Customer for each day during an Admission.

Per Unit: The Payment Method applicable to Covered Services rendered to a Customer for each unit of service. The units reported for Covered Services for which the contract rate is a Per Unit must always equal the number of times a procedure or service is performed.

Per Visit: The Payment Method applicable to Covered Services rendered to a Customer during one-calendar day period, for each Service Category. Facility is required to identify each date of service when submitting claims spanning multiple dates of service.

Physician: A Doctor of Medicine ("M.D."), a Doctor of Osteopathy ("D.O.") or another health care professional as authorized under applicable law and Facility bylaws to admit or refer patients for Covered Services.

SECTION 2
Contract Rate for Covered Services

2.1 Contract Rate. For Covered Services rendered by Facility to a Customer, the contract rate will be the lesser of (1) Facility's Eligible Charges, or (2) the applicable contract rate determined in accordance with Sections 2.2, 2.3 and/or 3 of this Appendix, less any Customer Expenses. Payment by CCO of the contract rate under this Appendix will be less any applicable Customer Expenses, and is subject to the requirements set forth in the Agreement.

2.2 Inpatient Covered Services. For the provision of Covered Services to a Customer during an Admission, the contract rate is determined as described in this Section. Unless otherwise specified in this Appendix, the negotiated percentage for an entire Admission is the negotiated percentage in effect on the first day of the Admission.

Table 1: Inpatient Service Category Table

SERVICE CATEGORY	PAYMENT METHOD	CONTRACT RATE AS OF THE EFFECTIVE DATE OF THIS APPENDIX	NEGOTIATED PERCENTAGE OF AGENCY RATE
General Inpatient Hospice (nonrespite) Revenue Code 0656 with Bill Type 82x (Hospital-Based) or Revenue Code 0656 with Bill Type 81x (Nonhospital-Based)	**Per Diem**	**As calculated**	**[XX]% of the Customer specific county rate, as described in Section 2.2.**
Inpatient Respite Care[1] Revenue Code 0655 with Bill Type 82x (Hospital-Based) or Revenue Code 0655 with Bill Type 81x (Nonhospital-Based)	**Per Diem**	**As calculated**	**[XX]% of the Customer specific county rate, as described in Section 2.2.**

2.3 Home Hospice Care Covered Services. For the provision of Home Hospice Care Covered Services rendered by Facility to a Customer during an Outpatient Encounter, the contract rate will be determined according to this Section. Unless otherwise specified in this Appendix, the negotiated percentage identified in this Section for an entire Outpatient Encounter is the percentage in effect on the date the Outpatient Encounter begins.

Table 2: Home Hospice Care Services Category Table

SERVICE CATEGORY	PAYMENT METHOD	CONTRACT RATE AS OF THE EFFECTIVE DATE OF THIS APPENDIX	NEGOTIATED PERCENTAGE OF AGENCY RATE
Routine Home Care - Hospice (Revenue Code 0651) [1] Days 1-60 or Days 61 and after *Note: Service Intensity Add-On is reimbursed at a Per Unit Rate (for each hour reported in 15 minute increments).*	**Per Visit**	**As calculated**	**[XX]% of the Customer specific county rate, as described in Section 2.3.**
Continuous Home Care - Hospice (Revenue Code 0652) [2, 3, 4]	**Per Unit**	**As calculated**	**[XX]% of the Customer specific county rate, as described in Section 2.3.**

Notes to Table 2

[1]**Routine Home Care** rate is reimbursable for each day the patient is under the care of Facility and receiving Hospice Covered Services, but not receiving one of the other service categories in this Appendix. However, Service Intensity Add-On is reimbursable in addition to Routine Home Care.

[2]**Continuous Home Care** is defined as a minimum of 8 hours of home care, not necessarily consecutive, during a 24-hour day, which begins and ends at midnight. Nursing care must be provided by a registered nurse (RN).

[3]Each unit for Revenue Code 0652 equates to 1 hour of Continuous Home Care service - Hospice service.

[4]For continuous home care, the rates are not applicable for a hospice patient who is a resident of a nursing facility or an inpatient of a free-standing hospice.

SECTION 3
Miscellaneous Provisions

3.1 Inclusive Rates. The contract rates established by this Appendix for the service categories listed in Table 1 and Table 2 are all-inclusive, including without limitation applicable taxes, and represent the entire payment for the provision to the Customer of all Covered Services that are in the given service category, including but not limited to those Covered Services that are generally provided as a part of the service in the given service category. All items and non-Physician services provided to Customers at Facility must be directly furnished by Facility or billed by Facility when services are provided by another entity. No additional payments will be made for any services or items covered under the Customer's Benefit Plan and billed for separately by Facility.

Services in the service categories listed in Table 1 and Table 2 that are not rendered in accordance with the treatment plan requested or recommended by the Customer's Physician are not subject to reimbursement under this Appendix. When these services are Covered Services, per the Customer's Benefit Plan, Facility will not bill and collect from the Customer for the services, as prohibited under the Agreement. However, when these services are not Covered Services, per the Customer's Benefit Plan, Facility may bill and collect from the Customer for the services, to the extent permitted under the Agreement.

3.2 Payment Code Updates. CCO will update CPT codes, HCPCS codes ICD-10-CM codes, or successor version, and/or revenue codes, according to Health Insurance Portability and Accountability Act requirements based on (a) the latest edition of the Current Procedural Terminology (CPT) manual which is revised by the American Medical Association, (b) the latest edition of the HCPCS manual which is revised by CMS, (c) the latest edition of the ICD- 10-CM manual, or successor version, which is issued by the U.S. Department of Health and Human Services, and (d) the latest revenue code guidelines from the National Uniform Billing Committee.

3.3 Facility Reimbursement for No Cost Items. If an applicable program is available to provide items or payment directly to Facility for specific Covered Services for Customers subject to this Appendix that would otherwise be payable under this Appendix, the applicable program will apply and not this Appendix. However, related items for services not provided or paid under the program may be payable under this Appendix (For example, the Campath Distribution program currently provides Campath (alemtuzumab) free of charge, and therefore no amount will be payable under this Appendix for Campath (alemtuzumab). However, the administration of Campath (alemtuzumab) may be payable under this Appendix, because payment is not provided to facilities under the Campath Distribution program.)

3.4 Changes to Agency Rates. Unless otherwise specified in this Appendix, contract rates based on Agency Rates (including a contract rate that is a fixed percentage of the Agency Rate), will be automatically updated within 28 days, or as specified by the Agency, ("Update Period") following publication of new Agency Rates with an effective date as published by the Agency. CCO will reprocess any claims at the updated contract rate.

3.5 Changes to Agency Payment Method. If the Agency changes the Payment Method set forth in this Appendix, CCO will make commercially reasonable efforts to implement new Payment Method within a reasonable time frame. Facility agrees it will accept the current methodologies as set forth in this Appendix, until CCO can implement the change in Payment Method. CCO will communicate the change and the effective date of the change.

If CCO is unable to incorporate all of the Agency Payment Method changes, CCO will notify Facility within 90 days after the Agency published the Payment Method change. The parties will negotiate an amendment to replace

this Appendix with an appendix with Payment Methods CCO can administer. If the parties have not reached an agreement within 90 days, either party may initiate dispute resolution according to the Agreement.

Ambulatory Surgical Center
Mississippi Medicaid
State Specific Payment Appendix

Ambulatory Surgical Center

Mississippi Medicaid

State Specific Payment Appendix

APPLICABILITY

Facility or Facilities subject to this Appendix as of this Appendix Effective Date: _____
Tax ID: _____
Provider ID: _____
This Appendix applies to the following types of Benefit Plans as described in the Agreement: • [Mississippi Medicaid Benefit Plans] • [Mississippi CHIP Benefit Plans] This Appendix does not apply to the extent another agreement or appendix between the parties or their affiliates specifically applies to a given Benefit Plan that would otherwise be subject to this Appendix.
This Appendix is effective for dates of service on or after: _____ Any prior Appendix applicable to the same Benefit Plan(s) are superseded by this Appendix.

Unless another appendix to the Agreement applies specifically to a particular Benefit Plan as it covers a particular Customer, the provisions of this Appendix apply to Covered Services rendered by or at Facility when it is acting as an Ambulatory Surgical Center provider to Customers with regard to Benefit Plans subject to this Appendix.

SECTION 1
Definitions

Unless otherwise defined in this Section, capitalized terms used in this Appendix have the meanings assigned to them in the Agreement. If any definition in this Appendix conflicts with another definition in the Agreement, the definition in this Appendix controls, with regard to Benefit Plans subject to this Appendix.

Agency: Mississippi Medicaid agency, responsible for sponsoring the Benefit Plans subject to this Appendix.

Agency Rates: The rates set by the Agency for Covered Services for the Payment Methods in this Appendix.

CMS: Centers for Medicare and Medicaid Services.

Customer Expenses: Copayments, deductibles, or coinsurance that are the financial responsibility of the Customer according to the Customer's Benefit Plan.

Eligible Charges: The Customary Charge for Covered Services, except for any Covered Services listed under Section 3.4 and 3.5 of this Appendix.

Institutional Claim: Any UB-04 or electronic version or successor form.

Invoice Cost: The manufacturer's invoice cost includes the manufacturer's invoice cost for the item and the allocated shipping and handling fees and taxes associated with the individual item.

Outpatient Encounter: Covered Services rendered to a Customer by Facility on an outpatient basis from the time of registration for outpatient services until discharge.

Payment Method: A methodology for determining contract rates under this Appendix. Unless otherwise specified in this Appendix, payment under this Appendix, less any applicable Customer Expenses, is considered payment in full for all Covered Services rendered to the Customer including (as applicable), but not limited to:

• Ancillary services
• Diagnostic and therapeutic services (including but not limited to diagnostic imaging)
• Durable medical equipment
• Medications
• Nursing care
• Observation
• Physician and other professional fees billed by Facility on an Institutional Claim
• Services rendered by non-Physician personnel (regardless of whether those personnel are employed by Facility and regardless of whether those services are characterized as professional services)
• Supplies (including, but not limited to, anesthesia supplies)
• Surgical services

Additionally, includes
• 23-hour care
• Extended recovery
• Post-surgical care
• Recovery care

Per Unit via Facility Fee Schedule: The Payment Method in this Appendix, based on the CPT/HCPCS specific fee listed in the applicable fee schedule for each unit of service and applicable to Covered Services rendered to a Customer for which a Per Unit via Facility Fee Schedule Payment Method is indicated in this Appendix. Facility is required to identify procedures by revenue code and CPT/HCPCS code to receive payment. The number of units for each procedure or service rendered will be billed in accordance with the guidelines in the latest edition of the Current Procedural Terminology (CPT) manual as published by the American Medical Association or the latest edition of the HCPCS manual as published by CMS. The units reported for Covered Services for which the contract rate is a Per Unit via Facility Fee Schedule must always equal the number of times a procedure or service is performed.

Physician: A Doctor of Medicine ("M.D."), a Doctor of Osteopathy ("D.O.") or another health care professional as authorized under applicable law and Facility bylaws to admit or refer patients for Covered Services.

Professional Claim: Any CMS 1500 or electronic version or successor form.

SECTION 2
Contract Rate for Covered Services

2.1 Contract Rate. For Covered Services rendered by Facility to a Customer, the contract rate will be the lesser of (1) Facility's Eligible Charges, or (2) the applicable contract rate determined in accordance with Sections 2.2, 2.3, 2.4 and/or 3 of this Appendix**.** Payment by CCO of the contract rate under this Appendix will be less any applicable Customer Expenses, and is subject to the requirements set forth in the Agreement.

2.2 Outpatient Procedures. This Section applies to Covered Services rendered by Facility to a Customer that involve an Outpatient Procedure, represented by a CPT or HCPCS code listed in the ASC Fee Schedule Exhibit (which is comprised of codes identified by Agency), performed in an ambulatory surgery center ("Outpatient Procedure"). For Outpatient Procedures rendered by Facility to Customers, the contract rates will be those set forth in Table 1. Facility is required to identify procedures by CPT/HCPCS code and bill on a Professional Claim form to receive payment. If a CPT/HCPCS code billed by Facility is not included in the codes identified on the ASC Fee Schedule Exhibit, it will not be considered for payment under this Appendix. Unless otherwise specified in this Appendix, payment under this Section, less any applicable Customer Expenses, is payment in full for all Covered Services rendered to a Customer during an Outpatient Procedure.

Table 1: Outpatient Procedures

SERVICE CATEGORY	PAYMENT METHOD	CONTRACT RATE AS OF THE EFFECTIVE DATE OF THIS APPENDIX	NEGOTIATED PERCENTAGE OF AGENCY RATE
Outpatient Procedures CPT or HCPCS codes listed on the ASC Fee Schedule Exhibit	**Per Unit via Facility Fee Schedule ID** # _____	**As calculated**	**[XX]% of the "Source Fee" as described in the ASC Fee Schedule Exhibit**

Fee Schedule Notes

Calculation of the contract rate for Outpatient Procedures is based on the following:

- Facility is required to identify procedures by revenue code and CPT/HCPCS code, and modifier code as applicable, to receive payment.
- The ASC Fee Schedule Exhibit was created based on Agency's Ambulatory Surgical Center Fee Schedule.
- The Per Unit via Facility Fee Schedule rates for existing codes are in effect until both parties mutually agree to rate changes.
- The ASC Fee Schedule Exhibit will be updated based on rates received from Agency. The contract rates will be set based on the same methodology used to establish the contract rates for the existing codes and will change due to a retroactive correction to the amount provided by the fee source. These changes will be effective on the same date the Agency rates become effective and any claims affected will be addressed.
- Unless otherwise specified, appropriately billed codes for a valid Covered Service that are not listed on the current ASC Fee Schedule Exhibit will not be eligible for reimbursement.

2.3 Multiple Outpatient Procedures. When multiple Outpatient Procedures are performed on a Customer by Facility during one Outpatient Encounter, the contract rate is as follows: (1) the highest contract rate specified in Section 2.2

Table 1 for which an Outpatient Procedure has been performed; plus (2) [XX]% of the contract rate specified in Section 2.2 for any additional Outpatient Procedure(s) performed during that Outpatient Encounter.

2.4 Separately Reimbursable Outpatient Medical Services/Supplies. The contract rate for Separately Reimbursable Outpatient Medical Services/Supplies that are Covered Services will be calculated as set forth in Table 2 and in addition to the contract rates set forth elsewhere in Section 2.2. Contract rates are subject to change according to the Notes to Table 2.

Table 2: Outpatient Medical Services/Supplies

SERVICE CATEGORY	PAYMENT METHOD	CONTRACT RATE AS OF THE EFFECTIVE DATE OF THIS APPENDIX	NEGOTIATED PERCENTAGE OF AGENCY RATE
Corneal Tissue HCPCS Code: V2785	**Invoice Cost**	**As calculated**	**[XX]% of Invoice Cost**

Notes to Table 2

- An itemized invoice must be included with the claim that lists the tissue cost and the transportation fees. Only the tissue cost is reimbursable. The fee for the corneal tissue must be included on the same Professional Claim form as the fees for the corneal transplant.

SECTION 3
Miscellaneous Provisions

3.1 Inclusive Rates. The contract rates established by this Appendix are all-inclusive, including without limitation applicable taxes, for the provision to the Customer of all Covered Services that are in the service category that corresponds to the contract rate and which are generally provided as a part of the service in the given service category. All items and non-Physician services provided to Customers at Facility must be directly furnished by Facility or billed by Facility when services are provided by another entity. For example, surgical procedures for implantable DME or for implantable prosthetic devices performed at Facility include the cost of the device in the contract rates listed in Section 2, as applicable. No additional payments will be made for any services or items covered under the Customer's Benefit Plan and billed for separately by Facility.

3.2 Payment Code Updates. CCO will update CPT codes, HCPCS codes, ICD-10-CM codes, or successor version, and/or revenue codes, according to Health Insurance Portability and Accountability Act requirements based on (a) the latest edition of the Current Procedural Terminology (CPT) manual which is revised by the American Medical Association, (b) the latest edition of the HCPCS manual which is revised by the CMS, (c) the latest edition of the ICD-10-CM manual, or successor version, which is issued by the U.S. Department of Health and Human Services, and (d) the latest revenue code guidelines from the National Uniform Billing Committee.

3.3 Facility-based Physician and Other Provider Charges. Facility will make its best efforts to assure that all Facility-based Physicians and other providers are participating providers as long as the Agreement is in effect.

At any time after the effective date of this Appendix, the current contract rates for all Covered Services under this Appendix will be reduced by CCO by [XX]% for each specialty type for which the Facility-based Physician or other provider group is not a participating provider (unless charges for the services of those Physicians or providers are included in Facility's charges under this Appendix). The reductions will be cumulative (so that if two Facility-based Physicians or provider groups are non-participating, for instance, the reduction would be [XX]%), as further illustrated in the Rate Reduction Table below. The reductions described in this paragraph will be implemented with 30 days written notice and would apply to claims for services rendered on or after the effective date of the reduction. These reductions will remain in effect until the Facility-based Physician or provider group becomes a participating provider or is replaced at facility by another Facility-based Physician or provider group that is a participating provider. CCO warrants that it will negotiate with each Facility-based Physician and provider group in good faith.

The following calculation will be used to determine the contract rates going forward to account for the percentage reduction:

Current Contract Rate (Current Contract Rate x Percentage Reduction) = New Contract Rate

Rate Reduction Table.

Facility-Based Physician Group	Contract Rates Reduced	Percentage Reduction
Anesthesiologists	All contract rates for Covered Services of any kind	[XX]%
Pathologists	All contract rates for Covered Services of any kind	[XX]%
Radiologists	All contract rates for Covered Services of any kind	[XX]%

3.4 Services Always Included Within the Contract Rate for Other Covered Services and Not Eligible for Consideration in Other Calculations for Payment.

Services or items listed in the table below and billed with indicated codes are not subject to additional payment and are not considered in any calculation for payment, including the calculation of "lesser of" determinations under Section 2.1 of this Appendix. When these services are Covered Services, per the Customer's Benefit Plan, Facility will not bill and collect from the Customer for the services, as prohibited under the Agreement. In these cases the contract rate applicable to the Outpatient Encounter is considered payment in full. However, when these services are not Covered Services, per the Customer's Benefit Plan, Facility may bill and collect from the Customer for the services, to the extent permitted under the Agreement.

Table 3: Services Always Included Within the Contract Rate for Other Covered Services and Not Eligible for Consideration in Other Calculations for Payment

Revenue Code	Description	Revenue Code	Description
0167	Self Care	0277	Oxygen/Take Home

Revenue Code	Description	Revenue Code	Description
0180-0189	Leave of Absence	0624	FDA Invest Device
0220-0229	Special Charges	0670-0679	Outpatient Special Residence
0253	Drugs/Take Home	0931-0932	Med Rehab Day Program
0256	Drugs/Experimental	0990-0999	Patient Convenience
0273	Supply/Take Home	2100, 2102, 2104-2109	Alternative Therapy Services

3.5 Services Not Payable Under This Appendix But May Be Payable Under Another Appendix To The Agreement Or Under Another Agreement.

Services or items billed with listed codes in the table below are not subject to payment under this Appendix. In the event Facility is a party to another agreement with CCO or an affiliate of CCO that is applicable to those services rendered to a Customer, or if another appendix to the Agreement applies to these services rendered to a Customer, the services below may be payable under that agreement or appendix. When these services are Covered Services, per the Customer's Benefit Plan, Facility will not bill and collect from the Customer for the services, as prohibited under the Agreement. However, when these services are not Covered Services, per the Customer's Benefit Plan, Facility may bill and collect from the Customer for the services, to the extent permitted under the Agreement.

If Covered Services with the listed codes in the table below are not subject to payment under another appendix to the Agreement or under another agreement, payment will be determined in accordance with CCO rules for providers that are not participating with Benefit Plans subject to this Appendix.

Table 4: Services Not Payable Under This Appendix But May be Payable Under Another Appendix To The Agreement Or Under Another Agreement.

Revenue Code	Description	Revenue Code	Description
0290-0299	Durable Medical Equipment	0650-0652, 0657-0659	Hospice Services
0362	OR/Organ Transplant	0660-0669	Respite Care
0367	OR/Kidney Transplant	0810-0819 w/o HCPCS Code V2785	Donor Bank/ Bone, Organ, Skin, Bank @
0512	Clinic – Dental Clinic	0882	Dialysis/Home Aid Visit
0513	Clinic – Psychiatric Clinic	0901-0907	Psychiatric/Psychological Treatments

0521-0522, 0524-0525, 0527-0528	Rural Health Clinic(RHC)/Federally Qualified Health Center (FQHC)	0911-0916, 0919	Psychiatric/Psychological Services
0550-0559	Home Health - Skilled Nursing	0941	Recreation/RX
0560-0569	Home Health -Medical Social Services	0944	Drug Rehab
0570-0579	Home Health – Home Health Aide	0945	Alcohol Rehab
0580-0589	Home Health – Other Visits	0953	Chemical Dependency (Drug and Alcohol)
0590	Home Health – Units of Service	0960, 0962-0989	Professional Fees
0600-0609	Home Health Oxygen	1000-1006	Behavioral Health Accommodations
0640-0649	Home IV Therapy Services	3101-3109	Adult Care

@ This Section applies when billed in conjunction with a transplant claim. If part of the care management of a transplant patient, this service will be treated as a transplant service and will not be payable under this Appendix. This service is payable under this Appendix only if it is a Covered Service and is not part of the care management of a transplant patient. When this service is not part of the care management of a transplant patient, this service is considered priced according to the terms of this Appendix. These services are part of the care management of a transplant patient, even if a Customer ultimately does not receive a transplant, if the services were part of the progression for a transplant, the patient was accepted for evaluation as a transplant patient, or if the service was covered pursuant to the Customer's transplant benefits under the applicable Benefit Plan.

3.6 Facility Reimbursement for No Cost Items. If an applicable program is available to provide items or payment directly to Facility for specific Covered Services for Customers subject to this Appendix that would otherwise be payable under this Appendix, the applicable program will apply and not this Appendix. However, related items for services not provided or paid under the program may be payable under this Appendix. (For example, the Campath Distribution program currently provides Campath (alemtuzumab) free of charge, and therefore no amount will be payable under this Appendix for Campath (alemtuzumab). However, the administration of Campath (alemtuzumab) may be payable under this Appendix, because payment is not provided to facilities under the Campath Distribution program.)

3.7 Changes to Agency Rates. Unless otherwise specified in this Appendix, contract rates based on Agency Rates (including a contract rate that is a fixed percentage of the Agency Rate), within 28 days, or as specified by the Agency, ("Update Period") following publication of new Agency Rates with an effective date as published by the Agency. CCO will reprocess any claims for which the Update Period is exceeded. CCO will reprocess any claims at the updated contract rate.

3.8 Changes to Agency Payment Method. If the Agency changes the Payment Method set forth in this Appendix, CCO will make commercially reasonable efforts to implement new Payment Method within a reasonable time frame. Facility agrees it will accept the current methodologies as set forth in this Appendix, until CCO can

implement the change in Payment Method. CCO will communicate the change and the effective date of the change.

If CCO is unable to incorporate all of the Agency Payment Method changes, CCO will notify Facility within 90 days after the Agency published the Payment Method change. The parties will negotiate an amendment to replace this Appendix with an appendix with Payment Methods CCO can administer. If the parties have not reached an agreement within 90 days, either party may initiate dispute resolution according to the Agreement.

ASC Fee Schedule Exhibit

As described on Table 1 of this Appendix, Outpatient Procedures, the contract rate is [XX]% of the "Source Fee" as described in the ASC Fee Schedule Exhibit, as noted under the column header "Contract Rate".

4.2.2.3 Care Management (Unmarked)

A. Care Management Proposal

1. Describe the Offeror's overview of its proposed Care Management Strategy, including the process and ...

Each individual is unique in their strengths, comfort and preparedness to address their physical and behavioral health. Our care management strategy is designed to **meet members where they are** in their personal health journey. All members will have a primary point of contact who is part of their care management team. These assignments will be made immediately upon enrollment. For most members, the initial assignment will be to a service navigator who will conduct needed assessments, such as the Health Risk Screening (HRS), and assist with accessing services and addressing any member-identified medical, behavioral health and social needs, including assisting with referrals to our care management programs for high- and medium-risk members.

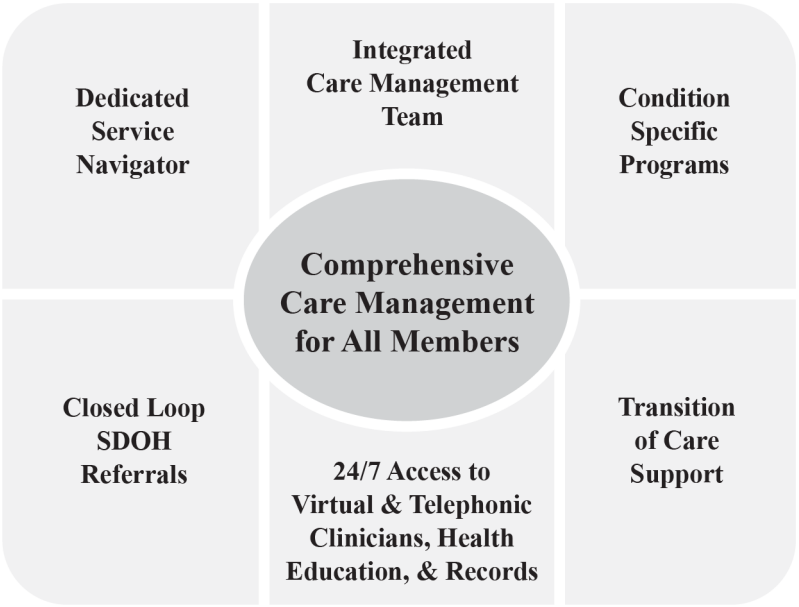


Figure 1: Comprehensive Care Management. Our teams work collaboratively with the Division, providers and members to increase access to high-quality care and improve population health outcomes.

We will use comprehensive assessments and person-centered, trauma-informed care planning to make sure services are directly linked to member needs. We will use a highly trained, skilled and experienced Mississippi-based care management team who will be prepared to work collaboratively with the Division, providers and members to achieve Mississippi's goals of increasing access to high-quality care, connecting individuals to needed services and improving population health outcomes. To achieve these goals, we will 1.) provide a supported health journey to all members, 2.) leverage data and information to build care teams that align with the member's goals and needs, and 3.) nurture local partnerships to confirm relevant and community-informed care management practices.

Dedicated to a Healthier Mississippi

We will monitor the effectiveness of our care management programs through performance measures aligned with the commitments above and overall outcome measures that tie to improved health and reduced health disparities, appropriate care utilization and improved and equitable member experiences. The following table summarizes our strategy for continued evaluation of processes and outcomes.

	Performance Measures	Outcome Measures
Provide a Supported Health Journey to All Members	▪ Health Risk Screening completion within 30 days (90 days at implementation) ▪ Comprehensive Health Assessment (CHA) completion within 30 days of HRS completion or high-risk identification ▪ % of members reached and engaged ▪ % of members with member communication preferences on file	**Improved Health and Reduced Health Disparities** ▪ Reduce preterm births and low-birth-weight babies ▪ Reduce severe maternal morbidity ▪ Timely initiation and increased continuation of anti-depressant medication ▪ Increase in HbA1c testing in members with diabetes ▪ Decrease ER utilization for members with asthma

	Performance Measures	Outcome Measures
Build Care Teams that Align with the Member's Goals and Needs	▪ % of member records with prioritized, member-centric goals ▪ % of members with a patient-centered medical home (PCMH) ▪ Improvements in HEDIS measures around timeliness of follow-up (seven-day follow-up, behavioral health 72-hour and seven-day follow-up)	**Appropriate Care Utilization** ▪ Decrease in inpatient admits ▪ Decrease in potentially preventable readmissions ▪ Decrease in ER visits ▪ Increase in % members with PCP annual visit ▪ Increase in timely prenatal care ▪ % of applicable members with medication-assisted treatment (MAT) scripts ▪ Decrease in behavioral health readmissions **Improved and Equitable Member Experiences** ▪ Increase in member satisfaction ▪ Consistently high member satisfaction ratings across race, ethnicity, gender, orientation and region
Nurture Local Partnerships	▪ % of members with SDOH screens ▪ % of SDOH referrals for identified needs ▪ % of closed-loop referrals ▪ % of warm handoffs	

In the following sections, we describe the commitments inherent in our care management model.

Provide a Supported Health Journey to All Members

All members can benefit from easy-to-understand information about their health and easy-to-access support when questions arise. For this reason, our care management model is designed to provide everyone, regardless of their enrollment in the MississippiCAN program or CHIP, access to:

- A Mississippi-based primary point of contact on their care management team who will support the member's care coordination needs across all benefits and available services, including providing closed-loop referrals and warm handoffs to address identified SDOH needs
- 24-hour online self-support access to personal member records and health education information
- 24-hour access to licensed clinicians for health and/or behavioral health-related advice, telehealth visits and crisis support
- Increased support to navigate transitions of care from inpatient or residential treatment to home or when a change of provider is needed
- Reminders and targeted member incentives to complete preventive care and encouragement to stay connected with their PCPs
- Spiritual care/chaplaincy services for members experiencing spiritual distress with the goal of reducing unnecessary hospitalizations and ER visits by addressing their spiritual needs

Use Data and Information to Build Care Management Teams

Using information gathered from Health Risk Screenings (HRSs), Comprehensive Health Assessments (CHAs), referrals (providers, partners, family) and our risk stratification tools, we will align the identified needs of the member with a primary point of contact who is appropriately equipped to serve the member. The comprehensive view will allow us to customize the care management team makeup, level and intensity of engagement and intervention based on condition profile, severity of illness, unmet needs and existing connection with care. Central to this approach will be a care management team and a sophisticated set of analytics, risk stratifications and a central care management platform.

Figure 2. Our Care Management Team. We customize the makeup of the team based on the needs of the member.

The care management team will include clinicians with physical health, behavioral health and pharmacy experience. In addition to licensed clinicians, the team will include nonclinicians, including peers and community health workers, and individuals with deep and direct understanding of and experience supporting Medicaid, behavioral health, housing and other social support programs. The care management team will include health plan leaders, provider engagement staff, service navigators and clinical program partners. It will include spiritual support and chaplaincy services to address members' spiritual care.

Our risk stratification tools will draw on medical, behavioral, pharmacy and SDOH data to identify diagnoses, impactable care management opportunities and SDOH. These opportunities will automatically feed into our care management platform with prompts that support the care management team when engaging with the member. Our risk stratification tools will be configured to identify any member who meets Mississippi's defined high-risk care management mandatory assignments, as outlined in Section 7.4.3.3.1 Mandatory Assignments of the Contract. Based on our work with members and communities in Mississippi, we will expand our high-risk criteria to include additional members for whom high-risk assignment is appropriate.

Nurture Local Partnerships

To support our members and support an efficient and effective program, we will work in close concert with state and local agencies, as well as state and local community-based organizations (CBOs), providers and stakeholder advisory boards for input on care management strategies and offerings.

Nurturing Local Partnerships

We will partner with Mississippi Serve as a vital resource for connecting members with needed services. We will deepen these relationships and support the growth of available resources locally. We are prepared to have over 100 local Mississippi organizations connected to our SDOH screening and referral tool in addition to national resources. Based on conversations with Mississippians and data available to us, we will invest in local CBOs to build school-based pantries, add food distribution sites in rural areas, purchase refrigerated mobile food trucks, provide doula support, train lactation support specialists, provide backpacks to foster youth, train behavioral health peer support partners in the community and provide iPads in schools to access medical and behavioral health appointments virtually.

Our care managers and service coordinators will have strong understandings of the geographic areas they serve and will develop relationships with local agencies that administer Women, Infants and Children (WIC), Supplemental Nutrition Assistance Program (SNAP), housing services, employment supports and other services. At the member level, we will confirm closed-loop referrals to these organizations. At a community

health level, we will collaborate with the Division's leadership to collectively impact the health of Mississippians.

Using a data-driven approach, we will inform provider partners on areas of opportunity at the member, health system, community and regional levels. Our PCPs and PCMHs will have access to gaps-in-care and SDOH data via our care management platform. We will bring tools such as remote patient monitoring into the hands of our network providers and advance quality improvement programs that support patient outcomes. For example, in another state, when faced with a rising number of pregnant members experiencing hypertension that complicated pregnancy and a COVID-19 pandemic that made trips to the doctor's office challenging, we worked with providers to build capacity for digital connection to prenatal care and remote blood pressure monitoring. When necessary, we will augment the existing local network with additional telemedicine capacity to meet unmet needs such as medication-assisted treatment and pediatric behavioral health support.

We will use member feedback to help understand preferences and experiences; verify access to the full range of covered services, inclusive of primary, acute, specialty, ancillary and behavioral health care; and identify opportunities for improvement and further development of local partnerships. Through member advisory boards, CAHPS® Health Plan survey, care management participant surveys and monitoring of our member satisfaction feedback and sentiments of members who call into our call centers, we will continually refine our approach to improve the way we serve our members.

Our Results and Experience

Advancing Population Health Outcomes

For more than four decades, we have had the opportunity to serve communities throughout the country in Medicaid managed care programs. This experience has led to a refinement in our approach, program design and engagement strategy to be the most effective with members to drive meaningful outcomes. In a similar state in 2021, survey data showed that 93% of members who received care management using our proposed process were satisfied or very satisfied with the service. **From 2018 to 2022, Medicaid and CHIP members enrolled in care management in our states experienced stable prescription refill rates while decreasing total cost of care (down 25%) and decreased ER visits 23%.**

We share the Division's perspective that care management should be member-centered, goal-oriented and culturally relevant, and we include logical steps to make sure a member receives needed services in a supportive, effective, efficient, timely and cost-effective manner. We have successfully achieved accreditation status from NCQA for our Medicaid health plans in multiple states. Our programs meet NCQA Distinction in Multicultural Health Care, demonstrating our commitment to providing culturally and linguistically sensitive services to reduce health care disparities. In 2023, we aim to hold full NCQA Health Plan accreditation and the Multicultural Health Care Distinction, which is being renamed by NCQA as Health Equity accreditation.

a. The challenges unique to the MississippiCAN and CHIP populations that the Offeror perceives and will ...

While there are unique challenges related to health equity and health care across the country, we understand each state, county and local community has unique needs and barriers. Through our Mississippi-specific research and analysis, we recognize the unique challenges of Mississippi — provider shortages that exacerbate health care access, systemic inequities that drive significant health disparities and severe socioeconomic pressures that contribute to a high chronic disease burden. Examples of these alarming disparities are that 9.2 babies per 1,000 live births die before their first birthday, 15% of Mississippians report having diabetes, 70% of Mississippians report being overweight and 82% of Mississippians report taking medication for high blood pressure. To close this disparity gap, our care management strategy will include building capacity to support access, advance healthy equity through humility and partnership and identify and eliminate inequities using patient-centered, integrated solutions to leverage resources specific to our member's health and social needs.

Building Capacity to Support Access

To provide services with cultural humility, our hiring strategy will focus on recruiting an inclusive local care management workforce that reflects and understands the diversity of our MississippiCAN and CHIP members. The local presence will enable us to meet with members face to face in their communities throughout the state. We will equip our care management teams with tools, such as our provider directory and our SDOH resource directory, to identify providers and CBOs who can meet our members' unique service needs, assist members in scheduling appointments and arrange for transportation to the appointment, as necessary.

Given the provider shortages in Mississippi that create challenges for members in receiving timely and effective health care, we are committed to bringing solutions that:

- Digitally connect members to care through telehealth partners, remote patient monitoring programs for diabetes, prenatal hypertension and other chronic conditions and the targeted provision of 4G/5G data plans and connected devices
- Enhance providers' capacity to meet care needs by providing PCPs access to pediatric behavioral health specialists, child psychiatrists and child psychologists for consults on behavioral health needs for their patients, payment for independent pharmacists to offer diabetic screening and reimbursement for and encouragement of pediatricians to provide varnish application when dental access is limited
- Identify and connect members to mobile care delivery opportunities within communities such as mobile mammography, mobile lab capacity and mobile vision/dental
- Provide telepsychiatry and other telemental health models to the state
- Promote and offer care through The Centering Pregnancy Model, which supports greater engagement with providers and care team for pregnant members by leveraging group visits and prenatal support

Advancing Health Equity through Humility and Partnership

Black, Indigenous and People of Color (BIPOC) experience health inequities due to systemic drivers that disproportionately negatively affect the level of stress, quality of care, levels of distrust and access to services they experience. Mississippi experiences significant health disparities in diabetes, childhood asthma and infant mortality. However, communities across the state are resilient, knowledgeable and rich with passion to improve quality of life for those around them. Given these realities, we will:

- Build, track and report on partnerships, programs, investments and outcomes about health equity progress on diabetes, childhood asthma and infant mortality
- Provide comprehensive training for all care management team members that focuses on trauma-informed care, race trauma and health equity, cultural competency and nondiscriminatory care management
- Hire and invest in a workforce in Mississippi that represents the population we will serve, and build career pathways for Mississippians from all communities, races and ethnicities to support long-term capacity for the health care workforce locally. This includes our plans to employ Mississippians and invest in tuition assistance. Similarly, we commit to working with local community colleges to support apprenticeship programs to train community health workers, pharmacy technicians, insurance navigators, health care advocates and health care educators. Graduates can enter the local workforce or become our community-based employees

Addressing Socioeconomic and Environmental Factors

Structural, socioeconomic and environmental factors underlie and affect individual- and population-level engagement with the health care system and health outcomes. With roughly 20% of the Mississippi population living below 100% of the federal poverty level, 27% of children and over 30% of Black Mississippians living below poverty rates, the Division and its partners must collaborate to build holistic community strategies within the context of the resources and pressures in the community. Whether it is responding to the COVID-19 public

health emergency, addressing the frequency of severe weather events or accounting for poor water quality in a community, our approach to serving members must adjust accordingly.

To make sure our health plan operations, care management interventions and our communities are prepared for the economic and environmental pressures, we will:

- Hire population health and equity leaders whose training and expertise are focused on accessing, engaging and designing community solutions to address pressing population health needs, including socioeconomic and environmental factors such as housing instability, food insecurity and transportation
- Deploy predictive analytics tools and community data tools that can be layered into our member identification and risk stratification to account for members' personal and community needs
- Partner with community stakeholders to review and understand how data and analytic insights can inform how we engage partners and invest in our community
- Hire an SDOH manager whose experience in these non-health-care-related fields augments the physical and behavioral health expertise of the care team. This person builds relationships with the housing community and works directly with members to secure and support housing placement.
- Use our SDOH screening and referral tools to support the member and care management team in identifying available resources and providing a closed-loop approach to make sure members receive the services.
- Deploy an emergency outreach program to efficiently outreach to members during emergency events, such as hurricanes. The program will leverage geographical information system analytics to streamline identification of members who are at risk due to the emergency event, allowing us to reach members faster, provide them more time to respond to the event and provide them rapid support pre- and post-disaster.

b. How the Offeror plans to ensure that closed-loop referrals and warm handoffs are executed and sufficiently ...

Our care managers and service navigators will be equipped with care management platforms and directories to support closed-loop referrals and warm handoffs. Using our community-based referral platform, we will refer MississippiCAN and CHIP members to culturally appropriate local resources to address their SDOH needs and know when social services have been delivered. Our SDOH resource directory and social care tool will be available in 130 different languages, use a closed-loop network model, allow for the ability to text and email referral information directly from the application and include a member-facing website for self-referral.

Our care management platform will be set to automatically remind the care manager to perform follow-up outreach with the member within seven calendar days of the referral. During that outreach, we will confirm the referral met the member's need, discuss any questions or challenges the member may have in using the referral and work to resolve any barriers. Depending on the barrier, we may engage our SDOH manager, community health workers or peer support specialists to support the member in accessing services. Our care management platform will facilitate care team collaboration and allow us to inform PCP and PCMH providers of referrals made so they can document in their own records.

To demonstrate to the Division the level of support and the diversity of our network of partners, we will create a Care Management Partnership and Referral Report detailing partner agencies and community agencies we will use in its care management strategy. This list will include relationships with both state and local agencies, as well as state and local CBOs for both input on care management strategies and for referral of members for services.

For our referral partners, we will implement a partnership agreement that supports the implementation of coordinated, culturally competent care strategies and includes all protocols as outlined in Section 7.2 Care Management Partnerships of the contract.

c. How the Offeror will ensure that Care Management is a tool to address health equity concerns;

We are committed to improving outcomes and identifying, addressing and mitigating health disparities and structural inequities affecting MississippiCAN and CHIP populations. Our aim is to understand, support and amplify the efforts already underway in Mississippi and to directly impact change for the MississippiCAN and CHIP populations. **We will use a four-step process for achieving health equity through clinical and community interventions.**

Identify and Define: Care management and related services are essential to advancing health equity through individual interactions with members and directed investments in local and national efforts. We will identify disparities affecting our members and communities through data sources, including claims, assessments (e.g., HRS, HRA, CHA), HEDIS, internal data tools and publicly available resources, such as U.S. Census Bureau, Mississippi Division of Medicaid, Department of Mental Health and Health Department reports.

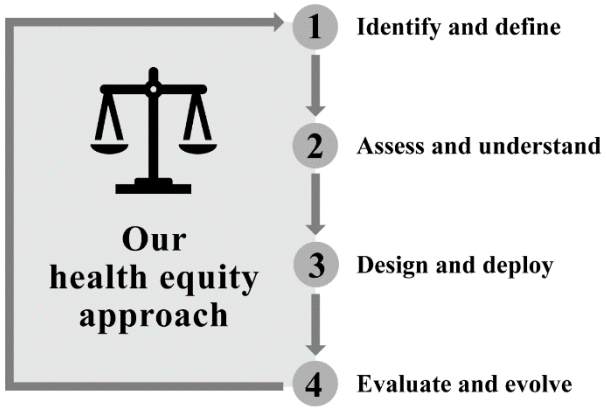


Figure 3. Our Health Equity Approach. Our four-step process for achieving health equity through community-based interventions to meet members where they are on their health care journey.

Assess and Understand: Our Health Risk Screening and comprehensive assessment processes will collect communication preferences — including pronouns and self-described identity factors such as gender, sexual orientation, race, ethnicity and other important identity components — and the member's perspective on how those factors influence their health and health care services. We will use this information to confirm our engagement honors and respects the member and their experiences.

Design and Deploy: We will collaborate with state and local partners, CBOs, providers, members and other CCOs to design and implement community-based interventions. These interventions will seek to address the complex roots of inequities by empowering members and families, advancing health system change and engaging communities.

Evaluate and Evolve: Finally, we will use a rapid-cycle approach to continuously evaluate and enhance our strategies, sustain action and improve outcomes. Our population health director and health equity director will work collaboratively to assess the impact and continuously improve our interventions through tracking of process measures (e.g., number and percent of members reached/engaged) and outcome measures (e.g., number of individuals/families housed, pre/post utilization).

In 2021, our SDOH initiative has committed more than $8 million to communities across the country who are building partnerships between public housing agencies and local providers to address childhood asthma in public assisted housing. This initiative is the evolution of efforts we have executed in five other states with community, family and individual needs similar to those faced by Mississippians. We executed data sharing agreements with public housing agencies, cross matched our membership, analyzed data to identify pressing community health issues and jointly worked to design interventions.

d. Creative methods to engage difficult to reach populations or Members who are unresponsive to outreach ...

Meeting members where they are in their health care journey means understanding their barriers to and preferences for communication and adjusting accordingly. When varying times of engagement, modalities of outreach and leveraging nonclinical peers and community health workers are not enough to get members connected and engaged in care management, we will:

- **Seek new contact information.** Outreach to providers and pharmacies to capture additional member current contact information. When we reach a household and the member is known but no longer residing at that location, we will collect any potential contact information volunteered by the household. We will document and use alternate contact information to reach the member.
- **Go to hospitals, shelters or other known locations.** When possible, we will use admissions or other real-time utilization data and established relationships that may indicate when members are in a location where they will likely remain for hours or days. Although the events that lead them to these locations are not ideal, they create an opportunity to engage and move forward with connection to our case management team.
- **Engage through providers.** We will outreach to pharmacists, behavioral health, durable medical equipment or PCPs/PCMHs when there is a member who is accessing some health care services, but who may be missing other care or support that is needed. We will share with the provider, who we are trying to reach, how we will support them once we engage and a primary point of contact for the member or provider to get connected with our care teams. In our experience, we have had success partnering with pharmacists to conduct HRS at the point of medication pick-up. We propose using a *member engagement bonus (APM 2c value-based payment)* for PCPs. In this program, PCPs would be rewarded for improving access to preventive care by engaging hard-to-reach members, getting them in for an annual visit and addressing care opportunities, including annual screenings and immunizations.

In one state, the 834 enrollment file from September 2019 indicated only 32% of new members had an address and 38% had a phone number. We analyzed data from network providers, subcontractors and internal service coordination and call center teams, which allowed us to significantly increase member engagement by obtaining correct contact information — **about 95% of our members now have a verified address, and 66% have a verified phone number**. We will use similar creative approaches and lessons learned from our health plans across the country to effectively connect with MississippiCAN and CHIP members.

Upon successful contact, we will help the member better understand the importance of providing current demographic information to the state and will collect a current mailing address, phone number(s) and email address. For members without phone service, we will connect them with cellphones and coverage so future connections are easier for the member and care manager.

Members Declining Participation in Care Management

We respect members' preferences, so we meet them on their own terms and always offer friendly low-barrier ways for them contact us and engage in their health care. Our local CHWs will use their knowledge of local communities to locate and engage members, establish relationships, connect members to their PCP or PCMH and remove barriers to care. The CHW will personally interact with the member to identify and resolve barriers that may be preventing a member from engaging fully in their care.

Our care management teams will use inquiry and motivational interviewing during conversations with the member. Members will be provided call center information and a primary point of contact, should they want to engage. Our care management team will reach out to providers serving members who have declined care management. This outreach will be an opportunity to share our observations and concerns so that the provider can help address the member's needs. We will inform the provider of the services available to the member through the health plan and note that if the provider identifies opportunities for the care management team to support the member, they can contact the care management team at any time.

e. The Care Management services the Offeror expects to provide by risk level (e.g., low, medium, high).

Our care management model will be tailored to the unique program design articulated by the Division and augmented by our own observed trends. In alignment with the service requirements outlined in the model contract, we will implement a three-level care management framework that meets members where they are in their personal health journey. Regardless of risk level, our care teams will focus on engaging members to drive

their health, connecting them with appropriate care and removing barriers that affect their ability to access the services they need to lead healthier lives.

Support for All Members

All members enrolled in our plan will have outreach from our plan encouraging completion of a HRS within 90 days of contract implementation or within 30 days after health plan enrollment, self-referral or provider referral for those enrolling after the initial contract implementation period. For members for whom the HRS reveals medium- or high-risk need, the member will work with a care management team member to complete a Comprehensive Health Assessment (CHA). During the CHA, the member will be asked to share about their physical, behavioral, social and environmental needs. The member will be supported through the screening process by team members trained in motivational interviewing and trauma-informed care to make sure preference, identity and health care experiences are honored and respected. If the member shares a need or goal that could be supported by a connection with a community partner, state agency or provider, the care management team member will facilitate a warm connection to appropriate resources. The timely, efficient and personal connection to these services, followed by monitoring that confirms the services were provided (closed loop), is of critical importance to the member and their health.

Our predictive analytics tool analyzes membership using data at the individual (conditions, inpatient and ER utilization, pharmacy utilization, SDOH needs) and community level (environmental, ZIP code) to produce a risk score. This risk scoring, combined with the details from the member's responses to screenings and assessments, will be used to create a comprehensive view of the member's risk profile, applicable programs and actionable opportunities for care management. Members' files will be updated in our care management platform to reflect the clinical program referrals and recommended assignment to care management team members. All members will be assigned to a care management team and have access to our member services call center. We will meet all contractual requirements as outlined in Table 7.1 of the model contract.

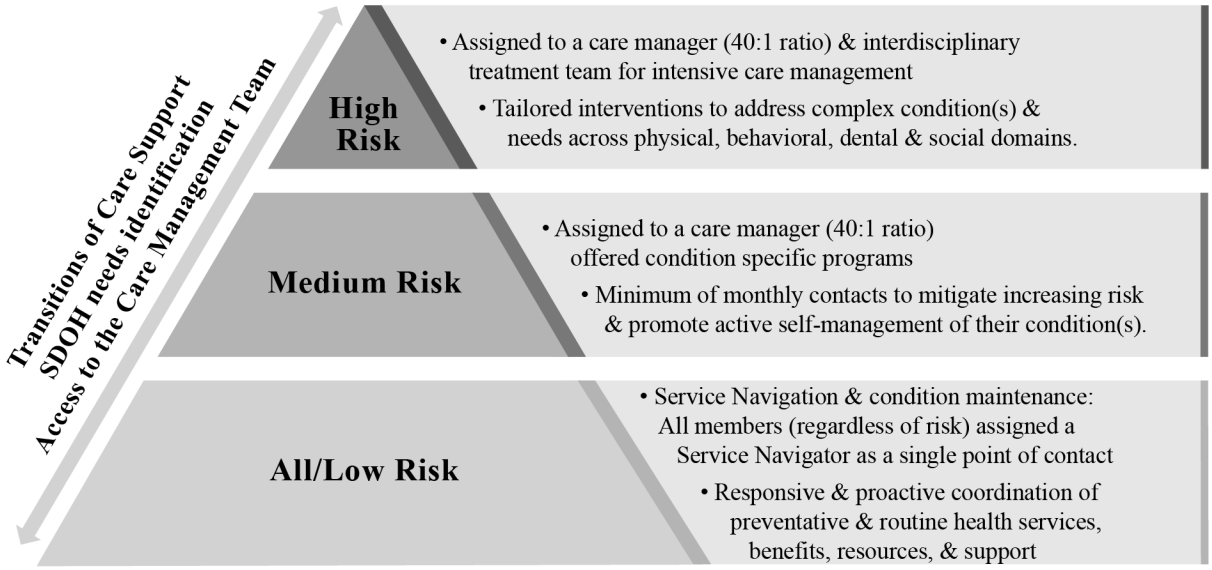


Figure 4. Health Pyramid. Our approach to member outreach and engagement.

Tools, Processes and Procedures

Across our states, our strong care management teams have extensive experience in physical, behavioral and social support programs. We have augmented this experience with tools, processes and procedures that support consistent but customizable member-centered experiences. Taken together, these assets make sure that: All members and/or authorized family or guardians are involved in treatment planning, as appropriate, pharmacy utilization data is used to tailor care management services, closed-loop referrals and warm handoffs to

specialists and sub-specialists are made consistently, documented in medical records and followed up on, all urgent care, emergency encounters and any medically indicated follow-up care is documented in the member's medical record, changes in PCP or PCMH trigger a review of and revision to treatment plans and referral services, continuity of care is maintained when a provider is no longer available.

Monitoring and Easy Escalation for Members at Medium Risk

Members we will stratify into the medium-risk level have medical or behavioral health needs that suggest emerging risk for increased utilization of services and poor outcomes. These members may have multiple conditions or life circumstances that make it difficult for them to consistently access and engage in services. Our goal for care management will be to provide integrated coordination across providers and ongoing support to make it easier for members to get the care they need, mitigate risk and promote self-management strategies.

After completing a CHA, the member and care manager will discuss referrals and connect the member with necessary appointments and resources. Members in the medium-risk level will work with their care manager on the maintenance of a recovery and resiliency plan if appropriate to their condition and goals. The member and care manager will collaborate on relapse prevention plans, particularly for those with substance use disorders, depression or other high-risk behavioral health conditions. Specific programs and monitoring tools will be used by the care manager and the member to monitor conditions, behaviors or unmet needs. At least monthly the care manager will outreach to the member to ensure that needs are being met. Members in the medium-risk care management programs will receive the services outlined in Section 7.5.2 of the Model Contract. Care managers will be supported by the care management team, including service navigators, leaders, CHWs, peer support specialists and local and national subject matter experts.

Targeted Support for Members at High Risk

When a member is identified for high-risk care management, they will be assigned a care manager with expertise aligned to their condition, location and other needs. Our Mississippi-based care managers will be staffed 40:1 care management ratio, trained and equipped to address the needs of high-risk members. Specialized care management expertise includes, but is not limited to, pregnancy, care of the chronically ill, children and youth in foster care, behavioral health and substance use disorders, and children with special health care needs. Members who are part of Mississippi's Native American community will be assigned to a care

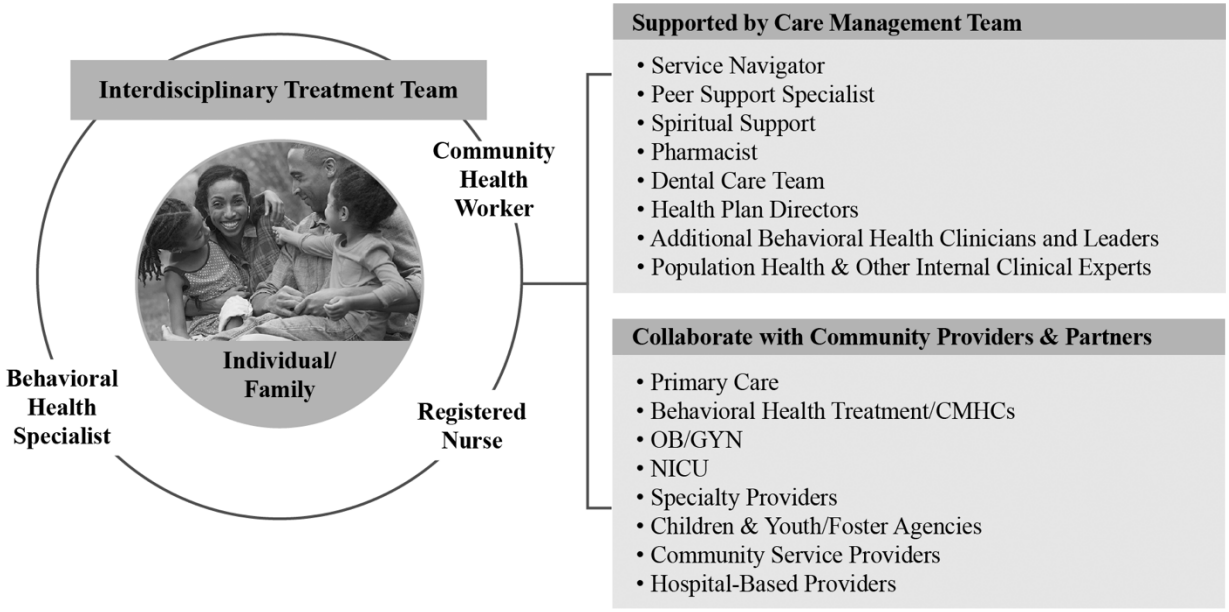


Figure 5. Interdisciplinary treatment team. The ITT wraps around the member through an integrated approach and enables continuous member feedback.

manager trained and equipped to address their needs. The care manager will reach out to the member to introduce the program, complete the CHA and learn about their goals and any unmet needs. This assessment will form the foundation of the action and goals-oriented treatment plan that will be maintained in our care management platform and made available to the member through their member portal and their PCP. Care managers will inquire about member's communication and meeting preferences, access to technology for virtual visits, others to be involved in their care management experience and their priorities for improving chronic conditions and reducing risk for health decline. Based off the initial conversations, the care manager will build an interdisciplinary treatment team (ITT) that aligns with the behavioral, physical or social health needs and goals of the member.

Care managers will meet with members at least monthly to facilitate progress on individualized treatment plans and provide the services outlined in Section 7.5.3 of the Model Contract. As part of the person-centered treatment planning, care managers will work with members to identify gaps in knowledge or understanding on topics related to their conditions, unmet needs and when and how to connect with providers or emergency support services. The care manager and member will identify changes in symptoms, signs of distress or environmental triggers in a way that empowers the member to prepare for these occurrences, anticipate increasing needs and seek care before a crisis occurs. The member and care manager will document a plan for responding to symptom exacerbations, preferred interventions and communication strategies to share with natural and family supports, health care and service providers.

B. Stratification and Assignment

1. Describe the Offeror's proposed initial Health Risk Screening (HRS) for new Members, including ...

The initial Health Risk Screening (HRS) will be conducted during our welcome call and is the first engagement with members. The goal of the initial call is three-fold:

1. Begin establishing trust and rapport with the member
2. Collect member information that will result in the service navigator addressing the member's highest priority needs either through referral, service connection or benefits education
3. Accurately assign risk stratification levels (e.g., low, medium, high) for members, including those who may have limited utilization history, undiagnosed conditions or emerging SDOH needs

Questions from Health Risk Screening

To meet and exceed NCQA standards, our care management teams will use a custom HRS that includes our standard health screening questions and additional questions covering identity factors for adults and children, experiences related to health equity and access to basic necessities. The HRS is particularly focused on capturing the member's description of their health, their known chronic conditions, their hospitalizations in the past year and the number of medications they are prescribed. This screening will be adapted for age-appropriate questions for the MississippiCAN program and CHIP and will include physical, behavioral, social and functional needs. A complete list of the proposed HRS for adults and children is available as **Att. 4.2.2.3-1 HRS Questions.** Sample questions include:

- **Adult HRS:** Compared to others your age, how would you describe your health? Have you been told you have any of the following, or are you being treated for any of the following? (List high-risk conditions.) Within the past 12 months, how many times have you stayed overnight in a hospital? How many different kinds of medication do you take each day?
- **Pediatric HRS:** Does your child have any of the following or is your child being treated for any of the following? (List several conditions.) If 11 years or older, is your child currently pregnant? Does your child currently need or use medicine prescribed by a doctor (other than vitamins)?

- **SDOH and Nonmedical Factors:** What is your housing situation today? Are you worried about losing your housing? In the past year, have you or any family members you live with been unable to get any of the following when it was really needed — food, utilities, medicine or health care, phone?

Methods for Seeking Answers

Our service navigators conducting the HRS will use motivational interviewing strategies and scripts that establish trust, demonstrate empathy and ultimately identify opportunities to develop a relationship and resolve barriers. For members who prefer, the HRS will be available via a secure web portal or through paper mail-in forms. We will work with providers to incent the completion of HRS for members in their care.

Answers Used for Identification and Escalation

Member responses to the HRS will be captured in the care management platform and will be used in the identification and stratification process. Key data points will inform our stratification algorithms and result in recommended care management programs when applicable. While the service navigator will address the most pressing needs during the initial call, the member may note other clinical needs or questions that will be captured for the care manager (for medium- and high-risk members) to address during the comprehensive health assessment and individual treatment plan development. Some answers to HRS questions will result in immediate escalation to a care manager for medium- or high-risk interventions, including those that indicate the member as having one of the conditions requiring mandatory assignment outlined in 7.4.3.3.1.

2. Describe the Offeror's proposed method(s) for the Comprehensive Health Assessment (CHA) of Members ...

Our CHA will be a member-centric, conversational tool that exceeds NCQA and Division specifications and validates findings from the HRS and the risk assessment tool; identifies immediate member needs to support safety, security, health and physical, mental or emotional wellness; and helps build the member's individualized treatment plan reflective of their natural supports, strengths, priorities, values and goals.

Questions from Comprehensive Health Assessment

Our custom comprehensive assessment tool will exceed NCQA and Division specifications and cover the domains in the following table. A complete list of the proposed CHA for adults and children is available as **Att. 4.2.2.3-2 CHA Questions.**

Adult CHA Domains and Sample Questions	Pediatric CHA Domains and Sample Questions
▪ Health Goals, Interests and Questions ▪ Demographic Information – including, but not limited to, ethnicity, education, living situation/housing, legal status, employment status, preferred language, literacy ▪ Physical Conditions – severity, disease state, comorbidities, or complex conditions ▪ Behavioral Health Conditions – severity, disease state, comorbidities or complex conditions, PHQ-2 and AUDIT-C ▪ Social Needs and Support System – housing, food, transportation, safety, social isolation, literacy ▪ Functional Strengths and Limitations – activities of daily living, instrumental activities of daily living ▪ Access to Care – current treatment providers and treatment plan, recent treatment history, review of prescriptions ▪ Health Literacy – understanding of conditions, questions ▪ Communication Preferences – text, email, phone, virtual ▪ Readiness to Engage	▪ Health Goals, Interests and Questions ▪ Demographic Information – including, but not limited to, ethnicity, education, living situation/housing, legal status, employment status, preferred language, literacy ▪ Parent/Guardian perception of child's health ▪ School, Education and Special Education ▪ Health Goals, Interests and Questions ▪ Cognitive and Developmental Needs and Care ▪ Functional Strengths and Limitations – activities of daily living, instrumental activities of daily living ▪ Behavioral Health Needs (including trauma, mental health, substance use), Services and Treatment ▪ Physical Conditions –physical health and wellness severity, disease state, comorbidities or complex conditions; Preventive and Primary Care and Wellness ▪ Housing/Physical Environment ▪ Quality of Life and Caregiver Support ▪ Social needs and support

We will rely on a maternity-specific comprehensive health assessment for individuals enrolled in our perinatal care management program that covers the unique medical and social factors experienced during pregnancy. Similarly, we will use a specialized comprehensive assessment tool to serve children and youth in foster care. In addition, our care teams will have a suite of appropriate supplemental screening tools that can be used based on the member's specific needs. Examples include CSDC-SF, CSHCN, PSC-17, PEARLS Questionnaire, and CRAFFT, and the Adverse Childhood Experiences Survey.

Methods for Seeking Answers

To support successful completion of CHAs, our care managers will:

- **Come Prepared:** Before outreach, the care manager will review the information from the HRS, available member medical record, including recent treatment history, ER, urgent care or inpatient admissions, current medications and gaps in medication refills, current providers and treatment plan, if available, and any additional risk stratification information available in the care management system. Available information may include data on time since last PCP visit, prescription history, likelihood to be admitted to inpatient facility and drivers of utilization costs (pharmacy, behavioral, medical).
- **Help the Member Prepare:** The care manager will reach out to their assigned medium- and high-risk members to coordinate the completion of the CHA within 30 days of completing their HRS or from time of identification as medium or high risk. The care manager will share details about the CHA, answer any questions the member may have and schedule a day and time to begin working together on the CHA. The care manager will offer the member the option to meet in person or telephonically. The care manager will note that the member should invite caregivers or trusted individuals who could help them feel most comfortable in completing the CHA.
- **Make the Member Comfortable:** Our care manager trainings, processes and procedures will train care managers to be respectful of member preferences, family dynamics and cultural practices when entering members' homes, meeting them in the community or connecting virtually or telephonically. The CHA can be done in multiple sittings. Our care managers will watch for signs that members are emotionally, mentally or physically fatiguing during the CHA to break or reschedule as needed.

Stratification and Treatment Plan Development

The care manager will capture the member's responses to the CHA in our care management platform. Leveraging the clinical insights of the care manager with the data-informed member record generated from our predictive analytics tool, the care manager will make a recommendation for the level of care management needed to support the member in their health journey. The care manager will look for actionable care management opportunities where interventions will support the member in driving their care, receiving appropriate care or accessing needed services. For those members who require high-risk care management, the findings from the CHA will inform the development of a member-specific interdisciplinary treatment team (ITT) who will consult with and serve the member.

The CHA will be used to develop an initial treatment plan. Our care management platform will generate recommended goals that are specific, measurable, attainable, relevant and time-bound (SMART) based on the member's responses. The member (and family or caregivers as appropriate) will review, revise and approve the treatment plan within 30 calendar days of the completion of the CHA. At the member's discretion, we will seek insights from treating providers and share the finalized treatment plan.

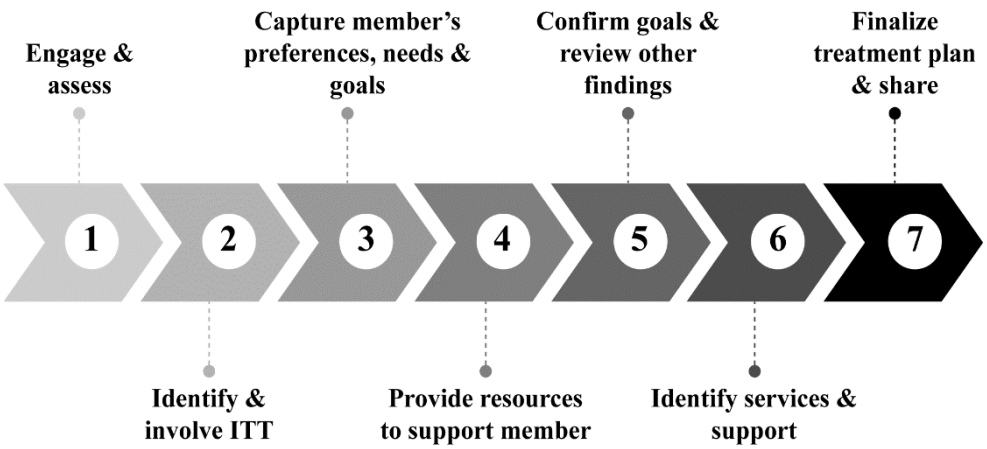


Figure 6. High-Risk Care Management. The CHA informs the development of the treatment plan with input from the member, their family and the ITT.

3. Describe the Offeror's proposed method(s) for reassessment of Members during the life of their enrollment ...

Reassessments and monitoring of service utilization are central to our commitment to provide person-centered, effective and timely care tailored to each member's evolving circumstances. Information gathered during the assessment and reassessment will enable our team to collaborate with members and adjust their plans for treatment and services. We will use reassessment opportunities to build on previously completed assessments and ask for updates or emerging needs.

We will use both systematic and ad hoc reassessments. Systematic reassessments will occur monthly through an analytic review of claims data and scheduled reassessments based on protocols aligning with member risk-level assignment. Ad hoc reassessments will be triggered when a member reports or data shows significant life events, inpatient admissions, provider, care team or community referral.

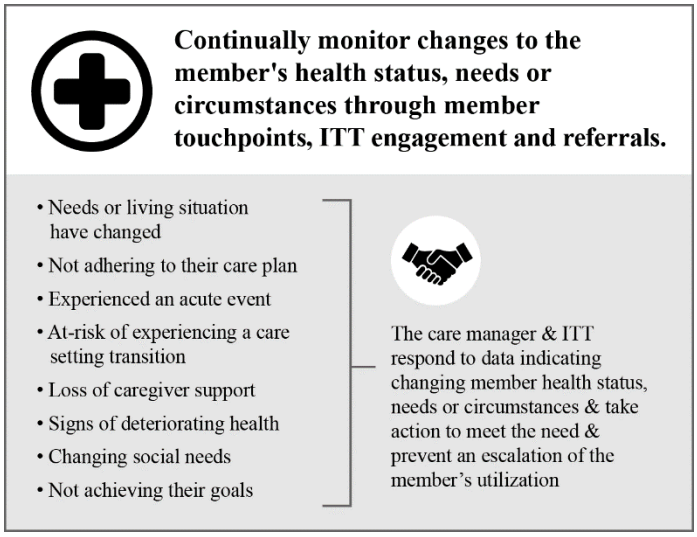


Figure 7. The reassessment and follow-up process makes sure changes or new needs are accounted for and addressed.

At minimum, we will update treatment plans annually; however, members engaged in medium- or high-risk care management will have more frequent reviews and updates as they achieve goals, have changes in priorities or experience a change in their condition or situation, as detailed in the following reassessment schedule:

Risk Level	Minimum Member Connection	Reassessment	Treatment Plan Review and Update
High Risk	Biweekly	Monthly risk stratification, evidence-informed protocols for condition-specific assessments, post-discharge assessment	Monthly
Medium Risk	Monthly	Same as high risk	Semiannual
All/Low Risk	Annually	Monthly risk stratification, annual HRS, service navigator review of automatic alerts, referrals, admissions	As needed or following transition of care from inpatient setting or PRTF

4. Describe any other methods the Offeror uses to identify Member acuity levels for assignment and Care ...

Predictive Modeling Informs Care Coordination

In addition to the clinical conditions outlined in the model contract, we will add enhancements to further detect members who need the most intensive involvement. Our predictive modeling system scores two categories of risk to determine an overall risk level:

- **Clinical Risk Factors:** Identifies members who are either high complexity or high risk or rising risk. Clinical risk factors account for multiple chronic conditions, mental health or substance use disorders, multiple prescriptions or high health system utilization, among other factors.
- **Actionable Factors:** Identifies opportunities for care management to positively influence member health behaviors and close gaps in care. Some examples include documented diagnoses that are not matched to claims showing engagement in evidence-based treatment (e.g., OUD without evidence of MAT), potentially receiving care that is wasteful or overly complicated or has other contributing social or environmental circumstances.

Additional Tools to Identify Individuals for Care Management

We will use a variety of tools and methods to help identify and stratify members and connect them to the appropriate tier of care management. These tools and reassessments will consider changes in condition, need and health status. Our primary identification tools will include:

- **Special Health Care Needs Reporting – Historical Claims Data:** We will use monthly reporting designed to capture data for those meeting the definition of members with special health care needs. Reporting will be based on ICD-10 codes in historical claims data and cross referenced with our predictive analytics data tool. These files will be updated monthly and reviewed by clinical leadership in Mississippi.
- **Hotspotting:** Our Hotspotting tool identifies cohorts or location-based concentrations of members with specific needs and patterns of high utilization of acute and emergent health care services, informing member-level identification, program enhancement and intervention design.
- **Geospatial Analysis:** We will employ geospatial mapping capabilities that overlay social determinant data with member addresses. The resulting map will allow us to observe population clusters with drilldown capabilities to the member location. This capability will provide insight on how to overcome disparities that may be associated with environmental factors such as pollution, flood zones and natural disasters.
- **Referrals:** We will encourage referrals from members, families, providers of all types, state agencies, community organizations and partners, and other company departments, including member services, utilization management and grievances and appeals. We will receive referrals through prior authorizations (e.g., PDN, PDHC and PCS) and staff interactions with community-based providers and institutions (e.g., PCPs, housing agencies). These tools will be continuously updated as referrals come into the health plan.

5. Describe how the Offeror will integrate Social Determinants of Health, health equity evaluations, and other ...

Care team members will address nonclinical questions (including demographic, identity and unmet social needs) as part of the HRS and CHA. In addition, care managers will have access to the PRAPARE® tool to assess a member's SDOH needs more thoroughly should such a need be uncovered in the HRS or CHA. PRAPARE is in use in numerous provider practices. We will make sharing PRAPARE assessment data easy for PCP offices and make sure our care management teams use the data to inform member engagement strategies, treatment planning and resource referrals as appropriate. The domains covered in each of these primary screening and assessment tools are outlined in the following table.

Screening Tool	Domains Included
Pediatric & Adult Health Risk Screening (HRS)	▪ Ethnicity and race, gender identity, sexual orientation ▪ Impact of race, ethnicity, gender identity and culture on health care experience ▪ Access to basic necessities, including food, clothing, medicine ▪ Housing instability and safety
Comprehensive Health Assessment (CHA) **Pediatric** **Adult** **Maternity** **Foster Care**	▪ Access to basic necessities, including food, clothing, medicine, transportation ▪ Impact of race, ethnicity, gender identity and culture on health care experience ▪ Care giving, familial and other social support ▪ Housing stability ▪ Neighborhood safety, other social stressors such as exposure to violence or other adverse factors in the home environment ▪ Education and military service ▪ Preferred language and communication capabilities
PRAPARE	▪ Access to basic necessities, including food, utilities, clothing, medicine, phone ▪ Housing instability and safety ▪ Transportation access ▪ Personal safety ▪ Criminal justice system involvement

C. Care Management Services

1. Describe the Offeror's proposed policies, procedures, and processes to conduct outreach to ensure that ...

Our care management team will follow policies, procedures and processes to engage members in preventive and medically necessary follow-up care. The most comprehensive and effective way to engage members in care requires a combination of population-based wellness awareness efforts, member-specific outreach processes and provider-enabled engagement strategies. Together, these strategies will heighten members' awareness of recommended preventive care and specific preventive care and medical follow-up needs. The following is a snapshot of our outreach efforts within each strategy.

Population-Based Wellness Awareness Efforts	Member-Specific Outreach	Provider Enablement and Partnership
Each communication channel will provide regular content focused on timely wellness: ▪ Member materials and handbooks ▪ Quarterly member newsletters ▪ Community health events	Triggered by data in our care management platform and quality reporting systems that note gaps in care, members will receive individualized outreach through: ▪ Mailings, emails and member portal communications ▪ Automated and live telephone outreach ▪ Care manager or service navigator outbound call	Each of the following tools will be targeted to encourage gaps in care closure: ▪ Sharing HEDIS analytics for patient panel ▪ Provider performance scorecard ▪ Provider portal with member gaps in care noted

Population-Based Wellness Awareness Efforts	Member-Specific Outreach	Provider Enablement and Partnership
▪ Community health initiatives with community-based partners	▪ Face-to-face engagement with CHW/care manager, peer support or other care team member ▪ Member incentives programs	▪ PCMH and CMHC case consults for medium- and high-risk members ▪ Quality incentive programs

These outreach efforts have collectively supported improvements in the way members experience and access care, as shown in the following improvements from 2018 to 2020 among members in states similar to Mississippi:

- Antidepressant Medication Management (effective acute phase) **improved by 31.94 percentage points**
- Antidepressant Medication Management (effective continuation phase) **improved by 21.64 percentage** points
- Follow-Up for Children Prescribed ADHD Medication (Continuation and Maintenance Phase Only) (ADHD) **improved by 7.71 percentage points**
- Immunizations for Adolescents (Combination 2) (IMA) **improved by 6.81 percentage points**
- Members enrolled in our high-risk care management program in a similar state to Mississippi saw a significant reduction in utilization and cost outcomes: **Inpatient Utilization: 30.7%, ER Utilization: 25.1%, Medical Expense: 14.2%**. Results did not change significantly when COVID-19 considerations were applied to the analysis

Our organizational policies, procedures and processes will link together with person-centered, trauma-informed engagement strategies to make sure our care management teams provide a supported health journey to all members, build care teams that align with the member's goals and needs and nurture local partnerships.

a. Facilitation and monitoring of Member compliance with treatment plans;

Our care management platform will provide guided support to our care managers with embedded resources and tools that promote efficient use of team resources and consistent identification of treatment plan opportunities, so members are supported in reaching treatment plan goals. Care managers will work from a comprehensive dashboard view of their member panel. Automated process alerts will be built into the dashboard to notify the care manager of the following:

- An upcoming scheduled review of member's treatment plan or required member touchpoint
- Inpatient admission or an ER admission for assigned members
- Provider has inquired about a member's care
- Member called in with questions for their care manager or service navigator
- Outstanding or unfulfilled referral to a community-based, state or county program
- Identified gaps in care (i.e., HEDIS measures)
- New or changed risk information available from our predictive analytic tools
- Member newly assigned to care manager's member panel

Each alert will have a corresponding procedure and task guide for the care manager that outlines the necessary engagement with the member, community-based organization or provider. This new engagement will be captured in the member record and new actions in the treatment plan. The care manager can create individualized alerts within each member file that denotes specific targets for progress on goals or check-in cadence outside the standard triggers for alerts reflected in treatment plan monitoring policies.

b. Partnerships of community-based partnerships and other state agencies; and

Advancing Population Health Outcomes

Working with community, state and county partners on community health initiatives is a powerful way to meaningfully engage members and align with strategies and resources that resonate with our members. We will apply a coordinated and flexible approach to communicating with the community organizations and state agencies, seeking out local expertise and nurturing relationships; we will assign a primary point of contact for each state and county agency. This person will be responsible for understanding whom to call and what do to if we need to escalate an issue within the partner agency or organization. This person will be known to the agency or organization as their key point of contact should they need to bring a member or community issue to our attention. This team member will be responsible for maintaining necessary data sharing agreements and tools that confirm appropriate data and privacy protections are adhered to, while making sure we can collaborate on member-specific problem solving and community-wide population health priorities.

Examples of our collaborative work with community-based organizations and state and county agencies from states similar to Mississippi include:

- Coordination with continuum of care (CoC) housing program providers to bridge health and housing programs. This has included coordination of screening questions and data sharing arrangements that allowed us to more easily identify and partner to support the individuals we serve to receive efficient, effective and timely services.
- Delegated perinatal care management programs focused on connecting and supporting prenatal and postpartum care for Black expecting parents. This includes home visiting for families and is administered in partnership with Historically Black Colleges and Universities.
- Disaster and emergency preparedness partnerships will be pursued at the local and state level with organizations such as Red Cross, Safe & Well and local utility companies.
- Referrals of chemically dependent pregnant individuals to housing, daycare, financial assistance, clothing, household assistance, infant items and comprehensive case management offered through community resources such as Catholic Charities and capacity building investments ensure those supports remain available for future member needs.

c. Coordination with other Providers.

Our care management processes and tools will give providers timely and accurate line of sight into the member's health journey, including utilization, care opportunities, referrals and outstanding needs. We will share HEDIS analytics reports quarterly and provider scorecards twice a month to all PCPs. These reports will highlight quality performance and gaps in care for members in the PCP's patient panel. Our care managers, provider consultants and health plan leaders will make providers aware of provider portal, which shows detailed insights on member treatment plans, care manager assignments and other providers serving the member. These tools support providers so every encounter with our members is as efficient as possible. Our care management teams will invite PCPs, and other service providers at the member's request, to participate in case conference forums and case management team meetings.

In addition, we will work with non-PCPs to expand access to preventive care services via nontraditional entities to make accessing and receiving care easier for members. For example, we will partner with Mississippi independent pharmacists to perform HbA1c testing and close gaps in care for members with diabetes not on statin therapy. We will seek to partner with Mississippi emergency medical service providers to allow paramedics to provide in-house services, such as substance use disorder treatment, prenatal care, fall prevention, diabetes care and education, hypertension treatment and education and vaccine/immunization distribution.

2. For Members with special needs, describe how the Offeror will ensure coordination of care across the care ...

We are committed to making sure our members with special needs have access to accessible services from providers, community-based organizations (CBOs) and state agencies and supporting continuity of care. In addition to required Health Risk Screening (HRS) and Comprehensive Health Assessment (CHA) information, our care teams will use claims data, prior authorizations, admissions data, risk stratification data and state enrollment data from 834 and supplemental files to identify members with special needs who could benefit from our programs and build interdisciplinary treatment teams with appropriate expertise to support the member. Members with special needs will be served by our person-centered care management program, tailored to address their unique special needs. Our care management team will use specialized assessments, expertise and local relationships to address frequent challenges, integration of interventions and coordinate with appropriate state agencies and community-based organizations necessary for serving the member.

Coordinating Across the Care Continuum to Address Member Needs

Our care teams will use person-centered care strategies and a trauma-informed approach when coordinating care across the continuum. In doing so, our treatment plans reflect member-driven goals and member/family-identified barriers to accessing care. We will document all services and interventions in the member's treatment plan, including paid and unpaid caregivers and family members, community resources and state agencies identified to support the member in achieving their goals. Members' short- and long-term goals will be established and measured to evaluate the plan and associated activities and revised as necessary to encourage optimal health for our members.

We will have established standing care team rounds and interdisciplinary team consultations that focus on addressing member needs and unique, complex cases. During these discussions, care managers will highlight the strengths and needs of the member, request specific coordination support, advice or direction and walk away with action items to integrate into their care management strategy. Through collective problem solving and rounds participation, attendees will recommend available resources, learn how other disciplines approach complex member needs and identify resource or service gaps for clinical leadership to address with partners.

Identifying and Accessing State, County and Community-Based Resources

We will ensure our Mississippi-based care management teams and health plan staff understand the services available and the programs offered in Mississippi. This will require concerted efforts to maintain relationships and communication with state and community partners. We will maintain a list of the services, intake process and priorities of the organization and populations served by organizations found in our SDOH resource directory and social care tools. Our care management teams will build relationships with representatives from the organizations, assist members in scheduling initial or follow-up appointments to access services and may accompany members to provide encouragement, support and advocacy. The following table shows areas of focus, state and county partners and examples of key community partners by identified special need population.

	Specific Focus	**State and County Partners**	**Examples of Key Community-Based Resources**
Maternity and Prenatal Care	▪ Improving outcomes (preterm birth) ▪ Timely prenatal care ▪ Reproductive health ▪ Planning for birth ▪ Postpartum care ▪ Family planning	▪ Mississippi Dept. of Health (MDH) ▪ PHRM/ISS program	▪ Diaper Bank of the Delta ▪ Pickles & Popsicles ▪ Mississippi Public Health Institute ▪ Jackson Safer Childbirth ▪ Mississippi SIDs & Safety Alliance ▪ Spring Imitative ▪ Delta Health Alliance ▪ Uplifting Mamas Doula ▪ Catholic Charities

	Specific Focus	State and County Partners	Examples of Key Community-Based Resources
			▪ Edward Street Fellowship Center
NICU and Children at Risk for Developmental Delays	▪ Post NICU discharge and readmissions ▪ EPSDT	▪ Mississippi Headstart Association ▪ MDH ▪ Mississippi Dept. of Education (MDE) ▪ PHRM/ISS program ▪ Early Childhood Intervention (EIC) ▪ University of Southern Mississippi	▪ Local school districts for ages 3 – 5 programs ▪ Mississippi Headstart Program for ages 3 – 5 ▪ Early Headstart for infants, toddlers, and pregnant members
Children and Youth in Foster Care	▪ Timely access ▪ Transitions of care ▪ Guardian support ▪ Medical management	▪ Mississippi Department of Child Protection Services (MDCPS) ▪ Mississippi Dept. of Mental Health (MDMH)	▪ Mississippi Families as Allies ▪ Children's Hospital ▪ MDCPS foster parent support groups ▪ The Little Light House Central Mississippi
Members with Physical and Developmental Disabilities	▪ Engagement in community ▪ Program eligibility ▪ Caregiver supports	▪ MDE ▪ Mississippi Department of Rehabilitation Services (MDRS) ▪ MDMH ▪ DHS Division of Adult and Aging Services (DHS DAAS) ▪ Early Childhood Intervention (EIC) programs	▪ The DMH Regional Centers for Intellectual and Developmental Disabilities ▪ The Arc of Mississippi ▪ Living Independence for Everyone (LIFE) ▪ Coalition for Citizens with Disabilities ▪ MDRS HCBS waivers and Vocational Rehabilitation programs
Members Receiving Private Duty Nursing (PDN)	▪ Team-based, medically necessary coverage determination ▪ Caregiver support ▪ Wraparound support (HHA and hospice) ▪ Hospital discharge support ▪ Disaster planning and	▪ DHS DAAS ▪ EIC ▪ MDH ▪ MDE	▪ Food-Heartland Hands Food Pantry, Olive branch Community Emergency Food Ministry ▪ DME/Supplies – Diaper Pantry, Cribs for Kids, Mississippi Society for Disabilities ▪ HCBS Waiver Administrating Agencies ▪ Disaster Relief, Preparedness and Response/Red Cross ▪ School IEP teams
Individuals Receiving 1915i Services	▪ Employment ▪ Engagement in community	▪ DMH, MDE and MDRS	▪ DMH Regional Centers for ID/DD services ▪ The Arc of Mississippi

3. Describe the Offeror's proposed process to ensure appropriate communication with the Provider, follow-up ...

a. The Offeror's role and the PCP's/PCMH's role in this process;

Health Plan Role in the Communication Process

Through our provider portal, providers will have on-demand access to up-to-date treatment and care plans and the member's gaps in care. The treatment plan for the member will include details of other providers, specialists and service referrals (completed and unfulfilled). Inpatient visits, new conditions, updated individual health screenings or comprehensive risk assessments that trigger updates to the treatment plan will be captured and

available to the member and the provider through our portals. We will update the member records in our portal to inform the provider of a change in acuity level.

When a member has been admitted to an inpatient facility, our care managers will reach out to the member and work with our utilization management team and the treating provider to support the member in understanding discharge instructions and preparing for their return home. At discharge, the care manager will work with the member and the PCP to schedule needed appointments and communicate details about the needed follow-up and provide instructions on how to access additional details in the member and provider portals.

Providers will be invited to participate in the treatment plan development at the member's discretion. Our care manager will call providers who cannot attend but are critical to the member's care to discuss the needs of the member, the provider's insights and any unmet needs or support that could be beneficial to the member or provider. We will provide peer-to-peer consultation between the medical director and the member's PCP or treating physician, behavioral health provider or specialist to collaboratively discuss the member's treatment plan options and facilitate access to services, supports or care in alternate care settings.

Provider/PCP/Patient-Centered Medical Home Role in the Communication Process

Our approach to coordination incorporates written policies, contractual requirements, training, oversight and follow-up to foster collaboration with our members and their primary care, behavioral health and specialty providers. Our provider manual, which is part of our provider contract, will outline the processes and expectations for providers to coordinate and collaborate regarding member care.

We expect providers serving our members, particularly those who are serving as a PCMH, to take the lead in managing the health care needs of our members. We support them through access to comprehensive data and analytic tools that offer insights at both the individual and practice level. We expect them to review and share information regarding the member's treatment plan, goals and concerns or any new barriers to access care or new conditions or diagnoses. We expect them to react and respond to the member's needs and listen to their concerns, participate in case conferences when invited and maintain a collaborative relationship with the care team to foster ongoing engagement and care of our members.

Although there are a limited number of NCQA-recognized PCMH providers in Mississippi, with some regions having very few to no PCMHs, we will prioritize assigning medium- and high-risk members to PCMHs where possible. In addition, we will actively work to increase the number of NCQA PCMH recognized providers and support PCPs who are serving established relationships with members experiencing increasing acuity but for whom a PCMH is not available or a transition in providers would be detrimental to the member's care.

b. Examples of information that the Offeror will provide to Providers;

We will empower providers by offering technology platforms to support clinical activities and transmit essential member information from our care management teams to providers. Many tools are web-based, augmenting telephonic and facsimile communications and can be accessed at a provider's convenience through our provider portal. Data available to PCPs and PCMHs will include a unified record of their patients' health history, including lab results and prescribed medications, based on claims submissions enabling coordination of care, a list of all medical, behavioral and SDOH referrals, including indication of fulfilled and unfulfilled status, gaps in care and needed preventive care, acuity changes of the member, member-level Health Risk Screening results, comprehensive health assessments (if applicable), individualized treatment plans and care manager contact information. In addition, for providers using Epic, Cerner, Athena, eClinicalWorks, Practice Fusion, Allscripts and NextGen, we will offer access to real-time data directly in the provider's EMR, including eligibility, quality care opportunities (refreshed biweekly), patient health history (13 months), specialty referral and real-time prescription benefit information.

c. Interaction between Care Manager and Members, Members' PCP/PCMH, family, other physicians, and ...

Performance Measure
In a state of similar size and makeup, our 2021 care management survey shows 93% of our members were very satisfied with care management services.

We will base our care management model on building a trusting and collaborative relationship that supports appropriate communication with the member and their interdisciplinary treatment team (ITT). Members will be empowered to actively participate and make decisions about their care and services in meaningful ways. The person-centered treatment plan will build on member's goals and preferences, such as choosing members of their ITT. At the center of the ITT, we will facilitate active member participation in a trauma-informed manner that draws on the stages of change and motivational interviewing to support members in directing their care and meeting their expressed goals. The member will be asked if they would like to have their family or caregivers participate on the ITT with their PCP and other providers. The care manager and all ITT participants will have access to view the member's care management file, at the member's discretion. The treatment plan will be proactively shared with treating providers and made accessible through the provider portals as appropriate.

Care managers of members engaged in medium- and high-risk care management will interact with members and relevant parties based on the preferred and most effective modality for the member. We will offer in-person, telephonic and virtual care management visits with members, their support system and their provider. Based on the needs of the member and with their agreement, we will talk with a member's caregivers, engage with the member's PCP and other specialists, attend provider visits with the member, ensure transportation for members and contact all physicians who have seen the member to reconcile drug orders.

d. Transition planning for Members receiving Covered Services from Out-of-Network Providers at the time ...

We are committed to making sure our members have access to medically necessary care, from providers they trust in their local communities, minimizing disruptions in care whenever possible. Our care team will consider each member's circumstances, including their clinical, cultural, linguistic and geographic needs, while using standard criteria for evaluating out-of-network exceptions.

Before go-live, we will seek data from the Division for all MississippiCAN and Mississippi CHIP members that will be assigned to our plan. Using this data, we will run reports to identify members who have recently received services from an out-of-network provider. The report will be shared with our clinical and network teams to determine whether there are potential actions needed to support network enhancements.

Where a transition results in a member's provider no longer being in the network, our teams will be guided by our transition of care (TOC) policy that aligns with the Division's requirements and will be made available online and in member and provider materials. Members will receive notification their provider is no longer in the network and be encouraged to call their service navigator to discuss next steps and address questions. Our transition of care policy will include:

- Members receiving medically necessary services from an out-of-network provider will have ninety (90) calendar days or until the member may be reasonably transferred to a network provider without disruption of services, whichever is less.
- It outlines which services will require prior authorization for continuation beyond thirty (30) calendar days.
- For members in their second or third trimester of pregnancy, our TOC policy will allow continued access to the member's prenatal care provider and any provider currently treating the member's chronic, acute medical or behavioral health condition through the postpartum period.

In cases where our care team deems it medically necessary or otherwise in the best interest of the member, we will extend the transition period beyond the standard transition period.

e. The Offeror's Care Management processes and specific communication steps with hospital inpatient ...

Communication with Providers for Post Discharge Care

We will use ADT data obtained through Mississippi's health information exchanges and continue to identify and track members in facilities through utilization management census data. Working across disciplines, our care teams will consult with inpatient staff and providers during a member's inpatient stay to monitor their response to the inpatient treatment plan, collaboratively modify the treatment plan, advocate for member preferences and inform discharge planning. Members experiencing an inpatient admission may already be enrolled and assigned to a care manager; in this case, the assigned care manager will continue to serve as a primary point of contact to coordinate and communicate with the care management team or smaller ITT, providing continuity for the member and inpatient team. Connectivity between our inpatient utilization management (UM) nurses and our care management teams means discharge planning will begin at admission, and UM nurses will serve as a conduit for communication between the member's health plan care management team and inpatient providers.

We will share insights from our predictive analytics tools in conversations with treating providers to broaden understanding and appreciation for the member's circumstances outside the hospital. Our care management team will engage with the member and their support system during the admission, proactively contributing to the member-centric discharge plan, collaborating with the inpatient team and aligning services and supports to prevent readmission. This includes identifying a comprehensive support structure for the member, such as family members, formal caregivers and community resources, so a member can return home to a safe environment. We may conduct an interdisciplinary meeting with our chief medical officer to discuss unique or complex discharge needs, such as the need for additional services (e.g., home health, behavioral health or community-based services). Before the discharge or other transition, the care management team will encourage the member and their caregiver to assert an active role in discharge planning; help to bridge communication gaps with the nursing and provider team and the member; proactively identify barriers to implementing the discharge plan or new SDOH circumstances; educate the member and family on the importance of scheduling and attending follow-up appointments based on providers' recommendations and plan; and equip the member with self-management skills to use upon discharge and transition.

Minimizing Readmissions

As our teams work with hospital and community teams to prepare for discharge, we will share insights on the member's risk of readmission using our readmission predictive model to develop a risk score based on historical claims and current admission data. The readmission predictive model identifies admissions with a high probability of subsequent readmission within 30 days. Predictors include age, sex, diagnosis/condition, number of admissions in the past year, distinct count of medications in the past year, ER use, DME, home health care or outpatient surgeries in last year, current admission length of stay and readmission status.

D. Transition of Care

1. Describe the Offeror's overall approach to Transition of Care, including the process and criteria used for ...

Meeting members where they are in their health care journey means identifying, adjusting and adapting when life changes require new team members, different resources or a new treatment plan. Whether the transition is driven by a change in health status, member preference/choice, program changes or provider availability, the goal is to maintain engagement in care, confirm a positive member experience and maintain positive health outcomes.

Our care management teams, working in concert with clinical and network leaders, will be informed of changes that impact members' individual treatment plan. To support members experiencing care transitions, we will:

- Timely outreach to the member notifying them of the support available to them during the transition, measured by % of members engaged within appropriate time frame (e.g., seven-day hospitalization, 30-day enrollment, 90-day contract implementation)
- Screen for SDOH needs and offer closed-loop referrals and warm handoffs, as appropriate, measured by number of screenings conducted and activity noted in the Care Management Partnership and Referral Report
- Support appointment scheduling with network providers, meet member needs and align with member preferences whenever possible (language, gender, location) demonstrated by appointments made and updated member treatment plans
- For new providers, communicate relevant context about the member's previous care (e.g., current treatment plans, signs of escalation, known engagement strategies that support positive member engagement, prescriptions, barriers to care)
- Where possible, anticipate and proactively plan for transitions of care demonstrated by updated member individualized treatment plans
- For members engaged in medium- and high-risk care management, the care manager will update the ITP within 30 days of the TOC to reflect changes in health status, resource needs or other goal adjustments demonstrated by updated member individualized treatment plans

2. Describe how the Offeror will provide Transition of Care to Members after discharge from an institutional ...

Transition of care support will be provided across any risk level through the member's primary point of contact and assigned care team and may be augmented by tailored interventions or programs specific to the member's condition, such as our specialized behavioral health transition of care intervention. We will use a readmission predictive model on historical claims data; for new members, we will use our risk screening tool to understand a member's readmission risk and identify the appropriate members of our care team to support the member during their transition. Critical aspects of our transition of care program will include scheduling follow-up visits before discharge, coordinating with hospital discharge planners and PCPs/PCMHs and behavioral health providers, arranging for home and/or community-based services and implementing medication reconciliation. Our proposed transition of care timeline and high-level activities are reflected in the following table.

Within 72 hours of discharge	▪ Verify the member has scheduled a post-discharge follow-up appointment with their PCP, behavioral health provider and other specialists, as needed ▪ Complete post-discharge assessment; identify and resolve barriers to accessing new services, medications or follow-up appointments ▪ All members who have an inpatient behavioral health or PRTF admission are enrolled in our high-risk care management program with a care manager with behavioral health expertise if not already enrolled. Recommend change in risk-level assignment or enrollment in targeted programs if not already enrolled.
Within seven days of discharge	▪ Monitor the member's adherence to the discharge plan instructions; identify and remediate barriers to accessing care or implementing post-discharge plan ▪ Follow up and document outcome of referrals (closed-loop referral)
Within 10 days of discharge	▪ Confirm the member has completed their PCP or other specialty follow-up visit ▪ Reinforce the importance of adhering to the discharge plan instructions ▪ Revisit education and self-management skills for new or changed condition
Additional or continued support as needed	▪ Evaluate the member for additional services, including ongoing or increased care management after the transition of care intervention

a. Scheduling outpatient follow-up and/or continuing treatment prior to discharge for Members receiving ...

Timely identification of inpatient admissions is crucial to successful transition of care. We will identify members experiencing transition through real-time admission, discharge and transfer (ADT) alerts in our

clinical management platform and Health Information Exchange, member or family notification, ongoing member touchpoints, provider identification or authorization request, utilization management daily census reporting, alerts from homecare providers and notification from the behavioral health crisis support teams.

While the member is admitted, our care management team will connect with the member or their designated family member to review discharge instructions and discuss follow-up appointments. Our engagement strategies while members are inpatient will include telephonic outreach, bedside visits and coordination with hospital treatment and discharge staff. Our care manager will support the scheduling of follow-up visits and any necessary transportation arrangements.

b. Coordinating with hospital discharge planners, PCPs/PCMHs, and Behavioral Health staff;

As part of our care management team, a group of specialized inpatient care management (ICM) experts will be assigned to coordinate with specific Mississippi hospitals. These care management team members will serve as the primary resource for the facility for inpatient prior authorizations and concurrent reviews, which helps promote collaboration with hospital staff. Discharge planning review will continue throughout an inpatient stay, and care management staff will assist with the arrangements for alternative services or programs, as appropriate, and facilitate transition to a higher or lower level of care at the appropriate time during care.

For all members, we will collaborate with the member, facility and member's chosen planning team to develop a transitional plan of care to make sure progress made during the inpatient stay continues after discharge. Our care management teams will call any member-associated PCP/PCMH, behavioral health providers or other specialists to inform them of the relevant inpatient admission and any need for follow-up appointments, potential need for medication reviews or level of care changes. Our goal is to make sure the treating providers are fully aware and prepared to support the member. We will provide a summary of the member's history and current medical, behavioral health, SDOH and any other social needs and concerns or update with new information. Care managers will attend provider appointments to support the members if needed.

We are prepared to participate in the Division's Potentially Preventable Hospital Returns (PPHR) reporting process. We will use the data from the PPHR to identify hospitals where members are experiencing hospital readmissions to discern patterns, root causes and opportunities to improve discharge coordination. This information will be shared with the Division, hospitals and influence design changes to our care management strategy and interventions accordingly.

c. Arranging for the delivery of appropriate home-based support and services in a timely manner; and,

Our transition of care will include engagement with hospital discharge planners focused on understanding necessary community and home-based supports needed to facilitate discharge. Our discharge planning processes and procedures will make sure we begin arranging any necessary home care supports and supportive equipment. Our care management team will work with discharge planners so all prior authorizations are completed and communicated in a timely manner or escalated if concerns emerge.

A specialized team of nurses who have experience with private duty nursing will be ready to support members in need of in-home care. Our PDN/PCS nurse supports will work with members, families and providers to collect necessary clinical and home-safety information to provide our medical director the most thorough understanding of a member's condition. Working in partnership, the medical director and PDN/PCS nurse will confirm coverage determinations and align complementary services as needed to fully wrap around our families for a successful transition home. Having dedicated nurses will allow us to establish strong relationships with PDN, PCS and medical daycare providers in Mississippi. These relationships will be used to arrange for appropriate in-home services before discharge. We will make sure all arrangements for clinical monitoring and teaching on any new diagnoses or in complex care newborns coming home for the first time are in place before transition. After discharge, we will conduct a post hospital assessment to rapidly identify any needs that

emerged during the transition home, offer support to in-home caregivers as needed and adjust the treatment plan accordingly.

d. Implementing medication reconciliation in concert with the PCP/PCMH, Behavioral Health provider, and ...

We will train our care management team on our end-to-end processes to achieve pharmacy continuity of care and seamless pharmacy transitions for members discharging from facilities. Our Mississippi clinical pharmacist will work collaboratively within our interdisciplinary treatment teams to provide input on pharmaceutical impacts to medical diagnoses and guidance on appropriate medication utilization post discharge. Pharmacy claims of members with high readmission rates or high-risk disease states will be reviewed to make sure the member is on the most appropriate and cost-effective regimen. Our pharmacy team will coordinate with the medical team through:

- **Interdisciplinary complex case rounds:** A coordinated care team, which may include medical director, behavioral health director, care managers and clinical pharmacist, will discuss medically and behaviorally complex members to identify gaps in care and strategies to prevent possible hospital readmissions.
- **An inpatient member census with disease states:** Following the census, our clinical pharmacist will assess members to determine if a medication-related problem may have contributed to the admission by working in collaboration with the care manager.
- **Pre-discharge pharmacy support:** We will streamline the discharge pharmacy fill for members so they can leave the hospital with their filled prescriptions in hand. We will offer medication coordination services between pharmacy and in-patient facilities to arrange for medication at discharge, pre-filled medication packages and subsequent at-home delivery. Together these serves will reduce the risk of readmission due to medication error while reducing the administrative burden of the facility and complexity for the member.
- **Collaboration with pharmacy providers:** Our clinical pharmacist will monitor pharmacy claims and take action to resolve any barriers at point of sale for discharge medication, through collaboration with pharmacists and prescribers. This may include education on drugs that are preferred on the state's drug list, updates on prescribing guidelines or prior authorization process.

3. Describe the Offeror's proposed transition plan and policies for ensuring continuity of care for members ...

We prioritize preserving relationships between the member and their established care providers. Our policies and procedures will offer options to support providers in joining our network or otherwise sustaining the treatment plan. We are committed to minimizing disruptions to member care whenever possible. When a disruption is unavoidable, we will support the member in identifying, communicating and securing care from a new high-quality, network provider.

Before go-live, we will seek data from the Division for all assigned MississippiCAN and Mississippi CHIP members. Using this data, we will identify any members who have recently received services from a provider who is not currently in our network. The report will be shared with our clinical and network teams to determine whether there are opportunities to support network enhancements. All new members will receive a welcome call — where we provide information about benefits, conduct the Health Risk Screening, answer initial questions and identify any concerns that require additional attention such as those related to the transition — and welcome packet upon enrollment, which educates members about continuity of care.

Where a transition results in a member's provider no longer being in the network, our teams will be guided by our transition of care policy that aligns with the Division's requirements and will be made available online and in member materials. Our transition of care (TOC) policy will note that:

- Members receiving care from a network provider may continue seeing that provider even if they leave our network if it is in the best interest of the member following clinical review. Our TOC policy will allow current members a transition period of 90 days, or until the member may be reasonably transferred to a

network provider without disruption of services, whichever is less, if the participating provider leaves the network (not for cause).

- Members in their second or third trimester of pregnancy may continue to access their prenatal care provider and any provider currently treating the member's chronic, acute medical or behavioral health/substance use disorder condition through the postpartum period.
- In cases where we deem it medically necessary or otherwise in the best interest of the member, we will extend the transition period beyond the aforementioned time frames.

E. Staff

1. During the next contracting cycle, it is required that Care Managers be located in the state. Describe the ...

Our care management program is strengthened by the talent of our passionate care managers. They embody the essence of our member-centered care delivery, cultivating deeply personal relationships with the members we serve to effectuate change in health behaviors. By hiring care managers who live in Mississippi, we will ensure our team is familiar with community resources and able to activate formal and informal supports on behalf of MississippiCAN and CHIP members. To sustain the strength of our care management program, our approach is designed to:

- Meet or exceed discipline-specific training and degree requirements of staff, while supporting career entry and advancement opportunities.
- Attract and retain local Mississippi top talent that is reflective of the communities we serve.
- Develop cultural competency and operate with cultural humility and responsiveness.
- Foster professional growth and clinical acumen through ongoing required and optional trainings.
- Offer generous pay rates to support retention.

Our care managers will represent disciplines across medical, behavioral and community health. We will embrace a multidisciplinary approach to care and establish processes and internal venues that cultivate the unique expertise and perspective of each discipline to formulate individual treatment plans and interventions. This holistic approach will drive improved engagement and overall member experience. In 2020 alone, in the midst of the global pandemic, our care managers found innovative ways to partner with members to achieve their care plan goals. Nationally, 65% of all goals in our emerging risk care management program were achieved and closed despite in-person engagement restrictions and remote work requirements.

a. Education and training required for Care Managers;

We will establish minimum education, formal training, certification and licensure requirements for the disciplines that can occupy a care manager role: community health workers (CHWs), registered and licensed practical nurses, behavioral health specialists and social workers. This will include current, active licensure for registered nurses (RNs) and licensed practical nurses (LPNs) and clinical licensure as an independent practitioner for behavioral health clinicians (e.g., LCSW, LPC, LMFT). Care managers working with specific populations must have experience in that area. Examples include maternal–child health, foster care or case management in an ambulatory or inpatient setting.

Consistent with the contract, all care managers will be local to Mississippi. We will hire regionally to build a diverse team representing the communities served and familiar with individual community resources and support networks. At least one of our care managers will have special training and knowledge of care management practices relevant to Mississippi's Native American community, though all care managers will receive training on the unique considerations for supporting Native American communities.

Service navigators and other roles on the care management team will augment the care manager's skill sets and expertise. Roles will include certified peer support specialist, housing navigator, pharmacist and dental care coordinators.

b. The Offeror's Care Manager hiring process, including how the Offeror plans to recruit and retain Care ...

Dedicated talent acquisition specialists will work directly with local hiring managers to recruit and hire locally based, culturally competent care managers. Our talent acquisition team uses standard processes (e.g., CareerBuilder, Indeed) and dedicated approaches (e.g., niche job boards, targeted social media groups) to attract a diverse candidate pool. Our talent recruitment process is as follows:

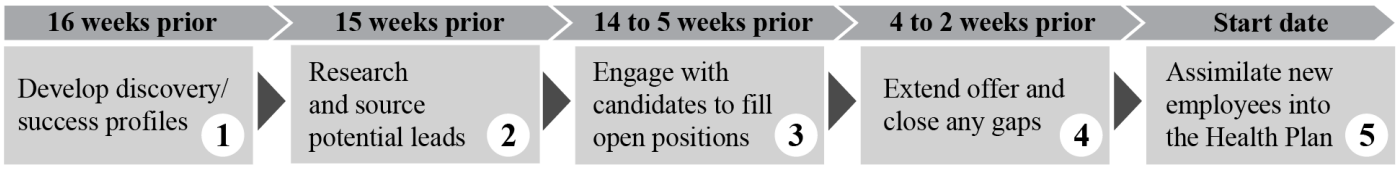


Figure 8. Summary of recruitment timelines and activities for clinical staff.

Because our care managers need to reflect the communities we serve, we have established initiatives such as:

- **Military Internship Program.** Working with the Department of Defense and SkillBridge Program, we will offer military internships to provide career skills training and workforce reintegration to transitioning active duty service members across all branches of the military.
- **Local Workforce Training.** We commit to working with local community colleges to support apprenticeship programs to train community health workers, pharmacy technicians, insurance navigators, health care advocates and health care educators. Graduates can enter the local workforce or become our community-based employees.
- **Hiring People of All Abilities.** We will foster wide-ranging disability inclusion programs to make our recruiting efforts consistent with the overall employee experience. Our strategic efforts include internal and external relationships, a new disability internship program launched in 2020, learning and development resources and evolving our workaround accommodations, accessibility, compliance and cultural readiness initiatives.
- **Human Rights Campaign Equality Index.** For the third consecutive year, we have earned a 100% rating in the Human Rights Campaign (HRC) Foundation's 2021 Corporate Equality Index (CEI). We earned its top rating, and a designation as one of the Best Places to Work for LGBTQ Equality, for taking concrete steps toward greater equity for LGBTQ workers and their families in the form of inclusive policies, practices and benefits.

Working with vulnerable populations requires the right attitude and aptitude, balancing skill and experience with a personal commitment to improve the lives of others through effective member engagement and care management. As we assess candidate talent, we will use standardized behavioral interviewing techniques to assess a candidate's capacity for or evidence of the following attributes:

- Helping to eradicate systemic racism and eliminate health disparities
- A humble approach to improving oneself and recognition of their own implicit bias
- Professional development to improve their own effectiveness in care delivery
- Familiarity with traditional and nontraditional local community resources
- Understanding the unique needs of the Medicaid recipients and a passion for helping them

Given the national landscape of labor shortages, we will deploy a robust retention strategy to confirm employment longevity of our talented care managers. Our pay is highly competitive, with our merit and

incentive programs tied to our values of integrity, compassion, relationships, innovation and performance. In states similar to Mississippi, we increased retention by recognizing our care managers' dedication and commitment to serving our members through state salary adjustments, retention bonuses, increased employee referral bonuses, increased sign-on bonuses and proactive sourcing to build our candidate pipeline. In addition to standard benefit options, we will offer a host of family and work/life balance options (e.g., paid parent leave, adoption assistance, discounted gym memberships).

To further support employees, we will have a rich portfolio of employee resource groups (ERGs). In another state, one group for working parents formed in 2014 grew in membership as a result of pandemic-related stresses and now includes specialty employee-parent support groups that include lactation support, single-parenting, parenting kids with mental health concerns and a Pride parent group.

c. How the Offeror will ensure that Care Managers are culturally competent and aware of implicit biases;

Delivering care that is sensitive and responsive to one's culture and cultural experiences is the bedrock of person-centered, trauma-informed care management. In addition to our data-driven processes that help identify gaps in care and claims-based medical, behavioral and dental needs, our care managers will be trained to deeply understand how an individual's self-reported identity, experiences and cultural trauma(s) impact their perception of and engagement with the health care system. We understand that individuals may have had their own experiences with systemic racism, resulting in mistrust of formal systems. As a result, we will embrace practices that help advance our effort of being an anti-racist organization and delivering anti-racist care management.

In 2021, in states similar to Mississippi, we piloted a staff-level curriculum that brought deeper awareness of implicit bias and how to become an ally in eradicating racism and discrimination. In 2022, we committed to developing and delivering a comprehensive baseline health equity curriculum for all staff, from front line to leadership levels. The curriculum will establish a unified understanding of key concepts that impact our members while providing our staff with actionable recommendations to develop a greater level of personal awareness and provide culturally responsive care for our members. This curriculum will include a blend of both concept and practice topics, such as health equity and health disparities, implicit and unconscious bias, inclusion and diversity, cultural humility, trauma-informed care and motivational interviewing.

To confirm our nondiscriminatory efforts are embedded in the fabric of our organization nationwide, we are evolving our internal infrastructure to support this goal. For instance, our comprehensive assessment, used for all members in care management, has been carefully reconfigured to include a thorough list of responses to key questions about an individual's sexual orientation and ethnic, racial and gender identities. We have leveraged internal experts and diversity groups to provide response options that are inclusive beyond binary definitions or the minimum federally established demographic groups. Further, our assessment prompts care managers to ask members what impact their identity has had on engaging the formal health system. These actions align with requirements of the NCQA Health Equity Accreditation standard and the National Institute of Health race and ethnicity standard.

In states similar to Mississippi, we are enhancing our clinical information technology platform to integrate demographic data to drive alignment between our members' self-reported identities and our internal systems that retain the information. Aligning our system platforms mitigates the risk of traumatizing or retraumatizing a member and enables staff to address members in a way that preserves their dignity. Through data alignment, we will ascertain our effectiveness with unique populations and invest in intervention approaches for populations where we may be having a lesser impact.

We are an organization that prides itself on our rapid-cycle, continuous quality improvement; our anti-racist care management initiatives will receive that same level of rigorous evaluation. We will track key initiatives and create action plans when performance falls below expectations.

d. And overview of the Offeror's continuing education and training plan for its Care Managers; and

Onboarding/New Employee. All new care managers will attend a rigorous 10-day standard immersive training. This curriculum will include key regulatory, adherence and clinical model topics to orient care managers around the delivery of care that upholds our member-centered, trauma-informed approach and quality standards. Care managers will complete population and program-specific modules, and new care managers will be assigned a "mentor" who will help integrate and apply training content to support consistency in care delivery while supporting staff during this phase of their employment. They will train on and receive a Mississippi-specific integrated care coordination guide with protocols, evidence-based interventions, population-specific information and available community resources. The guide will address contractual and model of care requirements for programs and populations.

Annual Requirements. For topics that are federally or contractually required, or the organization deems necessary for annual refresher training, we will assign trainings to care managers through our electronic platform in a self-paced delivery model. We will monitor completion and work with managers to help staff maintain their adherence rates.

Population and State-Specific Training. As an extension to our new hire trainings, our care management team will receive specific MississippiCAN and CHIP population training. Topics may include physical health, behavioral health, functional and SDOH needs of the communities being served, community and population assets, local health equity and health care access considerations, and education on services and supports for individuals with special needs.

Ongoing/Continuing Education. Care managers will be able to access a catalog of training topics, affording them the opportunity to become more proficient in clinical topics, enhance intervention skills (e.g., motivational interviewing or person-centered care planning) and explore topic areas of interest. Care managers who possess specific certifications (such as CCM) or licensure (LPN, RN, LCSW) will have complete access to these courses, many of which are free of charge to staff and offer continuing education credits.

Learning Modalities/Platforms. Our program will use a self-paced curriculum through electronic delivery, instructor-led curriculum facilitated by dedicated training teams and blended approaches that integrate didactic learning with self-guided components. Our highly skilled instructional designers are oriented toward adult learner theory and make sure content is constructed and delivered for adult learners. We will leverage clinical and subject matter experts to host and facilitate clinical "Lunch and Learns" on emerging clinical approaches or trending public health topics.

Additional Opportunities. In addition to the structured learning, we will offer a generous tuition reimbursement program for staff pursuing degree attainment. We will offer a cohort-based health care MBA program and an RN-MSN program for our nursing staff.

e. Expected wages to be paid to Care Managers (hourly/salary and what amounts).

Care managers will be paid based on the salary ranges shown in the following table, commensurate with experience, expertise and location within Mississippi.

Business Title	Wage/Salary Range
Community Health Worker (CHW)	[redacted]
Registered Nurse (RN)	[redacted]
Licensed Practical Nurse (LPN)	[redacted]
Licensed Behavioral Health Clinician	[redacted]

Care managers will be eligible for full benefits, including, but not limited to, health, dental, vision insurance, paid time off and 401(k) contributions.

F. Hypotheticals

1. Describe the Offeror's approach to providing Care Management in the following scenarios:

a. Member who had been stratified as low risk has had four (4) emergency department visits in the previous ...

Our person-centered care management model is designed to meet all members where they are in their health care journey. We understand all members are unique with varying needs driven by many factors, including health status, diagnoses, engagement, health literacy and duration of their condition. The member, who we will call Sherry, has been stratified as low risk and has a service navigator who monitors and follows up with her as needed. The service navigator, who we will call Elena, will help make sure that, as Sherry's risk rises, our flexible model adjusts to connect Sherry to more intensive services.

Monitoring and Identification

Elena could become aware of Sherry's ER visits in one of several ways. If Sherry visited one of the hospitals, such as UMMC, which shares hospital admission, discharge and transfer (ADT) notification data, including ER registrations, the information would flow into our care management platform and alert Elena. The ADT data would be used by our predictive modeling algorithm to identify impactable case management opportunities. This predictive modeling algorithm monitors for clinical risk factors, such as a new asthma or COPD diagnosis, and impactable risk factors, such as ER visits and no follow-up after ER discharge.

If Sherry visited a hospital ER that does not share ADT data, Elena could become aware of the ER visits through claims data or during follow-up calls, or otherwise self-referred for additional care management or if Sherry's PCP or other provider referred her for additional care management. Any of these points of entry would trigger Sherry, who previously stratified as low risk, for a higher level of care management support, including assignment to a care manager.

Care Management Team Engagement

After she learns about Sherry's first one or two ER visits, Elena attempts to support Sherry's transition of care by coordinating her discharge recommendations, identifying and removing any SDOH barriers to her accessing outpatient follow-up, coordinating with Sherry's medical and behavioral health providers, as necessary, and helping Sherry adhere to her medications. Elena informs Sherry of the member incentives available to her if she completes certain wellness exams. For example, if Sherry's first ER visit is driven by preventable medical reasons, Elena will help her schedule a follow-up visit with her PCP and provide education on alternate care delivery options. If necessary, Elena uses a variety of outreach methods to try to reach Sherry, including telephonic, mail and text outreach, at least three times at different times of the day over the course of weeks.

After the ER visit, it is clear we need to apply a higher level of care management intervention, either because Sherry's condition is worsening or because she is consistently using the ER inappropriately for non-emergent care. Elena knows our risk stratification will detect Sherry's frequent admissions and align her to medium or high-risk care management, however, Elena recognizes the need for swift action now. Sherry is elevated to our medium- or high-risk program. If Sherry's condition warrants changing care managers to meet more specialized needs, Elena and the new care manager will work together to seamlessly transition Sherry's care coordination. With Sherry's permission, Elena shares important details about Sherry's health, social and environmental circumstances with James, the new care manager. In addition, Elena shares Sherry's prior treatment plan and her progress to date to ensure there are no setbacks in Elena's care.

James reviews Sherry's file in our care management system before contacting her. He can see the ER utilization documented in her record and the clinical and impactable risk factors identified by predictive modeling. He can see the results of Sherry's prior HRS and other assessments. He has access to training materials and guides that offer pathways for chronic conditions such as diabetes, asthma or COPD, CHF, SMI, OUD and SUD, providing recommended actions and talking points based on Sherry's stage of change.

James reaches out to Sherry to discuss her ER use. He carefully assesses any SDOH needs that he can resolve on Sherry's behalf. He discusses with Sherry (and with any family or friends Sherry wants included in the discussion) the need for a greater level support and options available to assist Sherry. If during their discussion they identify another internal health plan resource or a CBO that can help, with Sherry's agreement, James will establish a conference call between himself, Sherry and the third party to conduct a warm handoff.

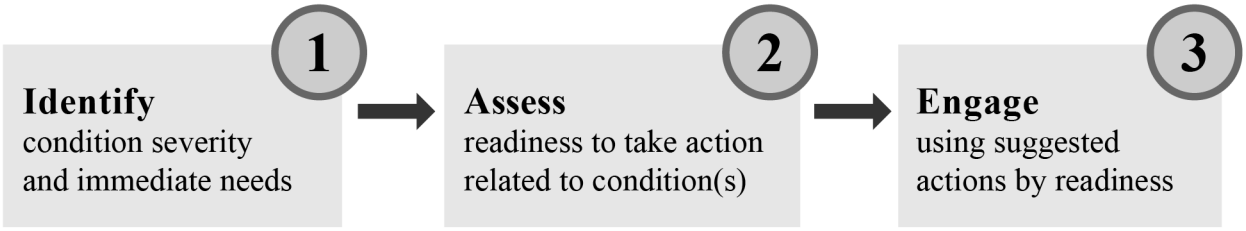


Figure 9. Process for identifying, assessing and engaging members in their care

Once James engages Sherry, together they complete a Comprehensive Health Assessment (CHA) to reassess her needs and amend her person-centered treatment plan to address her escalated needs. Her treatment plan focuses on developing specific, measurable, attainable, relevant and time-bound (SMART) goals to meet her assessed or perceived unmet needs. Here are some examples of actions and goals James and Sherry might develop for her treatment plan:

If Sherry has not established care with a PCP:

- **Care manager action:** James provides Sherry with education materials about the role of the PCP and helps her locate a PCP who meets her needs. James uses three-way calling to help Sherry schedule an appointment with her PCP and follow up with Sherry the day after her scheduled appointment.
- **SMART Goal:** Sherry has addressed barriers to accessing a PCP and will complete a visit with her PCP within seven days.

If Sherry has difficulty accessing her medications:

- **Care manager action:** James finds a local pharmacy that will automatically fill her prescriptions near her home, accessible by the bus and co-located at a grocery store that accepts SNAP benefits. During follow-up contact, James verifies with Sherry that she has received her medications and identifies if there are any additional barriers preventing her from adhering to her prescribed medications.
- **SMART Goal:** Sherry will pick up her prescription(s) at her local pharmacy on the 15th of every month.

If Sherry is experiencing homelessness or housing insecurity:

- **Care manager action:** James discusses housing options with Sherry and works with her care management team (CMT) and our housing coordinator to create a plan and address her housing needs, including referring her to one of our community-based partners who specializes in rapid rehousing and permanent housing.
- **SMART Goal:** Sherry has accessed housing resources to establish and remain in secure housing throughout the year and reports improved ability to meet her living expenses with use of community resources throughout the year.

If Sherry has been unable to attend physical therapy due to transportation issues, resulting in increased acute pain:

- **Care manager action:** James provides education to Sherry about her non-emergency transportation (NET) benefit and helps her make transportation arrangements to appointments.
- **SMART Goal:** Sherry verbalizes understanding of transportation resources and successfully schedules a ride for each visit within the next 30 days.

b. Member with diabetes and attention deficit hyperactivity disorder has been identified as high risk, but the ...

We recognize a member may be hard to reach for many reasons. This member, who we will call Douglas, may not have a fixed address or may not have access to email or a cellphone that can receive texts. Douglas' assigned care manager, Monique, will make multiple attempts to reach Douglas, including reaching out by telephone, mailing him "unable to reach you" letters, emailing and texting him. If she is unable to contact him after two attempts, she will work with one of our local community health workers (CHWs), who will check in face to face at his last known address and with any known providers or community organizations he may have had contact with to try to find him.

When she is still unable to find him, she will use alternative engagement strategies, as outlined:

- Monique may identify Douglas continues to fill his insulin and Adderall prescriptions monthly at a local community pharmacy. She will reach out to the pharmacy to request updated contact information and to engage their help in delivering a message to Douglas that we are trying to reach him.
- Monique will reach out to Douglas's PCMH and any specialists he has seen, such as an endocrinologist or durable medical equipment (DME) provider. She will ask them for updated contact information and ask them to let Douglas know at his next visit that we are trying to reach him.
- If Douglas is using the non-emergency transportation (NET) benefit to attend his appointments or pick up his prescriptions, Monique will coordinate with the transportation vendor to obtain his updated address and phone number.
- If Douglas has had any recent hospital admissions or ER visits, Monique will connect with any hospital-based or ER care managers or social workers. Monique will indicate she is trying to connect with Douglas to offer care management support and request a call if Douglas revisits the hospital or ER.
- Monique will search available data feeds and reports, such as those available from health information exchanges, for updated contact information.

Monique will document all outreach attempts in our care management platform. The platform facilitates coordination, integration and communication among our care management staff, providers, pharmacists and members. If Douglas calls into member services for support, his service navigator will be able to view Monique's notes, collect updated contact information and connect Douglas to Monique for care management support. Once Monique connects with Douglas, she will use person-centered practices and motivational interviewing techniques to complete his CHA. She will work with him and his providers to develop or revise his individual medical treatment plan. As part of her care management, Monique will assess any barriers to care due to SDOH needs and help him identify resources to overcome those barriers. For example, if Douglas is struggling to afford his cellphone bill, they will connect him to resources supporting the Federal Lifeline program, which offers free smartphones to members in need of reliable phone access. The phone will help Monique continue to provide member education and care coordination for Douglas. Monique and Douglas schedule time to follow up in two weeks to discuss Douglas's progress toward the goals in his individual treatment plan.

c. The Offeror's Care Management System identifies that a fourteen (14) year old Member with behavioral ...

We understand that members with behavioral health needs and accompanying chronic conditions, such as asthma, can sometimes struggle to adhere to their existing medication and treatment regimens. Accordingly, when a member with behavioral health needs presents at the ER for a medical issue, we work to address both the member's physical health and behavioral health needs. *Such is the case for Aaliyah, a 14-year-old member with behavioral health needs, who is admitted after presenting with an asthma attack.*

The following figure illustrates the major steps we would take in managing Aaliyah's admission, through discharge and beyond, as we describe in the narrative.

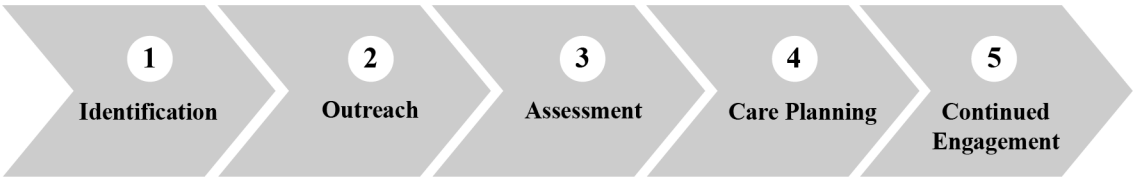


Figure 10. Inpatient Episode Action Plan. Continuum from identification to continued engagement.

Pre-admission: Since Aaliyah is our member, we would have already done a health screening and a behavioral health assessment for her, and with Aaliyah and her family, identified her medical and behavioral health needs and support systems. If Aaliyah had a history of asthma, we would have documented in our care management system the seriousness of her condition, whether it had resulted in prior admissions, and whether any prescriptions were being filled regularly. We would have assessed Aaliyah and her family for social determinants of health (SDOH) and any challenges or gaps that needed to be addressed, including any factors that could exacerbate her asthma or limit her access to medical or behavioral health care.

If, before admission, Aaliyah and her family have been able to reasonably manage her conditions with regular PCP and behavioral health interactions and adherence to any medications, she may not already have an assigned care manager. In such a case, our care management team is still alerted about Aaliyah's admission through our Admission, Discharge and Transfer (ADT) report, and a care manager is assigned to Aaliyah at that time.

However, in this case, we *identified* that Aaliyah's combination of behavioral health needs and asthma were serious enough to result in one or more inpatient admissions, so we connected Aaliyah with a care manager, Renee, to help Aaliyah manage her conditions. Aaliyah would have a designated PCP and behavioral health provider, with referrals to any specialists as indicated. Renee, as Aaliyah's care manager, would be supported by an interdisciplinary treatment team, able to assist her and her family in accessing behavioral and medical care and other necessary supports.

With respect to this admission, Renee and our integrated care team are alerted about Aaliyah's asthma attack through our ADT report. Medical and behavioral care management staff work together with the hospital team to assess and address the bidirectional impact of Aaliyah's asthma and behavioral health conditions.

During the admission: Once alerted, Renee makes immediate contact with the facility to understand Aaliyah's condition, verify she is receiving proper care and verify Aaliyah's family is engaged. Renee *outreaches* to Aaliyah's PCP and behavioral health provider to see that they are alerted about her admission and are engaged.

Renee and our care team participate in Aaliyah's *pre-discharge planning* to verify needed supports are in place. Aaliyah's care team, along with her family, facility staff, Aaliyah's PCP and behavioral health provider, and other members of our integrated care team as indicated, finalize Aaliyah's discharge planning, including:

- Identifying the factors leading up to Aaliyah's inpatient admission
- Reviewing her treatment plan and utilization to date
- Adjusting Aaliyah's treatment plan and medications as needed and making sure Aaliyah has needed medications in hand at discharge

Renee *reaches out* to Aaliyah's parents to discuss follow-up, and screens and assesses for any needed referrals, including for behavioral health. Renee does an *assessment* for any environmental causes for her asthma attack, and if any are discovered, verifies the environmental factors are addressed in Aaliyah's individualized plan of care and discussed with both Aaliyah and her family. In addition, Renee notes as part of Aaliyah's *care planning* whether she is using asthma medication as a preventive measure or a rescue measure, and if Aaliyah has been using medications only as a rescue measure, they assess whether preventive medications may be more beneficial.

The *assessment* includes investigating whether Aaliyah's asthma symptoms might be exacerbated or triggered by any behavioral health issues such as anxiety, including whether Aaliyah is using stimulant inhalers, which can make users feel anxious. If Aaliyah's medication is causing anxiety, the care team works to formulate a medication regimen and *treatment plan* accordingly.

For as long as Aaliyah remains in the hospital, our care team does rounding in the facility to assess Aaliyah and her conditions. The behavioral health assessment includes Aaliyah's and her family's feelings about her conditions, her willingness and ability to follow her medication and treatment regimens and the support her family provides.

Post-discharge: Before or upon discharge, Renee *follows up* with Aaliyah and her parents to complete a clinical assessment to identify any needs or gaps in care. Renee will complete a plan of care with the member and her parents and facilitate the development of short- and long-term goals supporting recovery. The plan of care may include interventions related to addressing barriers to care or community resource needs, such as transportation, food, housing, home safety issues and/or provider referrals. Renee will actively work with Aaliyah's family to close those gaps.

Renee has *continued engagement* with Aaliyah's family and providers to verify she is progressing well. During these outreach calls, Renee confirms she kept her appointments, prescriptions were filled and she and her family are satisfied with the support she is receiving. Subsequently, Renee makes periodic contact with Aaliyah and her family to monitor her continued progress and their continued satisfaction.

As part of our quality improvement process, following Aaliyah's return home, our care team reviews Aaliyah's episode and similar cases to assess for any possible systemic improvements in lines of communication, the care management process, the quality of services provided and the family and other supports provided to assess how the process can be refined or improved in the future.

d. Member with behavioral health needs is taking multiple psychotropic medications and will be discharged ...

Members with serious behavioral health conditions often have complex medication regimens and are at high risk for hospital readmission. We assess members and work with their treating psychiatric hospital staff during the hospitalization to determine the cause(s) of admission and what after-care needs the member has before returning to the community. We use peer support specialists and our clinical staff to bridge the member's discharge from inpatient settings. We know that nationally, behavioral health disorders and substance use disorders are two of the top five major diagnostic categories responsible for 30-day readmissions, with the diagnoses of schizophrenia, bipolar disorder and opioid disorder each accounting for 30-day readmission rates over 20%.

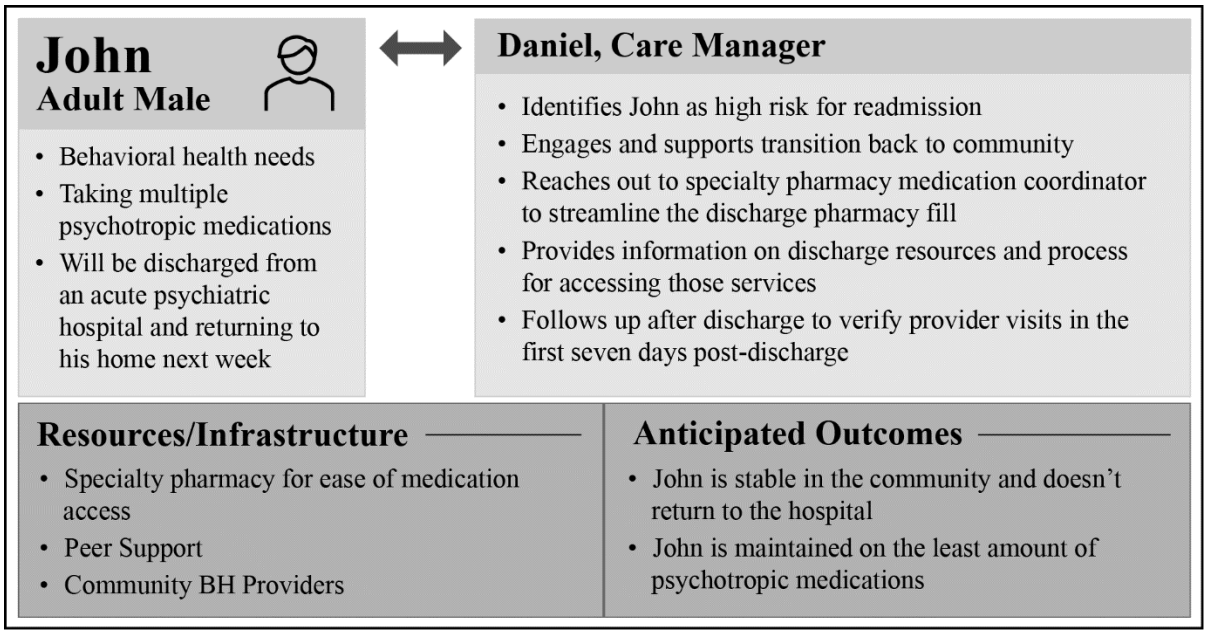


Figure 11. John's Care Management Synopsis. Actions from identification through anticipated outcomes.

As an existing member, our risk stratification process identifies *John* as high risk for readmission due to his behavioral health diagnoses and assigns him to a care manager, *Daniel*, for assessment and care management. Upon John's admission, Daniel receives an alert of the psychiatric facility admission through an ADT alert in our integrated care management platform. Daniel engages John and facility staff to support his transition back to the community. Our care managers effectively manage transitions of care from facilities to home and through the post-acute facility discharge to verify that the member is connecting regularly with their provider and community supports.

Daniel reaches out to our specialty pharmacy's medication coordinator, who is a clinical pharmacist working with the facility on medication management for members. This medication coordinator streamlines the post-discharge pharmacy fill for members so that they can leave the hospital with their filled prescriptions in hand, and clear instructions on which medications should no longer be taken.

Daniel confirms safe housing, transportation to appointments and food security are in place before discharge. Daniel engages with John's PCP and outpatient behavioral health provider(s) to notify them of his admission and to facilitate development and implementation of a comprehensive discharge plan.

The goals of care management for John's discharge back to the community are to develop a discharge plan with him that incorporates his preferences and provides:

- **Medication Management:** John and his chosen social supports are knowledgeable about medications, understand side effects and potential adverse events and have a medication management system.
- **Provider Follow-Up:** John schedules and completes follow-up visits with his behavioral health professional within seven days of discharge and is empowered to be an active participant in these interactions through development of a visit planning agenda.
- **Knowledge of Red Flags:** John and his chosen social supports are knowledgeable about indications that the member's condition is worsening and when to notify the behavioral health professional and receive assistance. Daniel offers to him a peer support specialist who works with him to create a personal Wellness Recovery Action Plan (WRAP) and crisis plan.

- **Personal Health Record (PHR):** Daniel educates John on use of a PHR to facilitate communication and facilitate continuity of the treatment plan across providers and settings.

Before discharge, Daniel is responsible for *three points of contact with John* (or any inpatient member identified as high risk for readmission):

- **Pre-facility discharge** to:
  - Reassess John for SDOH to identify and close any gaps
  - Review John's care management program and introduce peer services
  - Establish a written post-discharge contact plan and make sure John and his social supports have the written discharge plan
  - Verify medication needs are addressed and prescriptions are on our written formulary
  - Prior authorize medications not on our formulary before discharge
  - Validate that John leaves the facility with his medications in hand
- **Post-hospital discharge assessment** through telephonic or field visit within 72 hours to determine needs and medication reconciliation
  - The post-discharge intervention focuses on provider follow-up, knowledge of red flags and John's use of a PHR
  - Coordination with PCP and behavioral health provider for medication safety monitoring and preventive care since individuals with serious behavioral health conditions often have early morbidity and mortality from common chronic medical conditions
- **Follow-up call** to reinforce the value and importance of a provider visit within seven days of discharge, including support in scheduling and ensuring no barriers to attending the appointment

Daniel calls John's pharmacy three days after discharge to verify he filled and picked up prescriptions not filled in the facility. Daniel provides John and his chosen social supports information about alternatives to psychiatric hospitalization (e.g., crisis residential services, intensive outpatient treatment, community support groups) and provides information about social supports (e.g., NAMI groups, peer warm line). Daniel works with John to create a psychiatric advance health care directive, if John agrees to do so. Daniel remains engaged with him as long as John meets criteria for care management.

e. Hospital staff are resistant to having you assist with coordinating discharge and Transition of Care ...

Systemically, we have had success building successful collaborative relationships with hospitals and other facilities to prevent friction and make sure members are connected with the necessary follow-up care to prevent readmission. As part of our overall, multifaceted continuum of care, we will develop strong relationships between all Mississippi hospitals and health plan staff (e.g., hospital social workers and health plan care managers) and clinical leadership (e.g., chief medical officers) to build trust, creating more opportunities for collaboration. For example, in a state similar to Mississippi, we partnered with the state's largest hospital to conduct weekly rounds for our members in the hospital's NICU. Our NICU care managers and the hospital's care managers met collaboratively during rounds to share information and identify ways to engage and support parents and families during this stressful time such as connecting the mom to her local WIC office to enroll for supplemental food benefits. When we determined there was a specific need to address postpartum depression, we engaged behavioral health clinicians in the weekly rounds.

In a situation where hospital staff resist our help with coordination discharge and transition of care (TOC) activities, despite our best efforts to build collaborative partnerships, we will not let the resistance impede the success of our TOC team. The member's care manager will remain involved before, during and after discharge to make sure the member is well supported. The care manager will support the member's PCP or PCMH and

behavioral health provider in following up with the hospital to discuss discharge planning. The care manager will remain engaged directly with the member and their family or caregivers, following up with them within 72 hours after the member's discharge to make sure they have a follow-up appointment scheduled with their PCP or PCMH or with their behavioral health provider, if appropriate, and to help schedule appointments as needed. Our care managers will be trained to fulfill all transition of care requirements outlined in Section 7.8.5 of the Model Contract.

Collaborative Relationships Facilitating Transition of Care

Our transitional care management strategies are designed to prevent hospital readmissions, medical errors and miscommunication by working collaboratively with the member, their family, caregiver(s) and providers, including hospital staff, to improve adherence with medications and follow-up treatment. Our interdisciplinary TOC team will include the member's service navigator, care manager, transitional care nurses, our inpatient care management (ICM) nurses, behavioral health clinicians, our medical director and health services director, as needed. Our provider manual, which is an extension of the provider contract, will provide information to all providers, including hospitals, regarding their roles and responsibilities to help coordinate discharge and transition of care activities for our members. We also will provide training to providers about the transition of care requirements at least twice per year.

When our TOC team reaches out to a facility to support transition of care, they will begin by explaining the purpose of the collaboration, which is to make sure members safely transition from hospital to home. We will use a One Person One Hospital model, assigning an ICM nurse as the primary resource for the facility for inpatient prior authorizations and concurrent reviews. We find that this model promotes collaboration with hospital staff because our ICM nurses develop an intimate knowledge of the facility's staff, culture and procedures. This knowledge helps them access patient information quickly, keep abreast of how members are progressing through their hospital stay and support discharge and transition of care activities.

Throughout the discharge planning process, the TOC team will help arrange for alternative services or programs, such as coordinating delivery of meals post-discharge through a community care package and meal service program, so the member does not worry about going to the grocery store or preparing meals when they get home. They will facilitate transition to a higher or lower level of care at the appropriate time. Meanwhile, the service navigator or care manager, depending on the member's risk level, will engage the member's CMT, including the PCMH or behavioral health provider, to make sure they are aware of the member's inpatient admission and coordinate appropriate follow-up appointments.

[END OF RESPONSE]

Att. 4.2.2.3-1 Health Risk Screening (HRS) Questions

Proposed Mississippi Health Risk Screening 2022

*Division Required Questions in **BOLD**

Adult (20)	**Pediatric**
How would you prefer to be addressed? (salutation or nickname; example: Mrs. Jones vs. Samantha vs. Sam) • Member response:	How would you and your child prefer to be addressed? (salutation or nickname; example: Mrs. Jones vs. Samantha vs. Sam) • Member response: • Child's response
What are your preferred pronouns? o Prefer not to answer o "She/Her" o "He/Him" o "They/Them" o Other (explain/quote):	What are your child's preferred pronouns? o Prefer not to answer o "She/Her" o "He/Him" o "They/Them" o Other (explain/quote):
What is your preferred language for communication? o English o Spanish o Chinese o French o Tagalog o Vietnamese o Korean o German o Arabic o Russian o American Sign Language o Other (explain):	What is your preferred language for communication? o English o Spanish o Chinese o French o Tagalog o Vietnamese o Korean o German o Arabic o Russian o American Sign Language o Other (explain):
Compared to others your age, how would you describe your health? o **Excellent** o **Very Good** o **Good** o **Fair** o **Poor**	**Has there been a recent increase in your child's needs to access medical care, mental health, and/or educational services?** o **Yes** o **No** **Has your child's medical providers indicated your child is not meeting age-appropriate developmental milestones?** o **Yes** o **No**

Adult (20)

Have you been told you have any of the following or are you being treated for any of the following? Please answer Yes or No to each.

Anxiety	☐ **Yes**	☐ **No**
Asthma	☐ **Yes**	☐ **No**
Bipolar	☐ **Yes**	☐ **No**
Cancer	☐ **Yes**	☐ **No**
Congestive Heart Disease	☐ **Yes**	☐ **No**
COPD	☐ **Yes**	☐ **No**
Depression	☐ **Yes**	☐ **No**
Diabetes (sugar diabetes or too much sugar in your blood)	☐ **Yes**	☐ **No**
Heart Problems (irregular heartbeat, heart attack, or heart surgery)	☐ **Yes**	☐ **No**
High Blood Pressure/Hypertension	☐ **Yes**	☐ **No**
HIV/AIDS	☐ **Yes**	☐ **No**
Kidney Failure or on dialysis	☐ **Yes**	☐ **No**
Obesity	☐ **Yes**	☐ **No**
Schizophrenia	☐ **Yes**	☐ **No**
Sickle Cell Disease	☐ **Yes**	☐ **No**
Substance Use Disorder	☐ **Yes**	☐ **No**

Are you planning a pregnancy or currently pregnant? (Ask all people, regardless of gender)

o No
o Yes - Currently pregnant
o Yes - Planning a pregnancy

Within the past 12 months, how many times have you stayed overnight as a patient in a hospital?

- o **0**
- o **1-2 times**
- o **3-5 times**
- o **6 or more times**

Pediatric

Does your child have any of the following or is your child being treated for any of the following?

Please answer "Yes" or "No" to each.

ADD/ADHD	☐ Yes	☐ No
Anxiety	☐ Yes	☐ No
Asthma	☐ Yes	☐ No
Autism	☐ Yes	☐ No
Cancer	☐ Yes	☐ No
Cystic Fibrosis	☐ Yes	☐ No
Depression	☐ Yes	☐ No
Diabetes (sugar diabetes or too much sugar in your child's blood)	☐ Yes	☐ No
Hemophilia	☐ Yes	☐ No
HIV/AIDS	☐ Yes	☐ No
Sickle Cell Disease	☐ Yes	☐ No
Substance Use	☐ Yes	☐ No

Does your child have any kind of emotional, developmental, or behavioral problem for which he or she needs or gets treatment or counseling?

- o Yes
- o No

(If 11 years or older) Is your child currently pregnant?

o Yes
o No

Does your child need or get special therapy, such as physical, occupational or speech therapy?

- o Yes
- o No

Adult (20)	**Pediatric**
How many kinds of medication do you take each day? (Include prescription and over-the-counter medications). o **0** o **1-3** o **4-7** o **8 or more**	**Does your child currently need or use medicine prescribed by a doctor (other than vitamins**) o Yes o No
Do you identify as Hispanic, Latino/a/x, or Spanish origin? (One or more categories may be selected) o Yes o No o Unknown o Prefer not to answer	Does your child identify as Hispanic, Latino/a/x, or Spanish origin? (One or more categories may be selected) o Yes o No o Unknown o Prefer not to answer
Which option best matches how you define your race? Select all that apply: o Asian o African American / Black o American Indian / Alaskan Native o Pacific Islander o Native Hawaiian o White / Caucasian o Other (explain) o Prefer not to answer	Which option best matches how you define your child's race? Select all that apply: o Asian o African American / Black o American Indian / Alaskan Native o Pacific Islander o Native Hawaiian o White / Caucasian o Other (explain) o Prefer not to answer
What sex was listed on your birth certificate when you were born? o Male o Female o Other	What sex was listed on your child's birth certificate when they were born? o Male o Female o Other
How do you describe your gender? o Female o Male o Transgender woman/ trans woman/ male-to-female (MTF) o Transgender man/ trans man/female-to-male (FTM) o Gender queer/gender nonconforming neither exclusively male nor female o Additional gender category or Other (explain): o Prefer not to answer	How does your child describe their gender? o Female o Male o Transgender woman/ trans woman/ male-to-female (MTF) o Transgender man/ trans man/female-to-male (FTM) o Gender queer/gender nonconforming neither exclusively male nor female o Additional gender category or Other (explain): o Prefer not to answer

Adult (20)	**Pediatric**
Thinking about your race, ethnicity, culture, and religion: Do these impact your health, access to healthcare or your overall healthcare experience? o Prefer not to answer o No impact o Some impact o Significant impact	Thinking about your child's race, ethnicity, culture, and religion: Do these impact your health, access to healthcare or your overall healthcare experience? o Prefer not to answer o No impact o Some impact o Significant impact
Thinking about your gender identity, sexual orientation, and relationship status: Do these impact your health, access to healthcare or your overall healthcare experience? o Prefer not to answer o No impact o Some impact o Significant impact	Thinking about your child's gender identity, sexual orientation, and relationship status: Do these impact your health, access to healthcare or your overall healthcare experience? o Prefer not to answer o No impact o Some impact Significant impact
Thinking about the past year, have you or anyone in your household been unable to get any of the following when you really needed it? Check all that apply o Food o Clothing o Utilities (risk of turning off) o Phone o Medicine/Healthcare o Transportation o Housing o I have been able to get these things when needed o Prefer not to answer	Thinking about the past year, have you or anyone in your household been unable to get any of the following when you really needed it? Check all that apply o Food o Clothing o Utilities (risk of turning off) o Phone o Medicine/Healthcare o Transportation o Housing o I have been able to get these things when needed o Prefer not to answer
Thinking about the help you receive from support systems such as Health Insurance, Medicaid or Medicare, Long Term Care, VA benefits, food stamps, housing support etc. Are your needs met through your available benefits? Yes - Member's benefits meet their needs No - Currently has community services that fully meet their needs	Thinking about the help your child and household receive from support systems such as Health Insurance, Medicaid or Medicare, Long Term Care, VA benefits, food stamps, housing support etc: Are your needs met through your available benefits? Yes - Member's benefits meet their needs No - Currently has community services that fully meet their needs

Adult (20)	**Pediatric**
No - Currently has community services in place but still has unmet needs	No - Currently has community services in place but still has unmet needs
How many family members, including yourself, do you currently live with?	How many family members, including yourself, does your child currently live with?
What is your housing situation today?	What is your child's housing situation today?
Are you worried about losing your housing?	Are you worried about you or your child losing their housing?
Do you have any safety concerns in your home environment? o Yes o No o Prefer not to answer	Do you have any safety concerns in your child's home environment(s)? o Yes o No o Prefer not to answer

Att. 4.2.2.3-2 Comprehensive Health Assessment (CHA) Questions

COMPREHENSIVE HEALTH ASSESSMENT

Member Demographics – Member First Name, Last Name DOB Membership ID

1. **How was assessment completed?**
   ○ Telephonic ○ Face to Face ○ Virtual Visit

2. **Hello, is it okay if I ask you some quick questions to make sure I'm talking to the right person?**
   ○ Name/DOB/Address ○ Name/DOB/ID ○ Name/DOB/Last 4 SSN
   ○ Declines to verify (end assessment)

3. **CM Question- Who is/who are the sources of information? (Select all that apply)**
   ○ Member ○ Spouse/Significant Other ○ Primary Caregiver ○ Parent
   ○ Guardian ○ Responsible Party ○ Other (explain) _____

4. **What is your preferred language for communication?**
   ○ English ○ Spanish ○ Chinese ○ French
   ○ Tagalog ○ Vietnamese ○ Korean ○ German
   ○ Arabic ○ Russian ○ American Sign Language ○ Other (explain) _____

5. **Was language line used to complete the assessment?**
   ○ Yes – If yes, Indicate Interpreter ID: _____
   ○ No

6. **Do you have any hearing difficulty or hearing impairment?**
   ○ Yes – Please describe any devices or services in place to support your impairment, and if they are effective:
   ○ No - member has no unmet hearing needs that impact their daily lives or plan of care.

7. **Do you have difficulty seeing or vision impairment?**
   ○ Yes – Please describe any devices, equipment, or services in place to support your visual difficulties, such as prescription glasses, walking stick, magnifying glass, and if they are effective?
   ○ No- member has no unmet vision needs that impact their daily lives or the plan of care.

8. **Describe member's overall language, hearing, and communication needs that impact the member's care:**

9. **With that information, may I enroll you in our Care Management Program? (Educate member that they may opt out at any time)**
   ○ Yes ○ No (if no, stop)

10. **Do you agree to have your health information documented in our system?**
    ○ Yes ○ No (end assessment)

Section B: Self Identification *We believe that in order to truly be able to help someone, we have to have a genuine relationship with them- and that starts with understanding who you are, how you identify yourself and how your beliefs, values and culture play a role in your healthcare. The next few questions will help me to better understand this about you.*

11. How would you prefer to be addressed? (Salutation or nickname; example: Mrs. Jones vs. Samantha vs. Sam)

12. What are your preferred pronouns?

o She/Her o He/Him o They/Them o Prefer not to answer o Other (Explain/Quote: _____)

13. Can you share with me the highest level of education you completed?

o Less than high school o High school diploma o GED or other high school equivalency
o Technical school o Industry or skills certificate o Some college/no degree
o Associate degree o Bachelor's degree o Master's degree
o Doctoral degree o Other (explain) _____

14. Have you ever served in the military?

o No o Prefer not to answer o Yes

If Yes, have you ever or are you currently receiving any services from VA?

o No o Yes, Previously o Yes, currently

15. Do you provide care for or look for someone who needs assistance with their care?

o Yes o No

16. Do you identify as Hispanic, Latino/a, or Spanish origin? (One or more categories may be selected)

o No, not of Hispanic, Latino/a, or Spanish origin
o Yes, Please explain:
☐Mexican ☐Chicano/a ☐Puerto Rican ☐Cuban ☐Another Hispanic, Latino/a, or Spanish origin
o Unknown
o Prefer not to disclose

17. Which option best matches how you define your race? [CM Note: there is no wrong answer, record what the person tells you].

o American Indian/Alaskan Native o African American/Black o Asian
o Native Hawaiian o Other Pacific Islander o White o Other race
o Two or more races o Prefer not to answer

18. Thinking about your race, ethnicity, culture or religion, do any of these impact your health, access to healthcare or your overall healthcare experience?

o Prefer not to answer o No impact o Yes (Impact as shared by member: _____)

19. What, if any, beliefs, or preferences related to your race, ethnicity, culture, or religion would be important for me to know?

o Prefer not to answer o None stated
o Beliefs or Preferences shared by member (explain): _____

20. How would you describe your gender?

o Female o Male
o Transgender woman/trans woman/male-to-female (MTF)
o Transgender man/trans man/female-to-male (FTM)
o Gender queer/gender nonconforming neither exclusively male nor female
o Additional gender category or Other. Please explain: _____
o Prefer not to answer

21. Do you think of yourself as?

o Asexual o Bisexual o Heterosexual or Straight o Gay or Lesbian
o Queer, Pansexual, and/or Questioning
o Other; please specify_____ o Don't know o Prefer not to answer

22. How would you describe your relationship status? (Select as many as apply)

o Married o Have a partner/In a committed relationship o Divorced o Separated
o Widowed o Single o Other (explain): _____
o Prefer not to answer

23. Thinking about your gender identity, sexual orientation, and relationship status, how do these impact your health, access to healthcare or your overall healthcare experience?

o No impact o Some impact (Impact as shared by member: _____)
o Significant impact (Impact as shared by member: _____) o Prefer not to answer

24. Summary of cultural and identify preferences that impact member's care:_____

Section C: Physical Health "Now, I'd like to learn about your health and your health history"

25. Compared to others your age, how would you describe your health?

o Excellent o Very good o Good o Fair o Poor

26. Are you planning a pregnancy or currently pregnant? (Ask all people, regardless of gender)

o No o Yes-Currently pregnant o Yes, Planning a pregnancy
o Prefer not to answer

27. Are you being treated for, or have you been told you have any of the following? (Check all that apply)

Condition	Status	Description of Current or Past Treatment	Degree of Impact on Daily Living
☐ Anxiety			
☐ Arthritis			
☐ Asthma			
☐ Cancer			
☐ Chronic Kidney Disease			
☐ Chronic Pain			
☐ COPD			
☐ Coronary Artery Disease			

Condition	Status	Description of Current or Past Treatment	Degree of Impact on Daily Living
☐ Dementia/Memory Problems			
☐ Depression			
☐ Diabetes Type I			
☐ Diabetes Type II			
☐ Emphysema			
☐ Heart Failure or Enlarged Heart			
☐ Heart Problems (irregular heartbeat, heart attack or heart surgery			
☐ Hepatitis			
☐ High Blood Pressure			
☐ High Cholesterol			
☐ HIV/AIDS			
☐ Kidney Dialysis			
☐ Neurological Disorders (ALS, MS)			
☐ Obesity / Overweight			
☐ Paraplegia/Quadriplegia			
☐ Post- Traumatic Stress Disorder (PTSD)			
☐ Seizure Disorder			
☐ Severe Mental Illness			
☐ Sickle Cell Disease			
☐ Stroke			
☐ Substance Use Disorder			
☐ Traumatic Brain Injury (TBI)			
☐ Other Medical:			
☐ Other Behavioral Health:			
☐ Doesn't Know			

28. Thinking of these conditions that you're currently managing or managed in the past, were any so severe that you were considered disabled?

o Yes o No o Prefer not to answer

29. BMI Calculator

o Member Declines Member's Weight (In Pounds) _____ Member's Height (In Inches) _____ BMI Score_____

30. Have you received any of these preventive services? ***Instructions: For each service, check box to assign status: yes member has completed, no member has not completed, or N/A based on member age and gender***

o Annual Wellness Visit

o Blood Pressure Screening (Recommend annual BP screening age 18 and older)

o Cervical Cancer Screening (Female) (Recommended every 3 years for women ages 21 to 65)

o Colon Cancer Screening (Recommend Fecal occult blood test, sigmoidoscopy or colonoscopy beginning at age 50 - 75)
o Flu Vaccination (Recommend 1 dose annually)
o HIV Screening (Recommend screening for HIV infection in adolescents and adults aged 15 to 65 years).
o Mammogram Screening (Female) (Recommended screening every two years beginning at age 40)
o Tetanus Vaccination within the last 10 years (Recommend revaccination every 10 years)

31. When thinking about any of the health conditions you've shared with me, do you have any difficulty understanding those conditions or the instructions for managing those conditions?
o Yes o No o Prefer not to answer

32. Is it hard for you to concentrate, remember things, or make decisions?
o Yes o No

33. Summary of member's cognitive status, and ability to understand and communicate about their health care conditions and needs: _____

34. Can you tell me what providers you're currently working with, including your Primary Care Physician, to manage your healthcare?
o Yes, Provider Information: (List all Primary Care and Specialty) _____
o Prefers not to answer o Unknown

35. How many different medications do you take each day (including prescriptions and over the counter medications)?
o Zero o 1-7 o 8 or more

36. Thinking about any medications you mentioned, how consistently do you take them as prescribed? Please describe the reason for missing meds such as memory, cannot afford, doesn't like the side effects, etc.
○ Very consistent; never miss a dose
○ Mostly consistent; may miss a dose, but it is an isolated incident
○ Somewhat consistent; miss a dose about once per week
○ Somewhat inconsistent; miss doses about 2-3 times per week
○ Inconsistent; miss doses 4 or more times per week
○ Prefer not to answer

37. Do you currently use any of the following medical equipment to support management of your care needs? Check all that apply and enter additional information about the DME item as needed:
o Blood sugar monitor o Blood Pressure Cuff o Cane/Walker o C-pap/Bi-pap
o Hospital Bed o Nebulizer o Oxygen o PERS (Personal Emergency Response System)
o Ventilator o Wheelchair o Other(explain): o None

38. In the last twelve months, how many times did you stay overnight as a patient in a hospital?
o No, 0
o Yes, 1-3 times. Please describe reason for the admission(s): _____
o Yes, 4 or more times. Please describe reason for the admission(s): _____
o Unknown

o Prefers not to answer

39. Thinking about the past year, have you gone to the Emergency Room for care but were not admitted to the hospital?

o No
o Yes, One to three (1-3) times. Describe the reasons for ER visits: _____
o Yes, Four (4) or more times. Describe the reasons for ER visits: _____
o Unknown
o Prefers not to answer

40. Tell me about surgeries you have had in the past or are planning to have in the future?

o No past or planned surgeries
o Yes - Surgery in the past – describe past surgery(ies). Describe past surgery with dates: _____
o Yes - Planning surgery in the future – describe future surgery. Describe past surgery with dates: _____

41. Summary of member's overall physical health status including status of comorbidities, and key areas of focus for member's care: _____

42. Summary of clinical history, including past hospitalizations, major procedures/surgeries, past illness and treatments, and past meds: _____

Section D: Personal Care Needs

43. Do you need help with any of the following daily activities? Check all that apply.

For each, indicate: "No Assistance Needed/ Independent, Some Assistance Needed, Total Dependence on Someone Else.

Activities of Daily Living (ADLs)	Instrumental Activities of Daily Living (IADLs)
o Bathing o Toileting o Grooming o Dressing o Eating o Transfers/Getting in and out of a bed of chair o Mobility/Walking of moving around	o Housekeeping o Preparing Meals o Shopping o Running Errands o Paying Bills o Managing Money o Getting Transportation o Using Telephone o Taking Medications

44. For the items above that you mentioned needing help with, do you get the help you need?

o I do not need any help o I get all the help I need
o I could use a little more help o I need a lot more help o Prefers not to answer

45. Summary of ADL/IADL assistance - document reason and type of assistance needed for each ADL/IADL:_____

46. Who do you live with?

o Lives alone o Spouse or significant other o Family o Relatives
o Roommate arrangement o Caregiver o Shelter

o Rooming house / Boarding home o Other, Please explain: _____

47. Do you have any safety concerns in your home environment?

o Yes

☐ Physical safety (such as structure, mold, etc.) ☐ Environmental safety/violence

o No

48. Let's talk about the people or services who assist you with your care. Instructions for Assessor: Capture name of individuals who assist with care, relationship, and assistance they provide. Please indicate Primary caregiver (Caregiver).

o Not Applicable/ does not have caregivers

o Select

Name	Relationship	Support Provided	Primary Caregiver	Caregiver Paid or Unpaid
			o Yes o No	o Paid o Unpaid

49. When thinking about your primary caregiver(s), are they available when needed and do you think they have the skills to provide support care appropriate to address you needs?

o Yes o No. Please describe caregiver need: _____

o Not Applicable/ Does not have caregivers

50. Is the primary caregiver present during the assessment?

o Yes o No o Not Applicable

51. Caregiver Question: Caregiving is a big responsibility and can become overwhelming. Have you experienced any of the following due to your responsibility as caregiver? (Please select all that apply)

o Not having enough time for myself o Not having enough time with others in my life

o Felt Lonely o Feeling out of control

o Controlling my frustration or anger regarding caregiver responsibility

o Worsening condition of child o Other – describe_____ o None of the above

52. Caregiver Question: Would you be interested in receiving information on supports available in the community that address caregiver stress?

o Yes o No o N/A

53. Do you have a backup plan if your caregiver were unable to fulfill their care giver responsibility?

o Yes, Describe Backup Plan: _____ o No

54. Summary of caregiver resources available and needed. Document the current resources in place and if they meet the member's needs. If not, document the specific gaps that will be addressed in the treatment plan: _____

55. Thinking about the past year, have you been unable to get any of the following when you really needed it? Check all that apply

o Food o Clothing o Utilities (risk of turning off) o Phone

o Medicine/Healthcare o Transportation o Housing

o I have been able to get these things when needed o Prefers not to answer

56. Thinking about the help you receive from support systems such as Health Insurance, Medicaid or Medicare, Long Term Care, VA benefits, food stamps, housing support etc. Are your needs met through your available benefits?

o Yes - Member's benefits meet their needs. Describe current benefits in place and how they are meeting member's needs:

o No - Currently has community services that fully meet their needs. Please describe the resources in place and how they meet the needs:

o No - Currently has community services in place but still has unmet needs. Please describe the current needs in place, the unmet needs identified, and the plan to address:

57. Summary of Social Determinants of Health Needs and available benefits and resources (social determinants of health are economic and social conditions that affect a wide range of health, functioning and quality of life outcomes):

58. PHQ2– Over the last two weeks, how often have you been bothered by any of the following problems?

Little interest or pleasure in doing things?

o Not at all (0) o Several days (1) o More than half the days (2) o Nearly every day (3)

Feeling down, depressed or hopeless?

o Not at all (0) o Several days (1) o More than half the days (2) o Nearly every day (3)

Total Score (prompts PHQ9 if indicated)

59. If you indicated you were bothered by any of the previous problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

o Not difficult at all o Somewhat Difficult o Very Difficult

o Extremely Difficult. Please explain: _____

60. Have you ever or are you currently receiving any type of mental or behavioral health counseling or treatment (including counseling, medication, program)?

o No o Yes – Past, Please describe treatment and impact: _____

o Prefer not to answer o Yes – Current, Please describe treatment and impact: _____

61. Does this treatment meet your needs? (Is it helpful?)

o No o Yes

62. Have you ever experienced physical, psychological, intimate, or sexualized abuse or neglect?

o Yes, as a child o Yes, as an adult o Yes, as a child and adult

o No o Prefer not to answer

63. Have you ever been exposed to or experienced a catastrophic (very serious/life-changing) event or disaster?

o Yes o No o Prefer not to answer

We always ask about any substance use including prescribed/unprescribed medications as well as tobacco, street or illegal drugs, marijuana, and alcohol use to better assist and provide resources.

64. Do you currently smoke, vape or use other forms of tobacco?

○ Yes ○ No ○ Prefer not to answer

65. Have you used any street or illegal drugs or used a prescription medication for nonmedical reasons in the past year?

○ Never ○ Less than monthly ○ Weekly ○ Daily or almost daily
○ Prefers not to answer

66. How often do you have a drink containing alcohol? (Audit-C)

○ Never ○ Monthly or less ○ 2-4 times a month ○ 2-3 times a week
○ 4 or more times a week

67. How many standard drinks containing alcohol do you have on a typical day? (Audit-C)

○ 0 ○ 1 or 2 ○ 3 or 4 ○ 5 or 6 ○ 7 or 9
○ 10 or more

68. How often do you have six or more drinks on one occasion? (Audit-C)

○ Never ○ Less than monthly ○ Monthly ○ Weekly ○ Daily or almost daily

Audit C Score:_____
A score of 4 or greater for men and 3 or greater for women requires follow-up/BH intervention.

69. Has drinking or drug use ever negatively impacted your activities of daily living (bathing, dressing, grooming, eating, toileting, mobility), or your ability to work, maintain meaningful relationships, or accomplish goals you have set for your life?

○ Yes ○ No ○ Not applicable ○ Chooses not to answer

70. Summary of Behavioral Health status including mental health conditions and treatments, or the absence of. Also describe member's substance use or absence of:

Let's talk about life care planning. Life care planning includes writing down how you want medical decisions to be made for you when you're too ill to speak for yourself. It also includes identifying who can speak for you. There are many different types of life planning documents.

71. Have you completed any of the following life Care planning documents? Check all that apply.

○ Advance Directive ○ Healthcare Power of Attorney ○ Five Wishes ○ Living Will
○ Medical or Physician Orders of Life Sustaining Treatment (MOLST or POLST) form
○ Power of Attorney ○ Psychiatric Advanced Directive
○ I have not completed life care planning documents

72. Have you shared your wishes with your family, caregiver and/or provider?

○ Yes:
☐Family ☐Caregiver ☐Provider ☐Other - Please Describe:_____
○ No

73. Are you interested in receiving some information on life care planning to review and share with your family?

○ Yes ○ No

74. Summary of advance directives or other life planning documents:_____

75. I want to thank you for sharing this information with me. I know it isn't always easy to discuss. Is there any other information about these areas that we did not touch on today that would be important for you to share with me?

○ No ○ Yes, Please Explain: _____

76. What is your preferred way for us to contact/interact with you? (select all that apply)

○ Email ○ Phone ○ In person ○ Virtual visit ○ Other (explain): _____

4.2.2.4 Quality Management (Unmarked)

A. Quality Management Program

1. Describe the Offeror's proposed quality management program, including:

a. The program's infrastructure, including coordination with subcontractors/corporate entities, if applicable;

Our quality management (QM) program for Mississippi will be aligned to the Division of Medicaid Comprehensive Quality Strategy and will be demonstrative of our commitment to improving the quality and safety of clinical care for our members. Our quality management program will be built upon the primary goal of improving the health and health outcomes of our members and all Mississippi. In states similar to Mississippi, we have successfully implemented comprehensive quality management programs that drive quality through enhanced access to preventive services and reducing health disparities.

Our quality priorities will align with the challenges affecting Mississippi, including maternal health, behavioral health, child and adolescent health, chronic disease management and health equity. We will partner with our members, providers, other coordinated care organizations (CCOs), state agencies and community-based organizations (CBOs) to make sure our members have access to high-quality care services. Our comprehensive QM program, with oversight by the board of directors, will be designed to objectively monitor care rendered, systematically evaluate outcomes and effectively implement programs with the ultimate goal of improving the health and health outcomes of our members. We have experience implementing a unified QM program in states with similar Medicaid and Children's Health Insurance Program (CHIP) populations, including streamlined goals, innovative outreach program implementation and strategic community partnerships.

Quality Management Program

We integrate quality improvement into everything we do by using detailed, ongoing analysis to identify opportunities for improvement in care practices. The scope of our QM program will include all aspects of health care (i.e., clinical care, quality of care [QOC], quality of service [QOS], patient safety, coordination of care, member and practitioner satisfaction and access to and availability of care). The following functional areas will collaborate to implement our approach to quality: clinical operations, health services, health equity, member services, community outreach, clinical and data analytics, pharmacy, network, credentialing, analytics reporting team and regulatory adherence.

Our MississippiCAN and CHIP QM program will operate in conjunction with our care management, utilization management and credentialing programs to advance the Triple Aim of health care: improving quality of care, improving care experiences and reducing costs. Our population health management strategy, which is integrated into our QM program, will describe coordinated and collaborative activities and initiatives to promote access to care and improve health outcomes. Member-centeredness will be the basis for our quality structure and will be critical to improve the overall care and service levels provided to our members. We have successfully achieved accreditation status from NCQA for our Medicaid health plans in multiple states. In states similar to Mississippi, we have achieved NCQA Distinction in Multicultural Health Care, demonstrating our commitment to providing culturally and linguistically sensitive services to reduce health care disparities. The health plans in those states will apply for Healthy Equity Accreditation in 2022.

Figure 1. The Triple Aim of healthcare

We will develop a local program infrastructure, including two primary operating committees and seven subcommittees, to oversee and drive quality excellence at every level of the QM program.

Quality Management Infrastructure and Operating Committees

Quality Management Operating Committees	
The Board of Directors (Board)	The Board is the governing body of the organization and has oversight of the QM program and provides feedback and recommendations to the Quality Management Committee (QMC). The QM program documents, including the program description and annual work plan with recommended activities, are reviewed and approved by the Board. Members of the quarterly Board meetings include each local health plan CEO, medical director, quality director and quality program liaisons.
Quality Management Committee	The QMC, chaired by the local health plan CEO, will be the decision-making body who is ultimately responsible for the implementation, coordination and integration of all QM activities. The QMC will meet quarterly and reviews and accept decisions delegated by the Board. Quality Management Committee membership will include a representative from each subcontractor. The local leadership team, including the CEO, COO, medical director, behavioral health medical director, perinatal health director, health equity director, CFO, quality director, behavioral health quality director, utilization management director, care management director, compliance officer, network director and member services director, will all be members of the QMC.

Quality Management Subcommittees

The QMC structure will include seven subcommittees to oversee and drive quality. Each subcommittee chair will be a member of the QMC to provide alignment between the subcommittees and the QMC's quality plan.

- **Provider Advisory Committee (PAC):** Chaired by the medical director, the PAC will be a peer review committee of local community and hospital-based clinicians supporting our efforts to improve quality of care across the care continuum. The PAC will meet quarterly and perform peer review activities and confirm final decisions by the National Credentialing Committee. The PAC will approve Clinical Practice Guidelines and evaluate and monitor the quality, continuity, accessibility, availability, utilization and cost of the health care rendered in the network.
- **Healthcare Quality and Utilization Management (HQUM) Committee:** The medical director will chair the HQUM Committee, which will meet at least quarterly and monitor clinical QM and utilization management (UM) activities. This committee will oversee implementation of our UM strategy, monitor for overutilization and underutilization issues and recommend corrective action if needed.
- **Service Quality Improvement Subcommittee (SQIS):** The SQIS will be chaired by the chief operating officer and meet quarterly to monitor the quality of nonclinical member and provider services delivered by us or our subcontractors.
- **Behavioral Health Joint Operating Committee (BHJOC):** This committee will be chaired by the behavioral health executive director and will be responsible for the review of systemic issues related to the coordination of medical and behavioral health/substance use disorder requirements and the collaboration and oversight of behavioral health accreditation processes.
- **Delegated Vendor Joint Oversight Committee (DVJOC):** The delegated vendor manager will lead this committee performing continuous review of delegated vendors and subcontractor performance activities. The work group will meet quarterly, while the manager will meet monthly with delegated vendors and

subcontractors to review performance metrics and make recommendations to department leaders based on analysis of issues identified, corrective actions needed and opportunities for improvement.

- **Community Partnership Advisory Committee (CPAC):** The CPAC, which will meet quarterly, will be chaired by the member services/community outreach director. The CPAC will be a forum for members and community stakeholders to provide feedback and insights about program services and experiences. We will use this information to modify the quality improvement (QI) program and enhance how care and services are delivered to members.
- **Compliance Committee:** This committee, chaired by the compliance officer, will meet quarterly to assess the state of the compliance program and make sure it prevents, detects and corrects violations of applicable laws, regulations, guidance, government contract requirements, company policies and ethical guidelines.

A Story of Successfully Engaging Stakeholders and Using Data to Improve Quality

In a state of similar size and demographics to Mississippi, the infant and maternal mortality crisis has been at the forefront of public health concerns for several years. Public health data and our internal data analyses pointed to opportunities for improvement in prenatal and postpartum care for women and care during the first 15 months of life for babies. Our HEDIS® claims and internal clinical dashboard all pointed to specific needs in three counties. Of these, County A had the largest measured racial disparities and a large volume of our members. Using these insights, we launched a multiyear, multidisciplinary intervention to focus on this county to improve perinatal and infant care.

Our Approach to Engaging Stakeholders

We used a locally responsive, culturally sensitive approach to understand needs and barriers, available community resources, provider access, and barriers to accessing evidence-based care. We learned from our Member/Family Advisory Council that lack of access to transportation, food, stable housing and providers who were not sensitive to member needs were all part of the systemic issues that confronted members in County A. Cultural norms such as grandparents being very involved in care during early infancy, sleeping practices that were not in keeping with current evidence-based recommendations and low levels of breastfeeding were all identified as key influences.

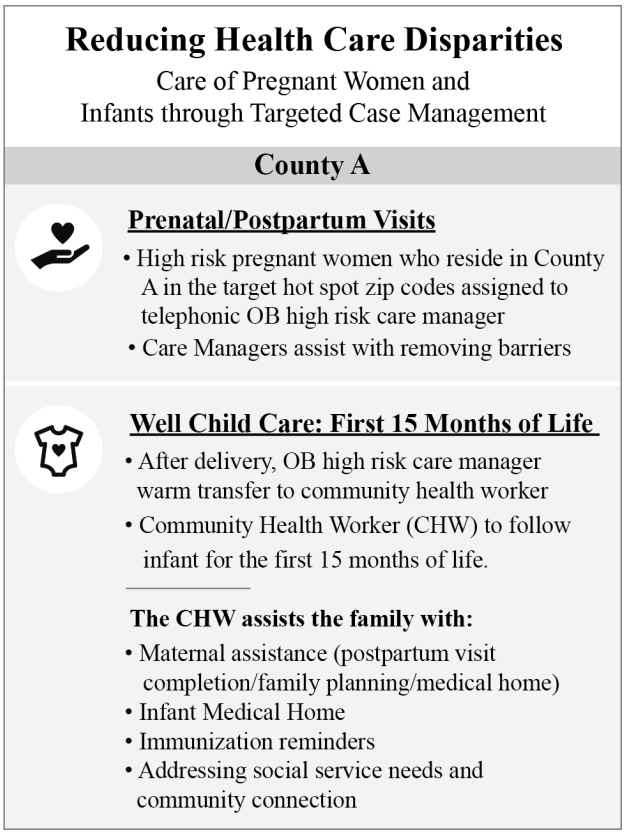


Figure 2. Provider Communication. County A intervention shared with providers to improve member outcomes.

To gain additional insights, we became an active member of a regional collaborative comprising multiple stakeholders focused on promoting equity and prevention of infant mortality. Our perinatal services director and a community health worker (CHW) participated in the collaborative and learned that systemic challenges, including a crumbling infrastructure, funding challenges and structural racism, were underlying the issues our members were experiencing. In addition, our medical director and vice president of population health engaged leaders at the County A Health Department to gain their insights on the health care delivery system.

Armed with this knowledge and direct feedback, we went back to our population health data to identify key providers in that community who were providing perinatal and pediatric care to our members. This included

contracted OB/GYNs and the major hospital in the county for births. We shared data from our claims and tools with these providers to engage them in developing solutions.

Solution

We launched several quality improvement interventions over the course of two years to address each identified key driver , including social determinants of health (SDOH), access to compassionate providers, prompt communication between providers and our health plan staff and member awareness of need for prenatal and postpartum care and infant care. We used input from individual members and their family members to identify suitable solutions and coordinated with the community agencies to which we were referring our members to create a closed loop referrals process. We relied heavily on our member feedback to improve our referral processes and preferences with community agencies.

We worked with two large provider practices to integrate a field-based RN consultant into their workflows to help address barriers in communicating with our plan and with members who were often hard to reach. We instituted several practice changes, including improving communication of identification of pregnancy and scheduling and keeping prenatal, postpartum and pediatrician appointments.

Outcomes

Due to the interventions outlined above, we saw improvements in the following measures in County A.

- **Prenatal Care Visits:** Among engaged members, visits increased by 2.1% from 2017 to 2018
- **Postpartum Care Visits:** Among Black or African American women, visits increased by 3.6%. from 2017 to 2018
- **Well-Child Checks:** The Health Disparity Index decreased from 11.16 to 10.43 among Black or African American women and white women from 2017 to 2018

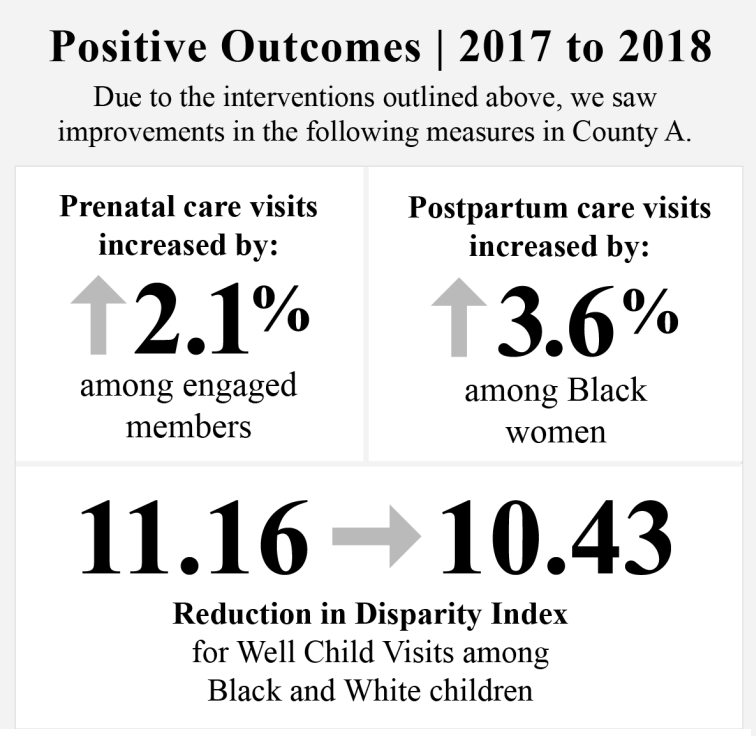


Figure 3. Outcomes in County A as a result of quality improvement interventions

This significant reduction in disparities due to our focused interventions means that more babies are receiving crucial early childhood health care services to set a foundation for improved health as they grow. The example described above demonstrates our engagement of voices of all parts of the local health care delivery system in the communities in greatest need. This engagement in County A informed the development, implementation and outcomes of an effort to improve maternal and child health, reduce disparities and support the state's focus on reducing maternal and infant mortality, setting a foundation for transforming populations at scale.

Subcontractor Coordination

We will conduct oversight activities to coordinate between external subcontractors and internal affiliates, including ongoing meetings to review performance metrics, contractual compliance, audit results, corrective action plans, improvement planning and reports, and early detection and resolution of operational or other potential issues. Subcontractor services reviewed during this meeting will include behavioral health, pharmacy, non-emergency transportation (NET), dental and vision. Our subcontractor relationships, including

subcontractors who are considered internal affiliates, are governed by a contract. We will require each subcontractor to submit monthly reports on established performance metrics, which we review during monthly Delegated Vendor Joint Operating Committee meetings.

b. The program's lines of accountability;

We will execute improvement activities outlined in our QM Program Description and QM Work Plan. Quality management program lines of accountability are built into the organizational structure we have in place today. Members of the Quality Management Committee (QMC) will participate on subcommittees directly aligning with their area of program oversight. The QMC members will have the expertise and experience to coordinate quality management activities in all functional areas. The following QM organization and governance diagram illustrates the lines of accountability.

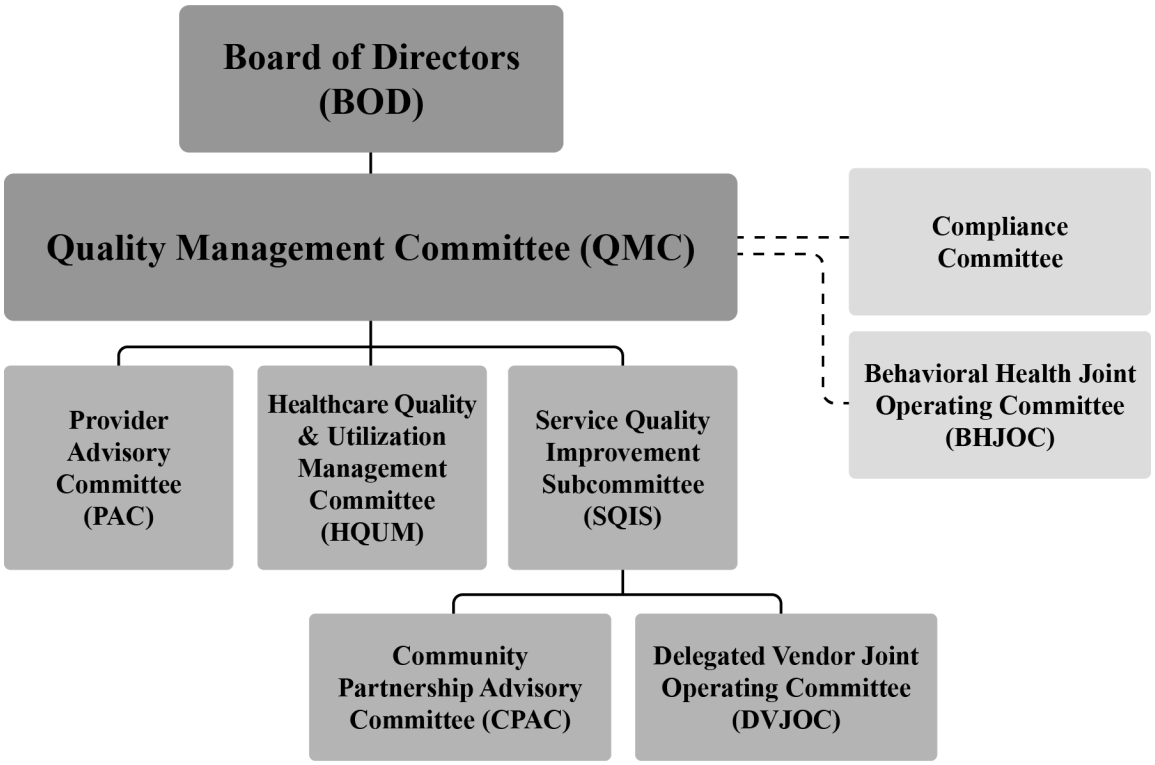


Figure 4. Quality Management Organization Structure. The Board has delegated oversight of the overall QMC program to the QMC.

For each identified priority goal established for the QM program, we will monitor relevant nationally recognized metrics based on established Clinical Practice Guidelines, including measures from Healthcare Effectiveness Data and Information Set (HEDIS®), Centers for Medicare & Medicaid Services (CMS), Consumer Assessment of Healthcare Providers and Systems (CAHPS) and Agency for Healthcare Research and Quality (AHRQ). These measures address preventive health, chronic disease management, acute care and member and provider satisfaction. We will dedicate resources, including staffing, provider value-based purchasing agreements, data analytics and develop community partnerships to address health equity and reduce disparities in the state. Additional staff will include the new health equity director who will monitor performance measures by race and ethnicity, identify opportunities for improvement and implement programs to address identified barriers to care.

The quality management (QM) staff will use bimonthly reporting to trend progress over time, tracking against established performance targets. The QM staff will work closely with the care management team (CMT), health equity director and population health team to analyze results and discuss actions. If key quality metrics do not

meet targeted performance thresholds, we will use our wide range of analytic tools to identify improvement opportunities, define the performance gap and establish our quality improvement approach. This approach includes an eight-step method of data collection, review and approval, benchmark setting, development analysis, re-measurement, monitoring and reporting. We will document the progress of each initiative in a comprehensive plan reported to the QMC.

d. Process for using evidence-based practices;

Evidence-based Clinical Practice Guidelines (CPGs) are the foundation of our clinical decisions, program design and monitoring of the quality of member care. We will apply and monitor performance against CPGs to enhance quality and outcomes while reducing variation and cost of care and treatment. We will continue to adopt evidence-based CPGs from nationally recognized experts, such as American College of Cardiology and American Heart Association, employing rigorous methodologies to evaluate peer-reviewed literature and routine endorsement or updates to guidelines. We will update these evidence-based guidelines at least annually and they will be approved by our local Provider Advisory Committee. These guidelines will serve as a resource when developing our QM program and during the quality improvement process for clinical initiatives.

We will use a team-based approach to transform this information into actionable quality of care drivers for our members and providers, conducting root cause analyses and combining with evidence-based research and stakeholder input to identify appropriate population health interventions. For example, in another state similar to Mississippi, we used data to identify a disparity in hypertension control among Black members, created a reduction SMART aim and implemented a data- and evidence-informed quality improvement plan (QIP) resulting in a 10% reduction in the blood pressure control disparity between Black and whites members with hypertension between 2018 and 2019. We will continue to collect and use data at every step of our approach to inform iterative decisions (adopt, adapt, abandon) for continued improvement.

e. How the Offeror will comply with and support the Mississippi Managed Care Quality Strategy;

Our QM program goals will align with the goals and objectives included in the Mississippi Managed Care Quality Strategy to improve the overall quality of care by focusing on accountability, consistency and respect. We are committed to applying evidence-based practices to our care delivery model to improve the care received by our members. We will apply the quality improvement process to monitor, analyze, implement and evaluate outcomes and implement innovative solutions to improve the health outcomes of our members.

Accountability

In support of the Mississippi Managed Care Quality Strategy objective to use innovation to advance value-based contract arrangements, we will deploy our specialized pay for performance Health Equity Program (HEP) Incentive. The HEP will address disparities seen between populations for key HEDIS metrics important to the Division and MississippiCAN and CHIP members, such as well-child visits, immunizations for adolescents, and comprehensive diabetic care. It will offer tiered incentives to engage providers in getting members in for needed care. While all our pay for performance programs address health equity, this program will closely align with QM program goals to address disparities seen between populations.

Our QM program will include value-based purchasing alternative payment models to reward providers for improving the quality of care for members assigned to their panel. One program will offer bonus payments to providers when they meet target performance thresholds on select quality metrics aligning with priorities outlined in state requirements and accreditation standards, such as timeliness of prenatal visits and asthma control for adults and children. To help providers meet targeted benchmarks, a team of RNs will collaborate with providers to set clinic goals, identify opportunities for improvement and implement targeted initiatives to

improve their overall quality scores. As part of our Quality Improvement Provider Education Program, we will provide our provider-specific quality reporting twice a month and allow providers to see up-to-date quality scores. This reporting will help the provider track their earnings associated with the provider incentive program, track progress on implemented initiatives and identify which members on their panel have open care opportunities.

We are committed to executing provider agreements to improve access to high-quality, cost-effective care and improve health outcomes for individuals and target populations. Our suite of value-based programs will include shared savings programs, health equity incentives and bonus payments for meeting quality goals. These models will support our commitment to quality through an innovative payment arrangement to reward physicians for providing members with the appropriate care in the appropriate setting to achieve better health outcomes.

Our QM and UM program priorities will mirror the objective to minimize wasteful spending by reducing low-value care. Cost and efficiency are driven by three primary drivers: benefits, provider fee schedules and effective utilization management (e.g., prior authorization, care management and preventive care). We will continuously monitor utilization and medical cost trends by annually evaluating our programs. We will review health care and pharmacy trends and provide quarterly updates via the HQUM Committee, led by our medical director. The HQUM Committee will monitor all clinical QM and UM activities, monitor health care trends and analyze any areas of improvement. The goal will be to provide effective, cost-efficient care to underserved populations.

Consistency

With decades of experience working with state, county and local partners across the country, we will develop community-based strategies to meet and support members where they are, close gaps in care and reduce racial and health disparities. Our commitment to quality will include a multipronged (member, provider, community-level) strategy to consistently identify and address needed improvements in the quality of care delivered to members. Our QM program will integrate quality improvement science with population health and health equity concepts, state and federal requirements, state priorities and accreditation regulatory standards. To align with the goal of working with communities to promote best practices of healthy living, our population health management team will implement meaningful quality improvement through organization-wide engagement and collaboration with all stakeholders, including members, providers, community-based organizations and CCOs within the state. Our QM program will include the Community Partnership Advisory Committee, which will be a group of members, stakeholders and community organizations who meet quarterly to discuss opportunities to improve services rendered and to improve care outcomes for the members we serve.

To help improve the quality of life of our members, our program will focus on health prevention, treatment and evidence-based interventions to address all care needs of the members, including physical, behavioral health/substance use disorder and social. Our QM program will include performance improvement projects and studies, Clinical Practice Guidelines, health promotion activities, ongoing measurement and monitoring of key clinical and service indicators (e.g., health outcomes, overutilization and underutilization, access and availability), continuity of care, health plan performance analysis and auditing (e.g., HEDIS), care coordination, educating members and physicians, risk management and compliance with all external regulatory agencies and NCQA accreditation standards.

We are committed to ensuring safe and equitable care delivery to our members. Similar to the objectives in the quality strategy, our maternal health program will emphasize patient safety. The perinatal health director, who will oversee our maternal health program, will review potential quality of care opportunities and help develop and implement corrective action plans. We recognize the importance of improving our members' adherence to prescribed medication regimens. Our QM program will include a medication adherence program targeting members who have diabetes, depression, respiratory conditions and/or HIV. The program will include member-

and provider-targeted interventions to increase members' medication adherence. Based on our experience in a similar state, on average 33% of Medicaid members who engage in our medication adherence program are converted to adherent status within eight months, with a post-intervention proportion of days covered of 94% and NCQA HEDIS scores for antidepressant medication management scoring in the 95th percentile nationally.

Respect

Our care management program will put the people we serve at the center of everything we do. Our member-centric approach will address the full spectrum of member needs, including behavioral health, SDOH, caregiver navigation and treatment of disease using nationally recognized standards of care. Care managers will develop trusting, authentic relationships to optimize the member's quality of life by empowering members through education and supporting services and benefits.

Our goal is to make health care more person-centered, coordinated and accessible. We will empower our members to take an active role in their care, and we value their feedback. Our members will have access to their benefits information 24 hours a day, seven days a week, via our member health portal, where they can find a provider or a pharmacy, view claims and learn more about covered services. Each year we will conduct member satisfaction surveys, including the CAHPS, for both adults and children, asking members and/or family members for input. Our QM program will include a multidisciplinary CAHPS task force to analyze survey results and develop action plans for further improvement. We will offer members the opportunity to respond to a brief survey at the completion of inbound calls to the member services center. This brief assessment will allow for more frequent checkpoints to assess the member experience and intervene when issues arise.

f. Use of data to design, implement and evaluate the effectiveness of the program;

We will use powerful analytics systems to collect data applied to designing, implementing and evaluating the effectiveness of the programs we use to serve our members in compliance with Section 11.B and G of Appendix A, Draft Contract. Our experience and knowledge of similar Medicaid programs will enable us to apply existing system configurations, data exchanges and interfaces already in place and provide efficiencies, expend fewer resources and avoid interruptions to the continuum of care for our members.

Design, Implement, Evaluate

Our data warehouse and analytics tool set will contain claim information (e.g., inpatient, outpatient, physician and specialist, pharmacy, dental, vision and lab), member data, provider data, authorizations, assessment data, care manager and care coordinator notes, external subcontractor data and predictive modeling information, which will be analyzed to initiate the quality improvement process. We will use this data and our analytics tool set to produce comprehensive reports used to assess performance and variation. We will view and analyze the extracted data by language, race and ethnicity to drive our quality improvement activities to reduce health care disparities. We will build our warehouse to support sexual orientation and gender identity factors as they become more available in the future, which will allow us to add additional axes to our health equity assessment. We will refresh these reports monthly and monitor them closely to identify opportunities for performance improvement. We will produce customized reports as requested to closely monitor priority areas or trends.

Once we select an area for improvement, we will use various databases to pull information on the intervention groups, including population characteristics such as ethnicity, culture, language preference or status (e.g., new member, consistently adheres to treatment, sometimes adheres to treatment, never adheres to treatment). Once we identify the population, we will select effective interventions to address specific root causes or barriers.

Our quality team will complete an annual evaluation of our QM program, including a thorough analysis and improvement plan for all elements of the program. This document will outline the effectiveness of each activity and will be approved by the QMC and the Board. We will complete a Quality Management Work Plan

quarterly, which will be an interim snapshot of the performance of all quality management activities, including HEDIS performance.

Approach to Evaluation of Quality Program

Evaluation is core to our efforts to improve our quality programs. Program evaluations will be designed to confirm that all aspects of our plan operations are systematically studied. Based on the IHI Framework and the Model for Improvement, our approach will begin by establishing our aim and continue as interventions are tested and documented via Plan-Do-Study-Act (PDSA) cycles. An example is shown:

Global Aim	SMART Aim
Reduce mortality related to cardiovascular disease and stroke among members with hypertension	Increase the percentage of Black members engaged in the Hypertension Control Improvement Project with controlled hypertension by 20% from 61% to 73% Dec. 31, 2020, to reduce disparities

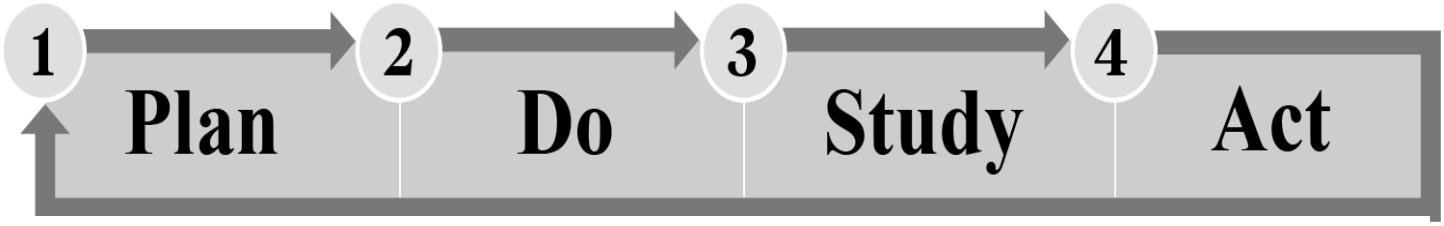


Figure 5. The Plan-Do-Study-Act (PDSA) cycle

Measure Our Progress

It is only by understanding our baseline performance level and ongoing tracking of our progress that we can determine whether our efforts are making an impact. We will monitor our progress at micro, meso and macro levels as we deploy initiatives and interventions to aim for better outcomes for members with chronic conditions. At the micro level, we will focus on process measures to help provide insights as to the effectiveness of specific interventions and PDSA cycles. One example is in our work with a local church in a state similar to Mississippi, where we formed a partnership to address the high prevalence and disparity of hypertension for Black men in a metropolitan area in a state similar to Mississippi. As part of this work, we jointly developed and deployed education programs focused on nutrition, fitness, heart health and diabetes along with specific exercise and yoga classes. We monitored the success of these programs using process measures to determine whether the classes were effective.

While specific process measurement of PDSA cycles is essential for timely insights into the effectiveness of our efforts and helps inform our decisions to adopt, adapt or abandon, we must keep our eye firmly on our SMART aims. To understand outcomes at the meso level, or SMART aim level, we will rely on run and control charts such as the one demonstrated, which tracks weekly progress over time for members with hypertension. Tracking our progress in this format will allow us to identify where significant improvements quickly and easily have been made and when enhanced by annotation, we can link our interventions to shifts in the outcomes. We recognize the importance of understanding variation to draw the right conclusions on the impact of our intervention versus that of chance or unrelated factors.

We will measure nonclinical outcomes, such as member and provider experience, in qualitative and quantitative ways, including through surveys we will conduct and standardized tools such as CAHPS. We will assess financial outcomes, the third part of the IHI Triple Aim, through utilization management report cards and dashboards that will be part of our health plan's key performance indicators — thus making quality and quality improvement an integral part of all plan operations.

The ultimate determination and evaluation of our efforts will be viewed from even broader macro-level measures. Included in this category will be measures that offer a comparison point to our performance relative to the broader system, such as HEDIS and available state data.

Sharing Evaluation Data and Information

Evaluating outcomes, both positive and negative, is most meaningful when the goals and measurements are owned and shared broadly, with both internal and external stakeholders. Our goal will be for providers to be empowered to have a role in driving quality and outcomes. As outlined previously, staff and leaders from all departments and levels will be responsible and actively involved in improving care and quality for our members.

We will share the results of measures broadly with stakeholders to gather input into further program refinements and improvements. In similar states, progress and evaluation results are discussed in weekly team huddles involving those closest to the work and in formal committees, which provide an avenue for broader sharing and perspective. Our Performance Improvement Committee will be charged with monitoring the effectiveness of our programs and services. This multidisciplinary committee will meet monthly and include staff and managers and executive-level sponsors who serve members across all population streams. A typical monthly agenda will be focused on one or two specific areas of work where all members of the committee engage in active learning and discussion for both input to that specific area and sharing of ideas and lessons learned across teams.

We recognize the need to share lessons learned and program evaluations beyond our organization. We will do this in several forums including with members and families through our different advisory councils, our external partners, such as local churches and community-based organizations, weekly forums with quality improvement staff from the other CCOs and regular meetings with state quality staff.

g. Assurance of separation of responsibilities between utilization management and quality assurance staff; and

To verify the continued compliance integrity of our QM activities, we will maintain separation of responsibilities, reporting, oversight and review processes for the UM team and the quality assurance staff, in compliance with Section 10.K and N of Appendix A, Draft Contract. We have provided additional details in the following table:

Program Elements	Quality Management	Utilization Management
Leadership	Quality management director	Utilization management coordinator
Responsibilities	Quality management will provide the framework for our quality programs, including responsibility for compliance and oversight of all QM programs.	Utilization management will provide an integrated, interdisciplinary process to evaluate the quality, continuity, accessibility, timeliness and outcomes of services rendered and the implementation of appropriate action plans.
Infrastructure and Reporting	Quality management infrastructure will encompass two primary operating committees (Board, QMC) and the seven subcommittees (PAC, HQUM, SQIS, BHJOC, DVJOC, CPAC and compliance) to oversee and drive quality excellence at every level.	The UM program strategy, initiatives, metrics and outcomes will be monitored through the National Medical Care Management Committee (NMCMC). The NMCMC is a senior-level body to develop, implement and evaluate the UM program for all entities within the program's scope.
Oversight	The QMC and the board of directors will oversee the QM program, providing a unified approach to quality metrics, analytics reporting and improvement efforts.	The Document Oversight Committee (DOC) will oversee the UM program operational procedures. The DOC will support functional areas in identification of the need for document creation and revision.
Review Process	All QOC issues will be reviewed by clinical staff assigned to the Quality of Care division of the	The UM program will conduct inter-rater reliability (IRR) assessments at least annually to establish the

Program Elements	Quality Management	Utilization Management
	organization. A RN will evaluate all cases with the medical director, specialty reviewer and Peer Review Committee, depending on the severity.	consistency of training and guideline application among clinical reviewers, both physician and non-physician. We will monitor and track the results of the IRR for coaching opportunities.

h. How the Offeror will address health access and equity in its quality management program

Dedicated to a Healthier Mississippi

According to the Mississippi State Department of Health, Mississippi is ranked close to last in almost every leading health outcome. These health disparities are worse for those who have systematically faced obstacles to health related to socioeconomic status, race, ethnicity and geographic location. Mississippi outcomes are worse in areas including diabetes, hypertension, infant mortality and obesity. To align state priorities with our quality management goal of improving the quality of life for our members, we will use our Health Equity Program to address health disparities, monitor access to care and enhance member experiences so every member has a fair opportunity to be as healthy as possible.

The Health Equity Program will be led by the health equity director, a leadership level position, who will coordinate activities among various departments within the health plan. The goal of the Health Equity Program will be to deploy programs and initiatives to remove obstacles so health care is equitable for all, including those who have been traditionally underserved.

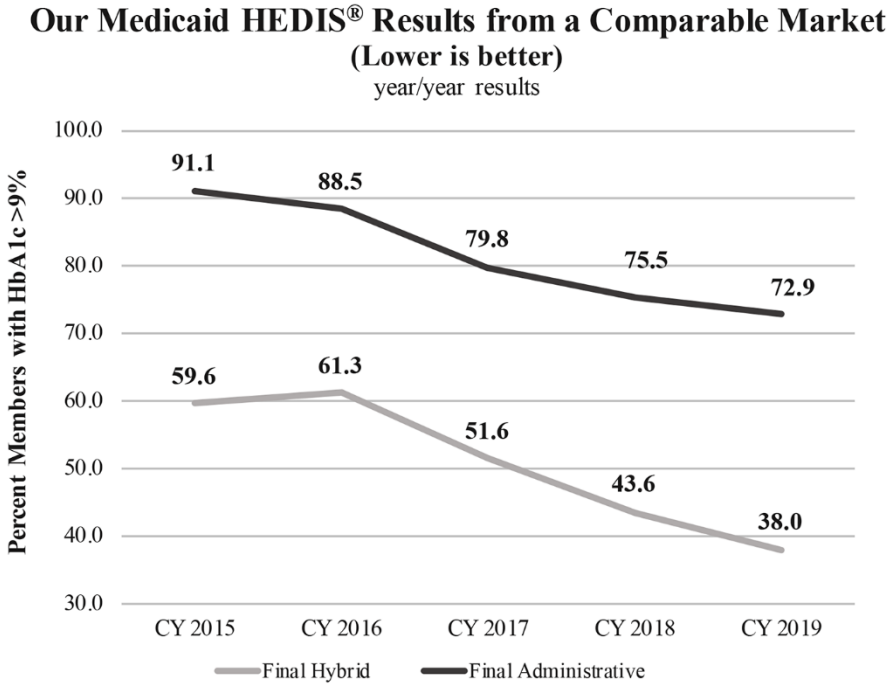


Figure 6. HEDIS® results from a comparable market

To reduce health disparities in Mississippi, we will deploy innovative programs drawing on our experience in programs to reduce health care disparities. We will collaborate with providers to monitor and reduce disparities by implementing our **Health Equity Program** (HEP) Incentive. Like other alternative payment models, the HEP will identify members attributed to provider panels with open care opportunities. The HEP provider scorecard will display compliance rates of attributed members sorted by race and ethnicity to identify disparities between populations. The goal of this program is to support providers as they try to reduce disparities on priority HEDIS measures important to the state. When applied to diabetes management in a state similar to Mississippi, over the course of a year, we observed that the percentage of members noted to be "poorly controlled" went from 59.6% to 38.0%, as measured by HbA1c.

We will assess access issues by identifying, addressing and monitoring health disparities associated with age, gender, address, race and ethnicity, language, disability, as well as sexual orientation and gender identity as that data becomes available. We will analyze this data by geographic location to identify access to care issues. We will perform quarterly access and availability studies to assess our network, crossmatching with geographic compliance data to determine whether access issues are a contributing factor to the disparity. When we identify

access issues, we will activate a multidisciplinary team, including staff from the quality team, provider network and care management, to remove barriers to access and enable members to receive appropriate care.

We have achieved the **NCQA Distinction in Multicultural Health Care in multiple Medicaid states**, which means these health plans were surveyed and NCQA determined the program structure and activities meet the needs of diverse populations. The QM program has data capabilities to collect, report and analyze data by race and ethnicity to make sure services we provide are culturally and linguistically appropriate. This data will help us communicate effectively with our membership and offer materials our members can understand. Our QI Work Plan will include quality initiatives based on analysis of quality measures by race, ethnicity and language. Our QM team will use the Index of Disparity, a nationally used and vetted measure to assess differences among groups. If an Index of Disparity exists, we will target an intervention to address the disparity. We will monitor implementation activities monthly, track progress quarterly on the QI Work Plan and report results annually in the QI evaluation. A targeted approach using Index of Disparity was implemented in a Medicaid population similar to Mississippi, and the Index of Disparity indicated the need to focus on Black pregnant members to improve their timeliness of accessing prenatal and postpartum care. Program enhancements were made and the percentage of Black members accessing postpartum care increased from 37% to 83%, and the number of members obtaining timely prenatal visits increased from 51% to 84%.

2. Provide models of the following documents: Annual Program Evaluation and Annual Program ...

Please refer to **Att. 4.2.2.4-1 Quality Program Evaluation, Description, Workplan Models**, which provides models of our program evaluation, program description and work plan, and demonstrate that we will comply with Section 8 of Quality Management, of Appendix A, Draft Contract. The following are descriptions of the program documents:

Quality Improvement Annual Program Evaluation: Each year, we will evaluate the overall effectiveness of our QM program, including all performance improvement activity throughout the year. The evaluation will review all aspects of the program as defined in the Quality Improvement Program Description (QIPD) and Work Plan (QIWP). It will cover all functional areas focusing on whether the QM program has demonstrated improvement in the quality of care and services provided to members.

Quality Improvement Program Description: The QIPD will describe our philosophy, structure and standards for quality improvement along with the mechanisms and strategic direction for evaluating, monitoring and enhancing quality of care and quality member outcomes. The QIPD will reflect how quality management and performance improvement are intrinsic parts of all operations throughout the organization and will be submitted to the Division for approval annually.

Quality Improvement Work Plan: The QIWP, based on the QIPD, will focus on the program goals, objectives and planned projects for the upcoming year. The QIWP will include specific tasks, responsible owners of activities and anticipated time frames for completion and committee reporting. The QI Work Plan will include action steps and target dates for completion and identification of responsible oversight committees. Monitoring activities will include tracking and trending of identified issues and planned interventions.

B. Clinical Guidelines and Compliance

1. Describe the Offeror’s proposed process to notify Providers of new practice guidelines and to monitor ...

We will partner with other CCOs to compile a comprehensive list of evidence-based Clinical Practice Guidelines (CPGs), which will be distributed to providers. Implementation and care delivery in accordance with these guidelines will be monitored in compliance with the requirements included in the Division’s RFQ. These CPGs will be the framework for clinical decisions, program design and monitoring quality of member care. The new CPGs will be consistent with national standards for disease and chronic illness management from

organizations such as the American College of Cardiology, American Academy of Pediatrics, and U.S. Preventive Services Task Force, for preventive and condition management and treatment.

Physician Notification

We want to enable providers to have easy access to tools to better care for our members. When new guidelines are developed, a notification will be included in the provider newsletter. Providers will be able to access the new guidelines via the Clinical Practice Guidelines link on our provider portal or request a hard copy from our provider services center. We will promote the new guidelines during quality performance review meetings with our field quality nurses and during provider trainings and town hall sessions.

Monitoring Implementation of Guidelines

Annually, the standard Clinical Practice Guidelines will be reviewed and approved by our local Physician Advisory Committee (PAC) and Quality Management Committee (QMC). The practice guidelines will be submitted to the state annually for review as required. Approved guidelines will be available to all providers, and the quality management team will promote use of the guidelines. Throughout the year, the quality management team will monitor provider adherence to the guidelines by completing an annual assessment of provider performance of selected guidelines, medical record review and bimonthly monitoring of provider outcome reports.

2. Provide a list of the behavioral health/substance use disorder clinical guidelines that the Offeror intends to ...

We will establish comprehensive behavioral health and substance use disorder clinical guidelines to be promoted with providers, and we will monitor in compliance with the terms of the model contract. These will include level of care guidelines (LOCG), which address given levels of care to align with evidence-based medicine and CPGs adopted by nationally recognized clinical organizations for the treatment of specific diagnoses.

Level of Care Guidelines: We will use multiple LOCG, including state-specific guidelines, to address behavioral health, substance use and community-based wraparound services to provide the most recent evidence-based care to members. Our guidelines, based on the broad clinical experience and input of our behavioral health clinical leadership, our national provider network and published references from professional sources are listed below:

- American Society of Addiction Medicine (ASAM) Criteria, Third Edition
- Level of Care Utilization System (LOCUS)
- Child and Adolescent Level of Care/Service Intensity Utilization System (CALOCUS-CASII)
- Early Childhood Service Intensity Instrument (ECSII)
- Centers for Medicare & Medicaid (CMS) National and Local Coverage Determinations (NCDs/LCDs)

Behavioral Health Clinical Practice Guidelines

We have adopted nationally-recognized CPGs developed by the American Academy of Child and Adolescent Psychiatry, American Academy of Pediatrics, and American Psychiatric Association. These guidelines define an objective and evidence-based standard of care. Guidelines include:

- Agitation or Psychosis in Patients with Dementia
- Alcohol Use Disorder
- Attention Deficit/Hyperactivity Disorder
- Anxiety Disorder
- Autism Spectrum Disorder
- Eating Disorder
- Obsessive Compulsive Disorder
- Oppositional Defiant Disorder
- Reactive Attachment Disorder
- Schizophrenia

We will adopt the following Mississippi-specific CPGs:

- Assertive Community Treatment
- Community Support Services
- Day Treatment Services
- Intensive Community Outreach and Recovery (Adults)
- Intensive Outpatient Treatment
- Intensive Community Outreach and Recovery (Children/Youth)
- MYPAC Clinical Services
- Psychiatric Residential Treatment Facility
- TCM/Wraparound Facilitation
- Other Mississippi-specific criteria

Promoting Use of Guidelines: We will promote the use of guidelines through peer review and training. Training regarding clinical initiatives will be available both online and in person. We will publish articles in our provider newsletter to reinforce use of guidelines. Providers will be able to access the guidelines via the Clinical Guidelines link on our provider portal, which will be tailored to Mississippi, and through the behavioral health-specific version of our portal, developed for behavioral health providers.

Monitoring Provider Adherence to Guidelines: We will assess providers' adherence to guidelines by monitoring gaps in care, authorizations and adverse benefit determinations. We will conduct peer discussions during adverse benefit decisions and appeals. If the level or type of care requested by the treating practitioner or facility does not appear to meet the criteria outlined in the LOCGs or does not align with our CPGs, our care manager will engage a peer reviewer for a clinical review or one-on-one peer review. We will use prior authorization data to evaluate the appropriateness of the treatment setting and the level of care in alignment with the benefit plan. We will obtain data from treatment record reviews and from member satisfaction surveys. For any issues found, our clinical staff will reach out to the provider to help resolve the issue. In addition, our outpatient care engagement model will use an advanced system of algorithms to identify cases that might benefit from additional intervention aligned with evidence-based treatment. For example, in a state similar to Mississippi we recently worked with a struggling provider to raise their case management quality score from 73% to 96%.

3. Describe the Offeror's proposed process for compliance with the SUPPORT Act.

We implement Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) Act compliance activities in all states where we serve Medicaid populations, and we collaborate with our state partners to validate overall compliance with behavioral health and substance use disorder services. We will implement the compliance efforts listed below in Mississippi.

SUPPORT Act Compliance through Drug Utilization Review: Our retrospective Drug Utilization Review (rDUR) programs will monitor compliance with the SUPPORT Act requirements. These programs will augment the prospective programs provided by the state's pharmacy benefit administrator (PBA) to validate all requirements of the SUPPORT Act are met. Specifically, our Mississippi pharmacy team will implement a Comprehensive Opioid Misuse Prevention Program to target opioid abuse in Mississippi while supporting safe and effective treatment of pain for MississippiCAN and CHIP members through our DUR programs. Our multi-tiered approach effectively reduces unnecessary opioid use and promotes clinically appropriate treatments for each member.

Identifying Potential Problems on a Timely Basis: We will have processes in place to enable secure electronic data transmission and exchanges with the state's PBA and other entities, and we can incorporate pharmacy claims data for Mississippi members into our data systems as frequently as it is received and evaluated through our rDUR analyzer. Using automated review triggers, our Comprehensive Opioid Misuse Prevention Program will monitor utilization behaviors to minimize drug abuse, diversion and inappropriate use, and identify opportunities for intervention. This program will target providers as the source of intervention for members whose opioid use patterns could indicate overuse and abuse. We will generate member-level detailed

reports and outcome summary reports monthly to assess the outcomes of the rDUR program. Retrospective pharmacy programs we provide in other Medicaid states, and will use in Mississippi, include the following:

- Provider outreach when high cumulative daily dose of opioid analgesics is detected, based on morphine milligram equivalent calculation for treatment-experienced and new-to-therapy members
- Prescriber alerts when members receive opioids from multiple prescribers or pharmacies
- Prescriber alerts when chronic early refill or excessive treatment duration of opioids is detected
- Prescriber alerts identifying potentially dangerous drug combinations, including duplicative use of short-acting or long-acting opioids, concurrent use of opioids plus benzodiazepines, concurrent use of opioids plus antipsychotics, opioids plus carisoprodol and opioids plus buprenorphine medication-assisted treatment

Pediatric SUPPORT Act Compliance: A component of our approach is our Antipsychotic Monitoring in Pediatrics Program, through which we will monitor and manage proper use of antipsychotic medications in children and adolescents, inclusive of those children in foster care.

Adult SUPPORT ACT Compliance: In compliance with the SUPPORT Act and through our Abused Medications Program, we will provide education and clinical engagement with opioid prescribers regarding optimal prescribing guidelines geared toward adult members. **Our nationwide program results from 2017-2021 show medication-assisted treatment prescribing increased 42%, and the number of members with concurrent use of opioids and benzodiazepines dropped by 71%, showing the efficacy of program outreach** in improving medication-assisted treatment utilization and remediating risky prescribing patterns.

Comprehensive Medication Management: Members are at higher risk of unnecessary inpatient utilization when medications are difficult to obtain, are prescribed with other medications in error or are not prescribed at all. To further comply with the terms of the SUPPORT Act and support a member's successful community tenure, eligible members can enroll in our comprehensive medication management program. The program will focus on members with serious mental illness or substance use disorder who may benefit from patient-centered support from a clinical pharmacist. The program will coordinate care with the member, care providers and pharmacies, and aim to optimize medication use, increase medication adherence rates, reduce unnecessary higher levels of care and increase member engagement. Unlike traditional medication management programs, this program will provide ongoing monitoring and support of the member's medical and behavioral health needs, strengthening the member's ability to maintain successful community tenure and actively participate in their wellness journey. Leading market indicators show provider acceptance of recommendations made by the clinical pharmacist averaged 86% among Medicaid states.

The **SUPPORT Act brings opportunities** for states to rethink where and how services are provided, such as engaging and beginning services while a member is still in an inpatient setting. We will propose innovative ideas to the Division of Medicaid on how we can collaborate with each other and other entities to meet and exceed the Division's expectations and SUPPORT Act mandates.

4. Provide a list of the physical health clinical guidelines that the Offeror intends to promote and discuss how ...

We have included a comprehensive list of the Physical Health Clinical Practice Guidelines CPGs we will promote to providers. These guidelines are consistent with national standards and are based on reasonable scientific medical evidence.

Physical Health Clinical Practice Guidelines			
Acute Myocardial Infarction with ST Elevation	Acute Myocardial Infarction without ST Elevation	Asthma	Atrial Fibrillation

Physical Health Clinical Practice Guidelines			
Behavioral Health Clinical Practice Guidelines	Cardiovascular Disease: Lifestyle Management to Reduce Cardiovascular Risk	Cardiovascular Disease: Primary Prevention	Cardiovascular Disease: Lifestyle Management to Reduce Cardiovascular Risk
Cholesterol Management	Chronic Obstructive Lung Disease (COPD)	Dementia	Diabetes
Dietary Guidelines	Heart Failure	Obesity	Hemophilia
Human Immuno-deficiency Virus (HIV)	Hypertension	Kidney Disease	Perinatal Care
Physical Activity	Preventive Pediatric Health Care Screening	Preventive Services	Sepsis
Sickle Cell Disease	Stable Ischemic Heart Disease	Tobacco Use	Violence and Abuse

Our processes for monitoring provider CPG adherence will comply with technical specifications by the NCQA and regulatory agencies. Our primary evaluation will use established quality measures aligned with standard clinical practice, including measures from NCQA (HEDIS), CMS, AHRQ and other national measures. In addition to data analysis, we will use the following processes to monitor provider adherence with the CPGs:

- **Annual Clinical Practice Guideline Assessment:** Each year the quality management (QM) team will select four clinical guidelines and measure provider adherence. To conduct this review, the QM team will make sure the guidelines selected address a portion of the population reflecting a high volume or high-risk condition. After the assessment, we will conduct provider education and outreach if compliance with the selected guidelines is low.
- **Medical Record Review:** Annually, we will conduct a comprehensive medical record review on PCP and pediatric providers. During this review, we will monitor records to determine whether criteria are met to show adherence to CPGs related to the record selected for review. For example, if a record of a member with diabetes was selected, the RN would determine whether all required diabetic screenings according to the CPG for diabetes from the American Diabetes Association were followed. In addition, field quality nurses will perform interim reviews and, if deficiencies are noted, deliver on-the-spot education to the providers and staff.
- **Provider Profile Reports:** Quarterly Quality Management Provider Profile Reports will pull data from claims to assess provider compliance with evidence-based performance quality guidelines. Field quality nurses will use these reports to build relationships with network providers and educate them about expectations relative to utilization and quality of care.
- **Provider Quality Scorecard:** The quality scorecard will allow providers to monitor their overall quality scores and see their performance at the group and individual provider level in closing open care gaps in compliance with evidence-based performance guidelines. They will be able to see their compliance by measure, which will help them assess their performance against individual CPGs. If the practice is participating in one of our value-based purchasing arrangement programs, a tab will help them track their earnings in the program and the number of additional gap closures needed to earn an additional bonus payment. The scorecard will include member demographic information used by providers to contact members who have open care opportunities. This report will be updated twice a month, and providers will be able to access it on demand via our provider portal.

5. Describe the Offeror’s proposed policies, procedures, and processes to conduct Provider profiling to assess ...

Our policy will describe how we will conduct provider profiling when we identify improvement opportunities through analysis of provider trends, member accessibility issues and provider feedback. We will apply HEDIS

measures, which measure performance against accepted standards of clinical practice, to the individual provider or practice level to ascertain whether there are variations from expected performance, such as fewer pediatric preventive care visits than would be expected for a pediatrician. When selecting performance measures for inclusion in the provider profiles, we will make sure priority focus areas identified by the state are included such as child and adolescent health, maternal health, chronic condition management and behavioral health.

Provider Profiling Process

To monitor quality performance, the provider profile will include claims data to indicate provider compliance with evidence-based performance guidelines. We recently enhanced the profiles to include more measures and give providers a wider view of clinical quality performance. Each profile will include a wide range of preventive and condition management measures such as annual child wellness exams, immunizations for children and adolescents, asthma medication control and lead screening for pediatric providers. Profiles for adult providers will include results on performance of measures such as cancer screenings, diabetes testing, antidepressant medication management and blood pressure control.

Our provider profiling process will support monitoring for over- and underutilization of services. These profiles will allow the medical director and quality team to educate providers about expectations relative to utilization and quality of care. The profiles will compare case mix-adjusted member PCP panels and clinics by PCP type for multiple indicators, including discharges, hospital days and ER visits. The HQUM Committee will monitor all clinical quality improvement and UM activities to identify over- and underutilization and determines when results indicate we need to contact network providers.

The QM staffing model will include nurses who will work with providers to improve quality outcomes for their assigned members. Field-based RN consultants will share provider profiles with providers during regular meetings to discuss performance. During these visits, field nurses will share resources from our Quality Management Provider Education Program, including evidence-based quality performance guidelines for preventive and condition-specific care, descriptions of each HEDIS measure and required documentation to close identified gaps, coding references and best practice tips for gap closure. We will establish systems for tracking when members are due for services and work with providers to reach members and bring them in to see their PCP for care. Our goal is to improve member health outcomes by making sure providers render all needed preventive and chronic care services per established Clinical Practice Guidelines. In a similar-sized state, during the COVID-19 pandemic, our field-based nurse consultants prioritized diabetes measures and worked closely with providers to track disease management using the provider profiles. We communicated trends alongside provider incentive earning potential, and **the efforts resulted in a 6.6 percentage point increase (from 84.4% to 91%) in the number of members with diabetes receiving their HbA1c tests.** Active engagement with providers using their profiles will allow them to become more familiar with the reports and evolve into a more self-sufficient model that espouses the patient-centered medical home approach.

6. Describe methods the Offeror will use to ensure the quality of care delivered by Non-Contracted Providers.

Our primary aim is to have our members receive the highest quality of care close to home while permitting freedom of choice. Since using a contracted provider is not always ideal, there are times when we will facilitate access to a non-contracted provider. We will verify the quality of care delivered by non-contracted providers through the same processes as network providers and will confirm their eligibility to participate as a Medicaid provider. Our provider services representatives will deliver the same level of support and service, whether the provider is contracted or not, assessing the provider’s qualifications and tracking outcomes. With our large network, we will usually be able to use provider performance data from other lines of business (e.g., Medicaid, employer-sponsored, Medicare). Services performed by non-contracted providers will be subject to a retrospective review to determine whether previous quality of care issues exist following our quality-of-care review process. Monthly, we will track quality of care concerns in a database to allow for trending of any issues

identified, which will help determine whether the services of the non-contracted provider are acceptable for our members.

If a contracted provider is unavailable, we will refer the member to a non-contracted provider and attempt to contract with the provider using the following methods:

- **Health Services Support:** Upon receipt of a member request to begin or continue treatment with a non-contracted provider, we will provide administrative and clinical reviews in accordance with state requirements. We will authorize services via non-contracted providers when a network gap is identified to support transition of care for newly enrolled members and to maintain continuity of care for our members. Concurrently, we will validate the provider's licensure status and Medicaid status. During transition of care or continuity of care, if we are unable to contract with a non-contracted provider, we will work closely with the member and the non-contracted provider during the 90-day transition period to gradually transition care to a network provider with a comparable certification, specialty and expertise. We will confirm the new provider has the expertise to serve the member's identified need, the provider is geographically located near the member (in accordance with state requirements) and the provider can deliver services that are sensitive to the member's cultural preferences. We will discuss the change with the member's PCP and non-contracted provider and involve the medical director as needed to review the appropriateness of the change.
- **Provider Validation (Provisional):** If the non-contracted provider agrees to sign a contract, we will quickly verify credentials. Providers can offer care while formal verification of qualifications is underway based on submission of licensure, Medicaid ID, disclosure and a signed attestation of credentials. Expedited credentialing will allow us to pull data directly from the provider's compared Council for Affordable Quality Healthcare file to fast track through the credentialing committee and local medical director. Our provider services team will assist providers with applicable prior authorizations during this provisional period and help them submit claims for reimbursement of services.
- **Single Case/Letters of Agreement:** When a non-contracted provider is needed to provide care immediately, or to continue care with a member, and they are unwilling to sign a contract to provide services, we will negotiate and implement a letter of agreement (LOA) for covered services to be rendered in compliance with 1) the recognized standard of care in the state and 2) all applicable federal, state and local laws. Both the single case agreement and LOA are binding agreements to provide care for our members and require providers to deliver services in compliance with stated policy.

Our Methods to Support Quality of Care

We will follow the same monitoring protocol whether a contracted or non-contracted provider delivered the care. We will maintain a quality of care (QOC) and peer review process in compliance with state and federal regulations. When we identify a potential quality of care concern, we will refer it to our clinical quality team for review and investigation. We will review cases with our medical director, and if a deviation from standard practice or potentially preventable adverse outcome is identified, we will present the case to our local Provider Advisory Committee (PAC). Our PAC will include participating network practitioners with a variety of clinical backgrounds. Based on the PAC review of the case, we will act based on the severity of the issue.

We will enter all issues into our confidential database for tracking and trending. In this database we will review a complete profile for providers who may have multiple quality of care concerns across several lines of business (e.g., Medicaid, employer-sponsored, Medicare). This database will enable us to determine whether the provider has an unacceptable quality of care trend. We will then evaluate the provider's records during their triannual recredentialing, and the credentialing committee will identify providers who exceed our threshold for QOC concerns before they determine whether to recredential. The following table details our QOC classifications and provider improvement action plans. To determine next steps, we will stratify QOC issues according to their severity.

Levels of QOC	Definition	Action Taken
Level 0 QOC	No QOC issue is identified.	No action
Level 1 QOC	A minor QOC issue is identified. Generally, a Level 1 case is a minor departure from the Standard of Care with a low likelihood of a potential serious adverse outcome.	Improvement Action Plan may be implemented to address identified issue.
Level 2 QOC	A moderate QOC issue is identified. Generally, a Level 2 case is a moderate departure from the Standard of Care with a moderate likelihood of a potential serious adverse outcome.	Improvement Action Plan(s) will be implemented to address issue identified.
Level 3 QOC	A serious QOC issue is identified. Generally, a Level 3 case is a serious departure from the Standard of Care with a high likelihood of a potential serious adverse outcome.	If the serious outcome presents an urgent risk to any member, the medical director in conjunction with a regional Peer Review Committee (PRC) chairperson and regional chief medical officer may summarily restrict or suspend the physician or health care professional's participation status in the network, as outlined in the credentialing plan. Upon approval by the national PRC, the provider may be terminated from the network and reported to the Mississippi State Medical Licensure Board. If the serious outcome does not present an urgent risk to the member, Improvement Action Plan(s) will be implemented to address the issue identified.

The QOC department will handle QOC issues felt to be either a Level 0 or Level 1. The medical director will review all Level 2 cases. The medical director and Peer Review Committee will review all Level 3 cases. All Level 2 and Level 3 cases will require an Improvement Action Plan for confirmed QOC issues identified.

Peer Review Committee

Our Peer Review Committee (PRC) will be comprised of both staff and community-based clinicians. The PRC will review all QOC concerns classified as Level 3 for both contracted and non-contracted providers. We will implement Improvement Action Plans to address the root cause of the QOC concern identified. All QOC activity, including PRC cases reviewed, will be reported to the PAC.

7. Describe the Offeror's proposed policies and procedures for reducing Provider Preventable Conditions, ...

Consistent with the Affordable Care Act administered through CMS, we will implement policies and procedures following the requirements related to the provider preventable conditions (PPCs) initiative, which include: 1) adjustment of reimbursement for Health Care Acquired Conditions, 2) Present On Admission indicator requirement 3) no reimbursement for never events and 4) Other Provider Preventable Conditions as defined by state regulations expanding or further defining the CMS regulations.

Reducing Provider Preventable Conditions

Provider Education

To reduce PPCs, we will proactively increase awareness and offer education to providers. We will explain our policies for reducing PPCs on our provider portal and offer education on patient safety in our provider newsletter and at expos and other educational provider seminars. In addition to the provider reimbursement information, the policy will include a list of references for more information on PPCs, including never events. These educational references will include the American Medical Association, Centers for Disease Control and Prevention, CMS, the Leapfrog Group and National Quality Forum.

Quality of Care Investigation

We will monitor for PPCs quarterly and tag any identified PPC issue as a Level 3 QOC issue. This occurs when a serious departure from the Standard of Care with a high likelihood of a potential serious adverse outcome has occurred. If the serious outcome presents an urgent risk to any member, the medical director in conjunction with a regional Peer Review Committee (PRC) chairperson and regional chief medical officer may summarily restrict or suspend the physician or health care professional's participation status in our network, as outlined in the credentialing plan. Upon approval by the national PRC, the provider may be terminated from the network and reported to the state Medical Licensure Board. If the serious outcome does not present an urgent risk to the member, we will implement an Improvement Action Plan to address the issue.

Provider Medical Record Review

We will track and trend all Level 3 QOC occurrences in a confidential database. When trends are identified, our QOC nurse will identify providers who may have multiple QOC concerns across several lines of business (e.g., Medicaid, employer-sponsored, Medicare). This medical record review will enable us to decide regarding a provider's participation if an unacceptable QOC trend emerges.

Precluding Payment to Providers

Consistent with CMS requirements, our policy will indicate we do not reimburse for a surgical or other invasive procedure, or for services related to a particular surgical or other invasive procedure when any of the following are erroneously performed:

- A different procedure altogether
- The correct procedure but on the wrong body part
- The correct procedure but on the wrong patient

We will align with any state-specific initiatives as approved by CMS.

Reporting Encounter Data

We will report encounter data monthly to the state as required by the contract. This report will include all paid and denied claims for validation by the state. Our policy will require providers to report PPCs, including never events with a no-pay claim. This claim will be included in the monthly file, which will be submitted to the Division for review. This encounter data will be used to report separately on the occurrence of PPCs, including never events.

8. Describe how the Offeror will encourage Providers to use electronic health records and eprescribing ...

We recognize and promote the value and benefits of health information technology (HIT), such as electronic health records (EHRs) and e-prescribing over traditional use of paper health records and prescriptions. These technologies improve clinical quality, data accuracy, convenience, health outcomes and care coordination. We will link technology adoption directly to our value-based purchasing so providers are financially incentivized to use these tools. We will work with providers in Mississippi to encourage use of HIT by promoting no-cost options and direct support solutions.

Encouraging Providers to Use Electronic Health Records

We will promote EHR transition and use by offering solutions to meet providers where they are in the EHR adoption process. The use of EHRs will help Mississippi achieve the Triple Aim of lower cost, better individual health and better population health. In some of our other state programs, the use of EHRs is a requisite for providers who wish to take full advantage of our provider incentive programs. We will not only promote EHRs as tools, but directly link enhanced payment models to their use. When we discuss value-based purchasing with providers, we will inform them of the extra incentive available if they employ EHRs. If providers are unable to secure an EHR vendor, we will offer solutions based on their readiness.

To assess providers' level of EHR adoption and functional use, we will implement tools we have developed for descriptive and predictive analytics. Most notable is our clinical data interface, which is a suite of dashboards and portals that collects clinical data from hospitals and providers to support quality programs, drive clinical innovation and lower costs. Commonly used tools we will use to track provider use of EHRs include:

- **EHR Access Tracker:** This portal will enable us to track all external organizations and facilities for which EHR access has been granted and supports corresponding operational processes
- **Structured Data Submitter Scorecard:** Year to date summary for each structured data submitter via CDSM feeds including enrollment data, file submission count by month and transparency into their EHR
- **Advanced Data Acquisition Dashboard:** Group of dashboards that includes the Discharge Summary (DS) Operations and Quality Content Summary Submitter dashboards and other features with alert and reporting capabilities.
- **Provider EHR Adoption Report:** tracks adoption and types of information being shared by providers

The dashboards will enable broad and drill-down reporting allowing tracking of volume and completeness by and among facilities and the ability to compare cross-product payer types (i.e., Medicaid, Medicare and commercial). This granular visibility will allow us to track and assess the current state and effectiveness of provider adoption of EHRs with engaging the provider directly to find opportunities for improvement.

Actions to Encourage and Facilitate Provider Electronic Health Record Adoption

Our provider support and network contracting teams will engage providers to understand the underlying barriers that may inhibit either adoption or expanded use of EHRs. Using this information, we will work with the provider to show them the next steps most appropriate for their organization. We will support them in developing documentation workflows to optimize their use and facilitate sharing of data externally to better coordinate care and gain access to incentives. At regular intervals, we will reassess their readiness to take that use to the next level.

We will share best practices, explain options and teach methods for data sharing with providers. We will educate providers on the value that can be achieved by increasing use via our value-based purchasing (VBP) programs for health quality metrics. For providers who have not implemented EHRs, most commonly in rural areas of the country or small provider practices, our team will work with providers to help them understand and secure available resources through the health systems by way of the CMS Medicaid Promoting Interoperability Program. This program will benefit health care providers and patients by using the most up-to-date standards and functions to better support interoperable exchange of health information and improve clinical workflows.

To further promote electronic connectivity and provider adoption, we will implement the following strategies in Mississippi:

- **Electronic Health Record Access: Real-Time Data Interoperability Participation Agreement:** This program will enable participating providers to communicate with us electronically using real-time services inside the EHR workflow. Real-time services may include eligibility inquiry, benefit information, gaps in care, encounter, discharge summaries, ADT notifications, high performing provider referral with cost estimation, preferred labs and diagnostic radiology locations and prior authorization for medical and pharmacy services. Participating providers will provide us with remote access to members' medical records in the provider's EHR. This will reduce administrative burden on the providers for service authorizations, utilization management and quality metric collection and reporting.

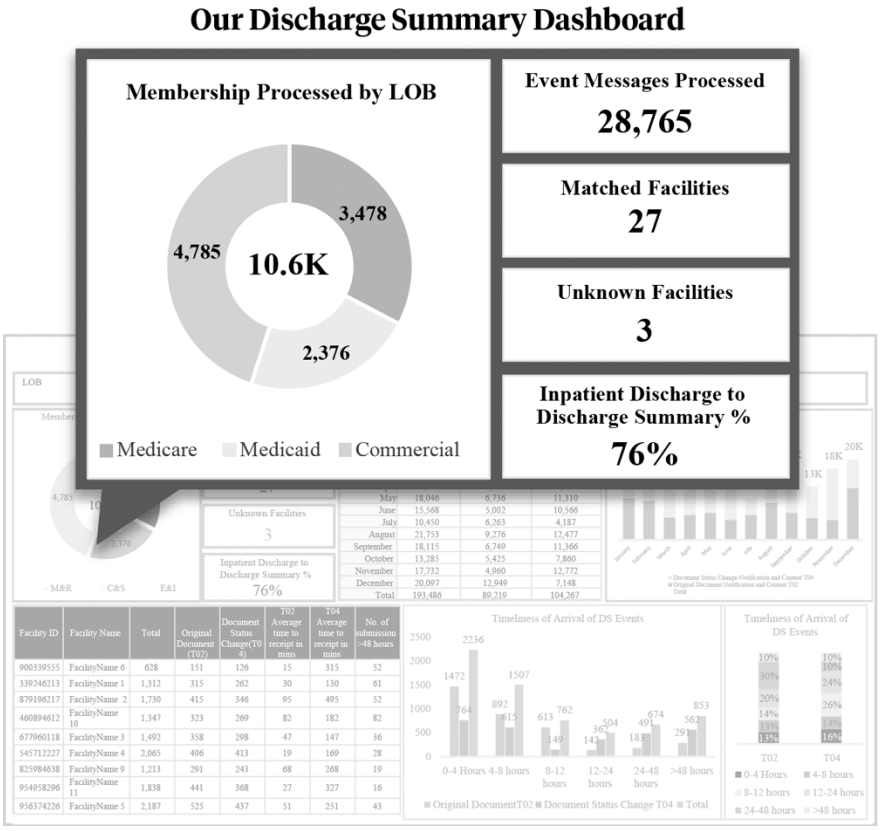


Figure 7. Discharge Summary Dashboard. This dashboard is one of several available on our provider portal. It gives providers line of sight into hospital discharges across our health plan.

- **Integrated Care Management Platform:** We will deploy our integrated care management platform that includes a person-centered care plan and important data, including gaps in care with alerts. Providers will use this platform to enable collaboration across care teams in real time. This feature will enable providers to:
  - Share clinical summaries, referrals, progress notes and registry data, including pharmacy data, and use of Direct Secure Messaging, a fully accredited Healthcare Information Services Provider (HISP) that manages data encryption, routing and directory services while maintaining the necessary trust relationships required for seamless and secure exchange of health care information nationwide between plans and professionals providing patient care
  - Benefit from timely engagement with members in care transitions using ADT integration
  - Exchange documents via C-CDAs (Consolidated Clinical Data Architectures)
  - Communicate in a timely fashion with members via an integrated member and caregiver portal and mobile tool
  - Collaborate across multidisciplinary care teams
- **Provider Portal:** We will deploy our cloud-based, real-time provider portal and the cornerstone of our goal to provide a single provider HIT platform. Through our single sign-on portal, we will bring together multiple websites and both administrative and clinical applications to simplify transactions. Our care management tool will be accessible from our provider portal, which will simplify access for providers both clinically and administratively. In addition, we will offer innovative solutions that integrate directly into the

health system's EHRs in real time to provide ongoing, seamless data exchange (e.g., eligibility enrollment data, gaps in care, member's chart and prescription data), giving providers more direct line of sight into their patient's current and recent health and wellness status. Equipped with this broader view, providers can improve member health outcomes and quality of care while also helping to control total cost of care, improving overall member satisfaction, and better manage their practice due to improved interoperability.

While the above steps are helpful, we recognize they are not enough to help providers reach a level of 100% adoption and use of EHRs in the near term. We understand that timely exchange of data is critical in successfully coordinating care and managing transitions across settings for our members, and we will leverage recent changes in interoperability rules to further promote member engagement, EHR adoption and exchanges of data.

How and What Data is Integrated from Providers' EHRs

To maintain positive relationships, we will build upon each provider's expressed desire to use EHRs in more advanced ways. Our approach to the "how" and "what" of data integration with providers' EHRs will be flexible while still making sure the information is "usable" and can be incorporated into our systems for everything from HEDIS® reporting to care management.

How Data is Integrated: Because data sharing between smaller business entities can be burdensome for some providers, such as behavioral health providers, due to disparate systems and HIPAA Privacy Rules, we will look to resolve barriers and decrease provider burden. We will seek to work at a system or data aggregator level to exchange data. For example, nationally we have worked with EHR vendors to enable direct data transfer between their provider users and our systems, reducing data exchange wait times for providers. We are in production with large-scale EHR solutions to integrate ambulatory data received in C-CDA formats to support Health Level Seven International (HL7) industry standards.

What Data is Integrated: The breadth and type of data we will integrate into our data warehouse includes member demographics, medical history, medication, allergies, immunization status, laboratory test results, radiology images, vital signs, personal statistics, such as age and weight, SDOH data and billing information. With deployment of our care management platform that supports Meaningful Use technology and workflows, providers will have the real-time snapshot of a shared person-centered care plan and important data, including gaps in care with alerts; ER and inpatient admissions and discharges, medical health, behavioral health and pharmacy utilization; referrals; Health Risk Screenings; messaging functionality for care team members; and health-related resource needs. The holistic member view will provide actionable data to facilitate internal communication and care coordination in conjunction with informing our population stream initiatives. Further, it will establish continuity of care and coordination between the provider, member and our care management team. One of many use cases of our care coordination platform will be that it helps to detect poor medication adherence. This information can be directly used and will be incorporated into our systems for use at the individual care manager level and for broader population health, quality improvement and measurement purposes such as HEDIS reporting.

We will provide flexibility and support for providers who are unable or not ready to implement an EHR. In situations where a provider lacks access to secure a vendor, our portal and application programming interface (API) options will be free of charge. Providers can contact provider services and interact with our interactive voice response (IVR) system. Providers can learn about our digital solutions via self-paced learning courses, quick reference guides, live webinar trainings and virtual live provider information expos.

We will promote our free provider portal and applications facilitating electronic recording and data exchange. Some portal applications allow providers to view whether a service has been rendered elsewhere. We will work with providers to determine their readiness for EHRs and other HIT. We have found an introduction to our basic technology accelerates readiness for advanced stages of HIT use, exceeding meaningful use criteria, so as we

help providers move along the continuum from basic transactional and look-up capabilities on our provider portal to becoming an active participant in EHR initiatives leads, we will help them improve care and their earning potential.

Future steps include further enabling connectivity in a way that efficiently and securely integrates data exchange, including more bidirectional clinical information exchange, from several sources, including health providers and CBOs.

Encouraging Providers to E-prescribe

We will engage prescribers who are not e-prescribing through online resources and letter campaigns advising prescribers of the clinical and efficiency benefits of e-prescribing. With the engagement of our pharmacy team and our targeted provider outreach, we will help drive use of e-prescribing, leading to better quality, safety and efficiency. **Across all states, our percentage of Medicaid prescription claims that have been e-prescribed has increased from 56% in 2018 to 78% in 2021.** Through our provider portal, we will offer free solutions to augment traditional e-prescribing, including:

- **Integrating technology with member and provider practices:** We will actively exchange the Mississippi Medicaid and CHIP preferred drug list (PDL) with electronic provider tools to help with medication management best practices. Among other benefits, this will enable us to track e-prescribing, confirm the use of the PDL and make sure members are getting needed prescriptions filled. This can be done before and after the state adopts its chosen PBA.
- **Provider portal applications:** We have recently collaborated with several EHR vendors to integrate our provider portal prescription application with EHRs. This application will facilitate e-prescribing by giving prescribers real-time, member-specific prescription coverage detail at the time of e-prescribing. This application will alert the prescriber of non-preferred drug status or drugs that would otherwise require prior authorization. By integrating this application into common EHR vendors, we will promote e-prescribing practices to add efficiency for prescribers and safety for members.

Further Encouraging Providers to Adopt Health Information Technology

In our provider relations education series, we will promote provider portal and e-prescribing applications, which are free to providers. Providers may take advantage of multiple applications depending on their readiness. Within our portal will be applications owned by our technology vendor and external vendors, all of which can communicate securely and participate in various levels of health information exchange (HIE) and health information technology (HIT). Given the array of solutions, providers can explore options and become familiar with the available technology. We are an industry leader in the use of HIT, engaging our business associates (e.g., the state, providers, our technology vendor and members) on several levels, and we seek out opportunities to work more closely with them. We have already promoted HIT and provided options that are direct solutions. The following represent our initiatives and available services that will support providers who are beginning to explore the use of technology and those who are ready to enhance their use of HIT:

- **Connectivity**: We will actively work with the Division to promote provider use of Mede Analytics to better care for members and contain costs resulting from repeated services. This no-cost solution will use data from a variety of sources to help providers, with or without an EHR, know the type of care their patients are receiving. This will often be a provider's first introduction to HIT and can serve as a catalyst to increase adoption of additional technology.
- **Intermediate electronic transactional solutions:** For a variety of reasons, many providers do not readily accept a full EHR system. To support greater acceptance, our provider portal will contain free programs that often serve as introductions to HIT, leading to greater levels of adoption. By implementing integrated solutions with easy-to-use, but effective tools to automate administrative tasks such as eligibility, financial

assessment and billing while enhancing member care, we can increase adoption and elevate a provider's operations to meet meaningful use (MU) requirements.

- **Regional extension center participation**: We participate in many Offices of the National Coordinator (ONC) Regional Extension Centers board of directors across the country to encourage and promote EHR adoption and MU certification. This provides opportunities to interact with other HIT leaders and further encourage provider adoption.
- **Care management platform**: We will deploy our next generation web-based platform to support MU technology and workflows. Providers can use this platform to share clinical summaries; send and receive secure messaging; engage and communicate with members and caregivers; access admission, discharge and transfer (ADT) information of provider facilities and HIE; exchange Consolidated-Clinical Document Architectures; and collaborate across actual and virtual care teams.

C. Quality Measurement

1. Describe the Offeror's data analytics and data informatics capabilities and how the Offeror will use those ...

At the core of our quality management (QM) program is the analysis of data to monitor and improve the delivery of care, member safety and service. By routinely analyzing key indicators to measure the processes and outcomes of care rendered to our members, we will identify where we should improve. We are contracted with an NCQA-certified HEDIS software vendor to generate our retrospective results annually and our prospective quality metric monitoring throughout the year.

We commit to track any state-required HEDIS measure by race, ethnicity, gender, geographic location and member language. Our reporting development will be flexible to meet the needs of the state as priority focus areas change.

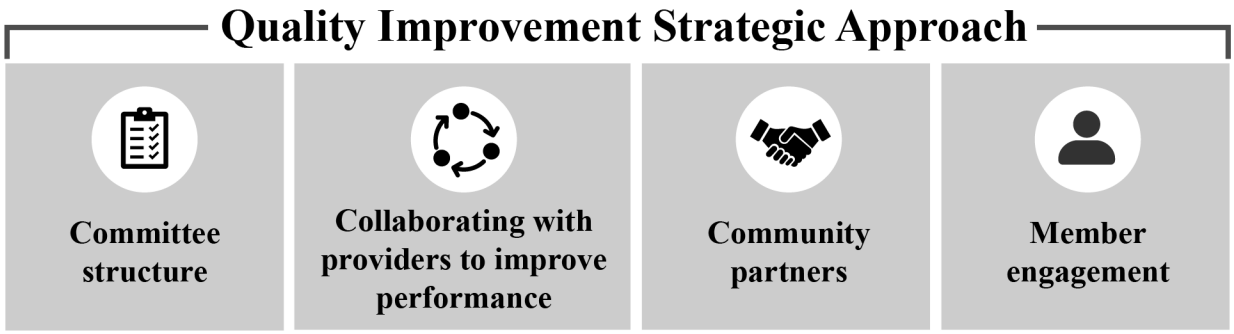


Figure 8. Quality Improvement Strategic Approach

Retrospective Reporting: We will monitor HEDIS rates that pass auditor review with our certified HEDIS auditor. We will submit these rates to the state and NCQA in compliance with state regulations and NCQA accreditation requirements. We will assess the final rates to determine where performance has improved, declined or plateaued and report the information to the QMC and PAC. These data results will drive the activities we include in our QM Work Plan, and when we receive final reporting after the calendar year ends, we will summarize the activities and results into the QM evaluation. Retrospective reporting will be helpful monitoring year-over-year improvement of performance measure outcomes. This tool will be helpful monitoring the tracking toward meeting the goals in the Comprehensive Quality Strategy.

Prospective Quality Metric Reporting: In addition to assessing our performance retrospectively, we will track year-to-date performance. We will view this information at the health plan, provider and member level to 1) determine where our QI Work Plan may need to be modified; 2) provide targeted information if additional interventions are needed to address performance gaps, monitor performance and drive member-specific

communication about care opportunities; and 3) identify opportunities to refer members with multiple outstanding care opportunities to care management. These efforts will include:

- **Performance Monitoring:** The QM team will have access to reports that are updated at least twice a month with year-to-date performance on HEDIS and state custom measures. The QM team can view performance at the product or reporting population level and by a variety of membership segments such as geography, gender, age and race or ethnicity. The ability to view performance by these membership segments will allow the QM team to identify any unwarranted variation and informs our intervention strategies to promote equity and drive overall improvement. Performance monitoring will allow the QM team to determine whether programs implemented to improve a measure are making a positive impact on the targeted population.
- **Member-Level Information:** We will identify members who have gaps in care using certified HEDIS software. We will use this information for direct outreach activities such as calls from our member advocate team to set up a needed appointment or support member incentive programs. We will push the information to providers through the 270/271 eligibility check process, so when a provider office checks on the eligibility of a member, we return a message listing any gaps in care for the member.
- **Provider Scorecard:** We will generate provider performance reports to include the practice's patients with care gaps twice a month. Providers can access these reports through our online provider portal. Our field staff will visit larger practices to review these reports with provider staff, collaborate to close gaps and verify members receive required services. The provider scorecard will help providers track their earnings associated with any active value-based contracts. The scorecard will include demographic information for each member who has open care opportunities for each measure reported in the scorecard.

a. Describe the type of build necessary to create these types of reports.

Additional build will not be required to generate the retrospective and prospective reports. Our QM team uses these reports to drive quality improvement activities. Our data warehouse and analytics tool set contain claims information (e.g., inpatient, outpatient, physician and specialist, pharmacy, dental, vision and lab), member data, provider data, authorizations, external subcontractor data and predictive modeling information. The data warehouse captures information, including geographic information, diagnosis and level of care, disease management categorizations, provider contracts, revenue capitation by rate cell, claims/encounters for each service category, service authorizations by day, actuarial reserving completion factors and risk stratification scores by member. We feed information from this data warehouse into our HEDIS rules engine, and the HEDIS rule results are fed back into the data warehouse to enable more comprehensive assessments of performance and variation.

Following this response are excerpts from five sample reports. Please refer to **Att. 4.2.2.4-2 Quality Sample Reports**. Report descriptions appear below:

- **Retrospective Interim Rate Report:** We generate this report twice monthly to allow the quality manager to track interim HEDIS rates. The sample report shows interim rates during the hybrid/medical record chase process and includes a snapshot of current performance and performance from the same time last year. This analysis helps the team determine whether we are trending toward meeting goals or need to implement performance improvement activities.
- **Prospective Quality Metric Report, Performance Monitoring:** The quality manager monitors this report bimonthly to track performance on HEDIS scores. The team monitors progress on measures where initiatives have been implemented, tracking success or identifying areas where additional performance improvement is needed. These measures are tracked on the Quality Improvement Work Plan.
- **Prospective Quality Metric Report, Member Level Information, Antidepressant Medication Management and Diabetes Noncompliant Report:** We use this report to identify members who are not

adhering to prescribed medications for depression or comprehensive diabetes care. The quality team uses this list to identify members who need outreach and education, to identify and resolve any barriers to care and to offer a member incentive, if available, to close the care gap.

- **Prospective Quality Metric Report, Member Level Information, Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Member Report:** This report shows all claims for completed wellness exams during a quarter. This report includes the first five diagnoses listed on the claim. The EPSDT team uses this report to review claims and diagnoses to determine whether a referral to care management is needed.
- **Provider Scorecard:** The provider scorecard helps providers identify members who have open care opportunities related to preventive health care. The opportunities align with HEDIS performance measures and state custom measures. Addressing care opportunities helps providers achieve positive health outcomes for their patients and earn incentives with value-based purchasing programs. The scorecard has four individualized reports:
  - **Quality Performance:** This report, based on claims data, offers providers at-a-glance information about open care opportunities such as cancer screenings and immunizations. This report shows any bonus payments earned as part of the physician incentive program. Providers can use this tab to identify how many more care gaps should be closed to meet target performance benchmarks and earn additional incentive dollars.
  - **Practice Level Detail/Performance:** This report shows the number of members with an open care opportunity at the health system or group level and highlights performance on key metrics.
  - **Provider Level Detail/Performance:** This report shows the number of members with an open care opportunity at the provider level, highlights performance on key metrics and shows the number of additional gap closures needed to meet the compliance targets.
  - **Member Demographic Report:** This report can be filtered by measure and includes demographic information for all members with open care opportunities. Providers use this report to identify their patients for additional outreach.

2. Describe any innovative approaches the Offeror plans to use to ensure that Quality Measurement is both ...

To validate our quality measurement process is accurate and demonstrates efficacy of our quality management program, one innovative approach we will implement is a dual performance measure validation process, including a primary data source validation (PDSV) on the source system and a medical record review validation (MRRV). A PDSV requires a query of claims data processing information to validate completion of a screening or test. A comprehensive MRRV includes medical record retrieval, abstraction and over-read to validate completion of reported screening or tests. Implementation of these processes in addition to standard processes conducted by the external quality review organization or our NCQA-certified HEDIS auditors will help achieve industry-leading accuracy standards. Dual performance measure validation will help the quality team evaluate the efficacy of program interventions, particularly those designed to support improved provider care and service.

We will begin PDSV and MRRV by selecting measures from priority focus areas identified by the state, those included in value-based purchasing arrangements or performance improvement project activities, or provider feedback from reporting associated with participating quality programs. Once we select measures, we will review a sample of records per measure identified by our prospective quality metric reporting as numerator positive. The sample selected for PDSV will only include records identified as numerator compliant through administrative claims data. The sample selected for MRRV will only include records identified as numerator positive during medical record review.

At a minimum, the following information will be provided for each numerator positive record for both PDSV and MRRV: line of business, member first name, member last name, member date of birth, member ID number and date of service for numerator hit. During the PDSV, the quality team member will first verify eligibility of the member based on their enrollment date and compare to the date of service included in the record selected for audit. Once verified, we will complete a query of the claims data processing system to match the member information, claim detail and date of service. The MRRV includes a member eligibility verification followed by a thorough review of the medical record to determine whether the record includes all information required by the technical specification of the measure.

The quality team will evaluate findings from the dual validation for opportunities to improve accuracy, which could include implementing improvements in data capture and reporting or educating providers on documentation and coding accuracy. In another state, we conducted a similar process after feedback from some providers stating their quality reports did not reflect completed services and they requested an audit of reporting associated with their value-based purchasing arrangement. The report indicated the provider had open care gaps for members, but the provider insisted the selected members had completed the services. The field quality team pulled the entire roster of members assigned to the provider, performed PDSV and identified claims detail showing the screenings had been completed. As a result, a request was submitted to the data analytics team who identified delays in reporting updates for the two measures included in the reports. We resolved the reporting issue, gave the providers credit for the completed screenings and improved the accuracy of our quality reports. We repeated the process the following reporting cycle and confirmed the reporting issue had been resolved.

Evaluation of Efficacy

Evaluation is at the core of our efforts to improve health outcomes by monitoring efficacy of quality management interventions and initiatives. We will design our program evaluations to systematically study all aspects of our plan operations to determine whether we are making an impact. We will establish our aim and test and document interventions via Plan-Do-Study-Act (PDSA) cycles. We will track all HEDIS measures by race, ethnicity and geography and monitor our progress as we deploy initiatives and interventions to achieve better outcomes for members with chronic conditions and make sure our members are accessing their PCP for preventive screenings.

We will share our goals and measurements broadly, with both internal and external stakeholders. We want to empower those closest to the work of improving care to act and to have a role in evaluating the outcomes of their work. As outlined previously, staff and leaders from all departments and levels will be actively involved in improving care of our members. We will discuss progress on initiatives in detail during weekly team huddles and in formal committee meetings, which will provide for broader sharing and perspective. We will report program outcomes to the board of directors in the QM evaluation.

[END OF RESPONSE]

Att. 4.2.2.4-1 Quality Program Evaluation, Description, and Workplan Models

2022 Quality Improvement Program Evaluation

Approving Body	Approval Date
Quality Management Committee	
Board of Directors	

TABLE OF CONTENTS

A. OVERALL EFFECTIVENESS SUMMARY

1. Effectiveness of the Quality Management Program

B. MEMBERSHIP

C. PERFORMANCE MEASUREMENT

1. Healthcare Effectiveness and Data Information Set (HEDIS®) Results
2. Clinical Medical Record
3. Performance Measures Reporting Results
4. Consumer Assessment of Healthcare Providers & System Survey (CAHPS®) Results
5. Provider Satisfaction Survey Results

D. ACCESS

1. Provider Network Access
2. Covered Services and Compliance with Provider Network Standard Requirements
3. Medical Home
4. Access and Availability Audits
5. Provider Directories

E. SPECIFIC POPULATION AND BENEFITS

1. Early Periodic Screening Diagnosis Treatment (EPSDT)
2. Foster Care
3. Pregnant Women
4. Multicultural Health Care

F. PHARMACY

1. Pharmacy Management Activities

G. PERFORMANCE IMPROVEMENT PROJECTS

H. MEMBER SERVICES

1. Community Outreach
2. Marketing (Member Education)
3. Cultural and Linguistic Services
4. Member Rights and Responsibilities
5. Member Connection or Member Advocate Programs
6. Evaluation of Health Education and Prevention Plan/Activities

7. Customer Service Access

I. GRIEVANCE AND APPEALS

1. Overview of Member Grievance and Appeals
2. Overview Provider Grievance and Appeals
3. Overview of Member Investigated Grievance Report
4. Overview of Provider Investigated Grievance Report

J. INCENTIVE PROGRAMS

1. Physician Incentive Plan
2. Member Incentive

K. CARE MANAGEMENT

1. Continuum and Levels
2. Member in Care Management
3. Inpatient Follow-Up and Referral for Transition

L. UTILIZATION MANAGEMENT

1. Turn Around Time
2. Service and Trends
3. Prior Authorizations
4. Inter-Rater Reliability

M. FRAUD AND ABUSE

N. QUALITY OF CARE

O. SUBCONTRACTOR MONITORING

P. CLINICAL PRACTICE STANDARDS

Q. CREDENTIALING AND RECREDENTIALING OF PRACTITIONERS/PROVIDERS

R. PATIENT SAFETY

S. ACCREDITATION

T. EVALUATION OF OVERALL EFFECTIVENESS

2022 Quality Improvement Population Health Management Program Description

Approving Body	Approval Date
Quality Management Committee	
Board of Directors	

TABLE OF CONTENTS

I. MISSION AND VALUES

II. INTRODUCTION AND BACKGROUND

III. SCOPE OF QUALITY IMPROVEMENT PROGRAM

A. Scope of Program
B. Functional Areas and Responsibilities
C. Multicultural Health Care Program
D. Multicultural Health Care Program Activities

IV. PROGRAM OBJECTIVES

A. Promote population health management programs and activities:
B. Improve the member and practitioner experience:
C. Adhere to accreditation and regulatory requirements
D. Serve culturally and linguistically diverse populations

V. QUALITY IMPROVEMENT PROGRAM AND POPULATION HEALTH ACTIVITIES

A. Population Health Management
B. Population Identification
C. Community Supports and Social Determinants of Health
D. Member Notifications
E. Coordination of Member Interventions
F. Quality of Care
G. Early and Periodic Screening Diagnostic and Treatment EPSDT Promotion
H. Coordination of Care
I. Integration of Behavioral Health
J. Patient Safety
K. Clinical Practice Guidelines

VI. SERVICE IMPROVEMENT

A. Performance Improvement Projects (PIPs)
B. Member Experience
C. Peer Review
D. Member Services
E. Language Services
F. Multicultural Health Care Program
G. Network Adequacy

VII. SYSTEMS OF CARE, ADMINISTRATIVE, AND OTHER QUALITY IMPROVEMENT AND PHM ACTIVITIES

A. Accreditation
B. HEDIS®
C. Delegation Oversight
D. Credentialing
E. Medical Record Review

VIII. PROGRAM STRUCTURE

A. Quality Improvement Committee Structure
B. Board of Directors

IX. COMMITTEES

A. Quality Management Committee:
B. Provider Advisory Committee:
C. Healthcare Quality and Utilization Management Committee:
D. Service Quality Improvement Subcommittee:
E. Behavioral Health Joint Operating Committee:
F. Compliance Committee:
G. Community Partnership Advisory Committee:

X. NATIONAL COMMITTEES

XI. REGIONAL COMMITTEES

XII. ORGANIZATIONAL STRUCTURE AND ROLES

XIII. DATA SOURCES

XIV. ATTACHMENTS

Model Quality Management Workplan

	B
1	**2022 Annual Quality Work Plan Goals**
2	**Promote population health management programs and activities**
3	Demonstrate improvement in the health care continuum through relevant quantifiable measures.
4	Promote use of evidence-based Clinical Practice Guidelines (CPG) from nationally recognized sources through annual adoption and dissemination, to practitioners and members.
5	Utilize Social Determinants of Health (SDOH) data to develop programs that reduce barriers and improve health.
6	Support practitioners in their delivery of better health outcomes through practitioner incentives which promote deliver of preventive services and appropriate testing for chronic conditions.
7	Support medically complex and fragile members through complex case management programs that reduce unplanned transitions.
8	Improve coordination of care and transitions through delivery of programs and measurement of key care transition activities.
9	Improve specific health outcomes including, but not limited to: - Reduction of pre-term births - Reduction of hospital admissions - Reduction of COVID-19 spread and hospitalizations
10	**Improve the member and practitioner experience**
11	Identify, investigate and take appropriate action on all Quality of Care (QOC) issues.
12	Monitor patient safety key indicators across all settings.
13	Improve member experience through analysis of Consumer Assessment of Healthcare Providers and Systems (CAHPS®), grievance and appeal data, and implement process improvements.
14	Monitor the adequacy of the contracted network through analysis of access, availability, and out-of-network (OON) data and adjust the practitioner network, as appropriate.
15	Monitor practitioner satisfaction through analysis of annual provider survey results, address opportunities as applicable.
16	**Adhere to accreditation and regulatory requirements**
17	Comply with state and federal regulatory requirements and accreditation standards
18	Facilitate and maintain partnerships between practitioners and the health plan through coordination of care activities, committee participation, and monitor for compliance with evidence-based medicine through QOC and CAHPS®.
19	Complete Performance Improvements Projects as required by the state contract.
20	**Serve culturally and linguistically diverse populations.**
21	Assess the cultural, ethnic, racial, and linguistic characteristics of the membership and practitioner network. Adjust the network as appropriate.
22	Provide training and tools for health plan staff and practitioners in support of culturally and linguistically appropriate practices, reducing bias and promoting inclusion.
23	Foster health equity by program development specific to linguistic and cultural populations (i.e., by race/ethnicity, language, gender, sexual orientation).
24	Close gaps in care through evidence-based member engagement programs targeted to specific linguistic and cultural populations.
25	Improve clinical performance by race/ethnicity, language, and gender through addressing identified areas of health care disparity.
26	Improve culturally and linguistically appropriate services (CLAS) through addressing identified gaps in the service experience by race/ethnicity and language.
27	Maintain effective national, regional, and local committee structures, which includes involvement from members of the culturally diverse community to evaluate and improve overall program.
28	**State Specific Goals and Objectives**
29	Developed based on priorities and objectives as identified by the State regulator.
30	

Objectives | Activities | Quality | HEDIS | PHM | Clinical Svcs | Network | Member Svc | EPSDT | MHC | Pharmacy | Committees

	A	B	C	D	E	F	G	H	I	J	K	L	M
1	**Objective (Related to Column B on Objectives Tab)**	**Accreditation / Regulatory Standard (NCQA 2021)**	**Accreditation / Regulatory Standard (NCQA 2022)**	**Activity**	**Responsible Person**	**Q1 Jan-Mar**	**Q2 Apr-Jun**	**Q3 Jul-Sep**	**Q4 Oct-Dec**	**Previous Issue/Barrier (Yes, No)**	**Comments / Status / Previous Issue Update**	**In Progress/ Completed**	**Reporting Committee**
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20													
21													
22													
23													
24													
25													
26													
27													
28													
29													
30													
31													
32													
33													
34													

Objectives | Activities | **Quality** | HEDIS | PHM | Clinical Svcs | Network | Member Svcs | EPSDT | MHC | Pharmacy | Committees

Att. 4.2.2.4-2 Quality Sample Reports

Retrospective Interim Rate Report

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S
1	Retrospective Interim Rate Report																		
2	Measure/ Submeasure	Highest Percentile	Compliant from Admin	Compliant from MRR	Compliant from SDS	Total Compliant	Sample Size	Current Rate	Initial Rate	Rate Same Time Last Year (STLR)	Current Hits to STLR	Prior Year Rate	Rate Difference PY	Hits to Reach 5% Threshold	75th Pctile	Current Hits to 75 Pct	90th Pctile	Current Hits to 90 Pct	Remaining Chases
3	ABA	<25	150	0	47	197	411	47.90%	47.40%	35.80%	-50	88.80%	-40.80%	147	93.60%	187	95.90%	197	319
4	AWC	<25	133	0	1	134	411	32.60%	32.60%	31.40%	-5	45.50%	-12.90%	32	62.80%	124	68.10%	146	381
5	CBP - rate	<25	45	0	29	74	411	18.00%	17.50%	2.90%	-62	53.50%	-35.50%	125	66.90%	201	72.30%	223	463
6	CCS	<25	187	0	19	206	411	50.10%	50.10%	51.30%	5	54.90%	-4.80%	-1	66.20%	66	72.00%	90	310
7	CDC - HbA1c<8	<25	11	0	37	48	411	11.70%	11.40%	6.80%	-20	46.20%	-34.60%	121	56.00%	182	60.70%	201	840
8	CDC - BP<140/90	<25	47	0	35	82	411	20.00%	19.70%	0.50%	-80	52.30%	-32.40%	112	71.30%	211	77.00%	235	840
9	CDC - Eye	<25	210	0	0	210	411	51.10%	51.10%	50.40%	-3	55.70%	-4.60%	-2	64.70%	56	69.50%	76	840
10	CDC - Neph	<25	346	0	3	349	411	84.90%	84.90%	87.80%	12	89.80%	-4.90%	-1	91.90%	29	93.40%	35	840
11	CDC - Poor Control	<25	334	0	20	354	411	13.90%	13.60%	7.80%	-25	54.50%	-40.70%	-109	32.90%	78	28.00%	58	840
12	CDC - HbA1c Test	<25	323	0	5	328	411	79.80%	79.80%	81.00%	5	84.40%	-4.60%	-2	90.50%	44	92.90%	54	840
13	CIS - Combo 2	<25	175	0	31	206	411	50.10%	49.40%	76.90%	110	80.80%	-30.70%	105	77.10%	111	80.80%	126	555
14	CIS - Combo 3	<25	169	0	33	202	411	49.10%	48.40%	75.90%	110	79.30%	-30.20%	103	74.50%	104	78.60%	121	555
15	CIS - Combo 4	<25	148	0	28	176	411	42.80%	42.30%	66.20%	96	69.60%	-26.80%	89	71.80%	119	76.20%	137	555
16	CIS - Combo 5	<25	152	0	33	185	411	45.00%	44.30%	67.20%	91	70.10%	-25.10%	82	64.80%	81	69.10%	99	555
17	CIS - Combo 6	<25	55	0	17	72	411	17.50%	17.00%	25.80%	34	27.50%	-10.00%	20	47.50%	123	54.00%	150	555
18	CIS - Combo 7	<25	136	0	26	162	411	39.40%	38.90%	59.10%	81	62.00%	-22.60%	72	63.50%	99	67.90%	117	555
19	CIS - Combo 8	<25	53	0	15	68	411	16.50%	16.10%	24.30%	32	26.00%	-9.50%	18	46.70%	124	52.80%	149	555
20	CIS - Combo 9	<25	48	0	15	63	411	15.30%	14.80%	23.10%	32	24.30%	-9.00%	16	42.10%	110	49.60%	141	555
21	CIS - Combo 10	<25	46	0	13	59	411	14.40%	13.90%	22.10%	32	23.40%	-9.00%	16	42.00%	114	49.30%	143	555
22	CIS - dtp	<25	224	0	58	282	411	68.60%	68.40%	80.10%	47	83.20%	-14.60%	39	80.80%	50	84.20%	64	555
23	CIS - flu	<25	106	0	12	118	411	28.70%	28.70%	30.90%	9	31.60%	-2.90%	-9	55.50%	110	61.60%	135	555
24	CIS - hep	<25	257	0	40	297	411	72.30%	71.50%	91.70%	80	94.60%	-22.40%	71	92.50%	83	93.80%	88	555
25	CIS - hib	<25	279	0	52	331	411	80.50%	80.30%	87.60%	29	91.20%	-10.70%	23	90.80%	42	92.90%	51	555
26	CIS - hpa	<25	276	0	24	300	411	73.00%	72.70%	79.30%	26	81.30%	-8.30%	13	88.10%	62	90.40%	72	555
27	CIS - mmr	<25	303	0	15	318	411	77.40%	76.40%	92.00%	60	93.70%	-16.30%	46	91.00%	56	93.20%	65	555

Prospective Quality Metric Report Performance Monitoring

	A	B	C	D	E	F	G	H	I	J	K	L	M
1	**Prospective Quality Metric Report,Performance Monitoring**												
2	Measure/SubMeasureID	Numerator	Denominator	Rate	PY Same	Final Admin	10th	25th	50th	66th	75th	90th	95th
3	AABMY20: AGE17	294	406	72.41%	31.93%	66.79%	47.59%	54.25%	60.52%	64.92%	69.03%	79.94%	85.16%
4	AABMY20: AGE64	9	13	69.23%	28.00%	66.67%	29.74%	32.82%	36.89%	39.32%	41.76%	50.87%	55.63%
5	AABMY20: TOTAL	303	419	72.32%		66.78%	40.49%	45.14%	50.77%	55.95%	58.23%	65.32%	73.56%
6	ADDMY20: CONTMAINT	52	104	50.00%	67.57%	66.00%	37.50%	46.14%	54.73%	58.76%	61.54%	67.98%	70.25%
7	ADDMY20: INITIATION	273	750	36.40%	46.99%	52.09%	31.22%	36.56%	42.95%	46.53%	48.05%	55.33%	58.95%
8	ADVMY20: 02TO03	383	1,537	24.92%	31.79%	57.12%	26.91%	34.41%	43.94%	48.53%	52.44%	59.13%	64.08%
9	ADVMY20: 04TO06	1,275	3,189	39.98%	51.12%	77.54%	51.11%	58.20%	66.24%	71.65%	72.86%	76.79%	78.21%
10	ADVMY20: 07TO10	2,494	5,586	44.65%	57.61%	82.81%	55.56%	63.21%	70.92%	74.18%	75.63%	78.37%	81.07%
11	ADVMY20: 11TO14	2,880	6,584	43.74%	55.72%	78.34%	48.47%	58.74%	65.93%	68.91%	71.09%	74.87%	75.85%
12	ADVMY20: 15TO18	2,634	6,672	39.48%	49.60%	69.80%	39.46%	50.43%	55.87%	60.65%	61.86%	65.76%	69.51%
13	ADVMY20: 19TO20	92	246	37.40%	41.26%	55.20%	25.91%	32.54%	39.52%	42.89%	45.37%	50.21%	54.70%
14	ADVMY20: TOTAL	9,758	23,814	40.98%		75.25%	30.22%	49.21%	60.15%	64.33%	66.18%	70.67%	73.15%
15	AMMMY20: EAPT	24	40	60.00%	67.86%	41.94%	46.12%	50.38%	53.57%	56.85%	58.93%	64.29%	69.47%
16	AMMMY20: ECPT	14	40	35.00%	35.71%	19.35%	30.43%	34.23%	38.18%	41.17%	43.10%	49.37%	53.86%
17	AMRMY20: 5TO11PDC50	143	161	88.82%	86.24%	86.85%	61.87%	68.35%	73.61%	77.12%	79.22%	83.82%	86.77%
18	AMRMY20: 5TO64PD50	316	372	84.95%		80.47%	51.85%	57.59%	62.43%	65.78%	68.13%	73.38%	79.01%
19	AMRMY20: 12TO18PD50	170	207	82.13%	81.22%	73.68%	54.61%	60.41%	65.39%	68.84%	71.24%	75.81%	77.80%
20	AMRMY20: 19TO50PD50	3	4	75.00%	0.00%	100.00%	44.13%	49.11%	53.33%	56.03%	57.51%	63.99%	66.35%
21	APCMY20R: 1TO5	0	2	0.00%									
22	APCMY20R: 6TO11	0	45	0.00%									
23	APCMY20R: 12TO17	0	90	0.00%									
24	APCMY20R: TOTAL	0	137	0.00%									
25	APMMY20: HBAGE111	20	66	30.30%		39.29%	35.67%	39.12%	44.64%	49.09%	52.61%	60.92%	76.34%
26	APMMY20: HBAGE1217	69	137	50.36%		48.84%	51.28%	54.93%	60.76%	64.06%	65.56%	72.65%	77.94%
27	APMMY20: HBTOTAL	89	203	43.84%		45.95%	45.42%	49.43%	54.42%	59.00%	61.03%	69.66%	76.42%
28	APMMY20: LDAGE111	14	66	21.21%		26.79%	23.63%	26.97%	33.63%	38.16%	40.55%	53.54%	70.66%
29	APMMY20: LDAGE1217	40	137	29.20%		27.91%	29.03%	33.58%	39.86%	44.34%	47.71%	58.36%	67.77%
30	APMMY20: LDTOTAL	54	203	26.60%		27.57%	26.56%	31.83%	37.08%	41.78%	45.59%	58.40%	68.43%
31	APMMY20: TAGE111	14	66	21.21%		25.00%	21.79%	24.48%	31.21%	35.91%	38.75%	49.55%	66.99%
32	APMMY20: TAGE1217	38	137	27.74%		25.58%	25.98%	32.34%	38.19%	43.12%	46.46%	56.41%	64.52%
33	APMMY20: TOTAL	52	203	25.62%		25.41%	25.00%	29.35%	35.43%	40.00%	44.30%	56.34%	65.89%
34	APPMY20: 1TO11	12	28	42.86%		60.53%	43.72%	53.57%	63.64%	67.59%	71.97%	78.38%	81.52%

Prospective Quality Metric Report- Member Level Information AMM and Diabetes

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U
1	Prospective Quality Metric Report- Member Level Information																				
2	Health Plan	Review Set	LOB	Measure	Sub Measure ID	Sub Measure Description	Compliance	Member ID	Medicaid ID	DOB	Age	Gender	Race	Ethnicity	Mem Language	Mem Full Name	Contact Address	Contact City	Contact State	Contact Zip Code	Contact Telephone
3	USA	MY_21	XX	Antidepressant Medication Management	EAPT	Effective Acute Phase Treatment	No	12345678	9.88E+08	12/05/1981	39	F	Black or African American	Not Hispanic or Latino	English	United, States	123 USA Drive, USA	AMERICA	USA	1234567	555555555
4	USA	MY_21	XX	Antidepressant Medication Management	ECPT	Effective Continuation Phase Treatment	No	12345678	9.88E+08	12/5/1981	39	F	Black or African American	Not Hispanic or Latino	English	United, States	123 USA Drive, USA	AMERICA	USA	1234567	555555555
5	USA	MY_21	XX	Comprehensive Diabetes Care	BP14090	Blood Pressure Control	No	12345678	9.88E+08	06/02/1974	47	F	White	Not Hispanic or Latino	English	United, States	123 USA Drive, USA	AMERICA	USA	1234567	555555555
6	USA	MY_21	XX	Comprehensive Diabetes Care	EYEEXAM	Eye Exam	No	12345678	9.88E+08	06/02/1974	47	F	White	Not Hispanic or Latino	English	United, States	123 USA Drive, USA	AMERICA	USA	1234567	555555555
7	USA	MY_21	XX	Comprehensive Diabetes Care	HBA1C8	HbA1c Adequate Control (<8)	No	12345678	9.88E+08	06/02/1974	47	F	White	Not Hispanic or Latino	English	United, States	123 USA Drive, USA	AMERICA	USA	1234567	555555555
8	USA	MY_21	XX	Comprehensive Diabetes Care	HBA1CCTL	HbA1c Control (<=9)	No	12345678	9.88E+08	06/02/1974	47	F	White	Not Hispanic or Latino	English	United, States	123 USA Drive, USA	AMERICA	USA	1234567	555555555
9	USA	MY_21	XX	Comprehensive Diabetes Care	BP14090	Blood Pressure Control (<140/90)	No	12345678	9.88E+08	05/01/1962	59	F	White	Not Hispanic or Latino	English	United, States	123 USA Drive, USA	AMERICA	USA	1234567	555555555
10	USA	MY_21	XX	Comprehensive Diabetes Care	POORHB	HbA1c Poor Control (>9)	No	12345678	9.88E+08	05/01/1962	59	F	White	Not Hispanic or Latino	English	United, States	123 USA Drive, USA	AMERICA	USA	1234567	555555555

Prospective Quality Metric Report- Member Level Information EPSDT Compliant Report

MEMBER ID	LNAME	FNAME	MI	DOB	AGE	MEMB_ADDRESS_LINE_1	CITY	STATE	ZIP CODE	PHONE	SERVICE DATE	DIAG	DIAG2	DIAG3	DIAG4	DIAG5
123456	Happy	One	G	1/1/1991	13	123 USA Street	United States	XX	123455	5.556E+09	7/30/2021	Z00.129	Z23	N/A	N/A	N/A
123456	Happy	One	R	1/1/1991	13	123 USA Street	United States	XX	123455	5.556E+09	7/12/2021	Z00.129	Z23	N/A	N/A	N/A
123456	Happy	One	M	1/1/1991	13	123 USA Street	United States	XX	123455	5.556E+09	7/13/2021	Z00.129	N/A	N/A	N/A	N/A
123456	Happy	One	M	1/1/1991	13	123 USA Street	United States	XX	123455	5.556E+09	7/1/2021	Z00.121	Z71.89	Z71.3	Z68.54	R73.03
123456	Happy	One	J	1/1/1991	14	123 USA Street	United States	XX	123455	5.556E+09	8/5/2021	Z00.129	N/A	N/A	N/A	N/A
123456	Happy	One	L	1/1/1991	12	123 USA Street	United States	XX	123455	5.556E+09	8/27/2021	Z00.121	D64.9	Z71.3	Z68.54	Z71.82
123456	Happy	One	T	1/1/1991	12	123 USA Street	United States	XX	123455	5.556E+09	7/19/2021	Z00.129	Z23	Z68.54	N/A	N/A
123456	Happy	One	T	1/1/1991	12	123 USA Street	United States	XX	123455	5.556E+09	8/18/2021	Z02.5	Z13.31	Z71.3	Z71.82	Z68.54
123456	Happy	One	K	1/1/1991	13	123 USA Street	United States	XX	123455	5.556E+09	7/21/2021	Z00.129	Z23	N/A	N/A	N/A
123456	Happy	One	A	1/1/1991	14	123 USA Street	United States	XX	123455	5.556E+09	7/26/2021	Z00.129	F90.2	J30.2	N/A	N/A
123456	Happy	One	R	1/1/1991	10	123 USA Street	United States	XX	123455	5.556E+09	7/13/2021	Z00.129	N/A	N/A	N/A	N/A
123456	Happy	One	R	1/1/1991	10	123 USA Street	United States	XX	123455	5.556E+09	7/13/2021	Z00.129	Z13.220	N/A	N/A	N/A
123456	Happy	One	K	1/1/1991	13	123 USA Street	United States	XX	123455	5.556E+09	7/30/2021	Z00.129	N/A	N/A	N/A	N/A
123456	Happy	One	J	1/1/1991	13	123 USA Street	United States	XX	123455	5.556E+09	8/10/2021	Z00.129	Z13.0	Z01.10	Z01.00	Z68.54
123456	Happy	One	A	1/1/1991	12	123 USA Street	United States	XX	123455	5.556E+09	7/8/2021	Z00.129	Z23	N/A	N/A	N/A
123456	Happy	One	S	1/1/1991	12	123 USA Street	United States	XX	123455	5.556E+09	7/22/2021	Z00.129	Z68.53	Z23	N/A	N/A
123456	Happy	One	K	1/1/1991	12	123 USA Street	United States	XX	123455	5.556E+09	8/2/2021	Z13.9	Z00.129	Z23	N/A	N/A
123456	Happy	One	S	1/1/1991	14	123 USA Street	United States	XX	123455	5.556E+09	8/3/2021	Z00.121	Z13.31	Z23	N/A	N/A
123456	Happy	One	S	1/1/1991	13	123 USA Street	United States	XX	123455	5.556E+09	7/14/2021	Z00.129	Z23	N/A	N/A	N/A
123456	Happy	One	N	1/1/1991	14	123 USA Street	United States	XX	123455	5.556E+09	8/30/2021	Z00.121	B34.9	Z13.89	Z13.9	Z23
123456	Happy	One	C	1/1/1991	19	123 USA Street	United States	XX	123455	5.556E+09	8/12/2021	Z00.00	Z13.1	Z68.43	N/A	N/A
123456	Happy	One	C	1/1/1991	19	123 USA Street	United States	XX	123455	5.556E+09	8/12/2021	Z00.129	Z13.1	N/A	N/A	N/A
123456	Happy	One		1/1/1991	13	123 USA Street	United States	XX	123455	5.556E+09	7/20/2021	Z00.121	E66.9	J30.9	Z23	N/A

Provider Scorecard: Group Summary Report

	A	B	C	D	E	F	G
1	**Provider Scorecard**						
2	**Quality Performance**						
3	**2021 USA Providers (123456789) Group Summary Report**						
4	Physicians: 41	Total Patients: 1,675				Total Open Care Opportunities: 1,132	
5	The following data shows metrics for HEDIS and other standardized quality measures that indicate a potential care opportunity. Metrics include members specific to USA Providers. Note that only measures where there are eligible members will appear on the report.						
6				**Current Reporting Period**			
7	**Quality Measure**	**State**	**Eligible**	**Compliant**	**Non-Compliant**	**% Compliant**	**Target**
8	**AMM : Antidepressant Medication Management - Effective Acute Phase Treatment	XX	3	2	1	67%	0.00%
9	**AMM : Antidepressant Medication Management - Effective Continuation Phase Treatment	XX	3	1	2	33%	0.00%
10	AMR : Asthma Medication Ratio - Total 5 to 64 Ratios > 0.50	XX	20	14	6	70%	71.28%
11	BCS : Breast Cancer Screening	XX	14	2	12	14%	52.25%
12	CCS : Cervical Cancer Screening	XX	39	12	27	31%	56.05%
13	CDCB : Comprehensive Diabetes Care Non-Medicare - Non-Medicare HbA1c Test	XX	21	14	7	67%	81.10%
14	IMA : Immunizations for Adolescents - Combination 2 Immunizations	XX	80	9	71	11%	34.43%
15	**PPC : Prenatal and Postpartum Care - Postpartum care	XX	1	-	1	0%	72.14%
16	**PPC : Prenatal and Postpartum Care - Timeliness of prenatal care	XX	1	-	1	0%	92.00%
17	SPD : Statin Therapy for Patients With Diabetes - Non-Medicare Statin Therapy	XX	14	7	7	50%	56.07%
18	W30 : Well Child Visits in the First 30 Months of Life - Well child visits in the first 15 months	XX	132	80	52	61%	85.00%
19	WCV : Child and Adolescent Well-Care Visits - 3-11	XX	826	359	467	43%	75.00%

Provider Scorecard: Quality Incentive Summary Report

	B	C	D	E	F	G	H	I	J	K
1		**Provider Scorecard**								
2		**Practice Level Detail/Performance**								
3		**2021 USA Provider (123456789) Quality Incentive Summary Report**								
4		Physicians: 40		Total Patients: 1674			Total Open Care Opportunities: 1130			
5		The following data shows metrics for HEDIS and other standardized quality measures that indicate a potential care opportunity for all Quality Incentive members in USA Provider. The following data shows metrics for HEDIS and other standardized quality measures that indicated a potential care opportunity for all members on the USA Provider panel. The quality incentive program payment information is also included.								
6		**Contract**								
		Start Date: 01/01/2021 - **End Date:** 12/31/2021								
7					**Current Reporting Period**					
8		**Quality Measure**		**State**	**Eligible**	**Compliant**	**Non-Compliant**	**% Compliant**	**Payment for Current Performance**	**Estimated Payment If All Gaps Closed**
9		**AMM : Antidepressant Medication Management - Effective Acute Phase Treatment		XX	3	2	1	66.67%	$40.00	$60.00
10		**AMM : Antidepressant Medication Management - Effective Continuation Phase Treatment		XX	3	1	2	33.33%	$0.00	$60.00
11		AMR : Asthma Medication Ratio - Total 5 to 64 Ratios >		XX	20	14	6	70.00%	$0.00	$400.00
12		BCS : Breast Cancer Screening		XX	14	2	12	14.29%	$0.00	$280.00
13		CCS : Cervical Cancer Screening		XX	39	12	27	30.77%	$0.00	$780.00
14		CDCB : Comprehensive Diabetes Care Non-Medicare - Non-Medicare HbA1c Test		XX	21	14	7	66.67%	$0.00	$420.00
15		IMA : Immunizations for Adolescents - Combination 2 Immunizations		XX	80	9	71	11.25%	$0.00	$1,600.00
16		SPD : Statin Therapy for Patients With Diabetes - Non-Medicare Statin Therapy		XX	14	7	7	50.00%	$0.00	$280.00
17		W30 : Well Child Visits in the First 30 Months of Life - Well child visits in the first 15 months		XX	132	80	52	60.61%	$0.00	$2,640.00
18		WCV : Child and Adolescent Well-Care Visits - 3-11		XX	826	359	467	43.46%	$0.00	$16,520.00
19		**Totals**		XX	**1152**	**500**	**652**		**$40.00**	**$23,040.00**

Provider Scorecard: Physician Summary Report

	A	B	C	D	E	F	G	H
1	**Provider Scorecard**							
2	**Provider Level Detail/Performance**							
3	**2021 USA Proivder (123456789) Physician Summary Report**							
4	Physicians: 41	Total Patients: 1,675	Total Open Care Opportunities: 1,132					
5	The following data shows metrics for HEDIS measures that indicate a potential care opportunity. Metrics include members specific to USA Provider.Note that only measures where there are eligible members will appear on the report.							
6				**Current Reporting Period**				
7	**Physician Name**	**Quality Measure**	**State**	**Eligible**	**Compliant**	**Non-Compliant**	**% Complaint**	**Target**
8	Provider 1 (123456789)	BCS : Breast Cancer Screening	XX	1	-	1	0%	52.25%
9	Provider 1 (123456789)	CCS : Cervical Cancer Screening	XX	3	1	2	33%	56.05%
10	Provider 1 (123456789)	CDCB : Comprehensive Diabetes Care Non-Medicare - Non-Medicare HbA1c Test	XX	4	1	3	25%	81.10%
11	Provider 1 (123456789)	SPD : Statin Therapy for Patients With Diabetes - Non-Medicare Statin Therapy	XX	3	-	3	0%	56.07%
12	Provider 2 (123456789)	CDCB : Comprehensive Diabetes Care Non-Medicare - Non-Medicare HbA1c Test	XX	1	1	-	100%	81.10%
13	Provider 3 (123456789)	CCS : Cervical Cancer Screening	XX	1	-	1	0%	56.05%
14	Provider 3 (123456789)	EPSDT : On Track for EPSDT Scheduled Visit Compliance Ages - 4-20	XX	1	-	1	0%	0.00%
15	Provider 3 (123456789)	WCV : Child and Adolescent Well-Care Visits - 3-11	XX	1	-	1	0%	75.00%
16	Provider 4 (123456789)	EPSDT : On Track for EPSDT Scheduled Visit Compliance - 1Y	XX	73	38	35	52%	0.00%
17	Provider 4 (123456789)	EPSDT : On Track for EPSDT Scheduled Visit Compliance - 1Y	XX	2	-	2	0%	0.00%
18	Provider 4 (123456789)	EPSDT : On Track for EPSDT Scheduled Visit Compliance - 2Y	XX	22	8	14	36%	0.00%
19	Provider 4 (123456789)	EPSDT : On Track for EPSDT Scheduled Visit Compliance - 3Y	XX	21	13	8	62%	0.00%
20	Provider 4 (123456789)	EPSDT : On Track for EPSDT Scheduled Visit Compliance Ages - 4-20	XX	101	75	26	74%	0.00%
21	Provider 4 (123456789)	IMA : Immunizations for Adolescents - Combination 2 Immunizations	XX	3	-	3	0%	34.43%

Provider Scorecard: Member Demographic Report

	A	B	C	D	E	F	G	H	I	J	K	L	M	N
1	**Provider Scorecard**													
2	**Member Demographic Report**													
3	**2021 USA Provider (123456789)**													
4	Our records show that the following patients who are member have preventive care opportunities for HEDIS or other standardized quality measures, or may be due soon for care. Please check													
5	**Program**	**Measure**	**Sub Measure**	**Compliant**	**Member ID**	**First Name**	**Last Name**	**DOB**	**Race**	**Phone**	**Address**	**City**	**State**	**Zip**
6	Quality Incentive	Antidepressant Medication Management	Effective Acute Phase Treatment	No	123456789	First Name	Last Name	01/01/1111	Other / Unknown	5555555555	123 Healthy Street	United States	XX	12345
7	Quality Incentive	Antidepressant Medication Management	Effective Continuation Phase Treatment	No	123456789	First Name	Last Name	01/01/1112	Other / Unknown	5555555555	124 Healthy Street	United States	XX	12345
8	Quality Incentive	Antidepressant Medication Management	Effective Acute Phase Treatment	Yes	123456789	First Name	Last Name	01/01/1113	Other / Unknown	5555555555	125 Healthy Street	United States	XX	12345
9	Quality Incentive	Antidepressant Medication Management	Effective Continuation Phase Treatment	Yes	123456789	First Name	Last Name	01/01/1114	Other / Unknown	5555555555	126 Healthy Street	United States	XX	12345
10	Quality Incentive	Antidepressant Medication Management	Effective Acute Phase Treatment	Yes	123456789	First Name	Last Name	01/01/1115	Other / Unknown	5555555555	127 Healthy Street	United States	XX	12345
11	Quality Incentive	Antidepressant Medication Management	Effective Continuation Phase Treatment	No	123456789	First Name	Last Name	01/01/1116	Other / Unknown	5555555555	128 Healthy Street	United States	XX	12345
12	Quality Incentive	Asthma Medication Ratio	Total 5 to 64 Ratios > 0.50	No	123456789	First Name	Last Name	01/01/1117	Other / Unknown	5555555555	129 Healthy Street	United States	XX	12345
13	Quality Incentive	Asthma Medication Ratio	Total 5 to 64 Ratios > 0.50	Yes	123456789	First Name	Last Name	01/01/1118	Other / Unknown	5555555555	130 Healthy Street	United States	XX	12345
14	Quality Incentive	Asthma Medication Ratio	Total 5 to 64 Ratios > 0.50	Yes	123456789	First Name	Last Name	01/01/1119	Other / Unknown	5555555555	131 Healthy Street	United States	XX	12345

4.2.2.5: Utilization Management (Unmarked)

A. Approach

1. Describe the Offeror's proposed approach to utilization management, including:

Our utilization management (UM) program will be built on four central pillars: improving the provider experience; improving the member experience; improving population health and reducing the costs of health care.

Pillar One – Improving the Provider Experience
Our medical directors, behavioral health specialists, nursing and pharmacy staff will work closely with health care providers to optimize health care outcomes. We will continually work with providers to improve their experience with UM. We will offer provider workshops at least twice a year to make sure they understand our UM process. Medical directors will be available for peer-to-peer consultations and frequently outreach to providers when additional information is needed to make an informed decision. We will work closely with local professional associations to address questions, concerns and trends that may be identified in the community of members they are serving.

Pillar Two – Improving the Member Experience
Our person-centered approach will enhance the member experience by promoting health care services management, facilitating access to appropriate care, identifying and addressing gaps in medical, behavioral, substance use disorder care and social determinants of health (SDOH), which could be barriers to better health outcomes. This approach will allow us to proactively identify and refer members with chronic or complex conditions into tailored programs providing early interventions and options for alternative care.

Pillar Three – Improving Population Health
A broader approach through data-driven population health management will contribute to the improvement in the overall health of our population. Regular monitoring will enable early identification of trends in over- and underutilization and subsequent mitigation of undesired use. Here again, an integrated approach with quality management and care management will allow us to have a more significant impact on our member population.

Pillar 4 – Reducing the Costs of Health Care
We understand a healthier population leads to a lower cost of care for the populace. Consistent monitoring for unfavorable utilization trends will allow us to create prompt and feasible plans to address these trends. When we reduce the cost of care for our member population, we will enable businesses to be more competitive, lessen the pressure on publicly funded health care budgets and expand the opportunity for more investment in our members' communities.

The effectiveness of these four pillars will rest on the integration of UM with quality management and care management and enables us to provide more coordinated care. Significant enhancements will be realized through our ability to evaluate the quality, continuity, accessibility, timeliness and outcomes of rendered services and the implementation of appropriate action plans through our multidisciplinary approach.

The UM department will function as an interdisciplinary team and place the member in the center of its activities. Our medical, behavioral health and pharmacy staff will work collaboratively with health care providers to manage health care resources in the amount, duration and scope necessary to achieve optimal health care, improve health outcomes and reduce the overall cost of health care. We will use objective, evidence-based and nationally recognized medical policies, clinical guidelines and criteria to support our activities. Our UM program will be monitored to ensure compliance with the Division of Medicaid

administrative rules and state regulations. The UM program and its policies and procedures will be designed to meet federal and state regulations and the UM requirements of NCQA.

a. A description of the utilization management program;

Our UM program will provide comprehensive health care delivery for members in Mississippi through a network of primary care and specialty practitioners, behavioral health/substance use disorder practitioners, ancillary care providers, hospitals and other facilities.

Our UM program and approach will include:

- Intake and review of service authorizations and conducting prospective and concurrent review to confirm the appropriate utilization of resources in the amount, duration and scope necessary to achieve desired health outcomes
- Developing discharge planning tools and processes for transitional care coordination and health education programs
- Monitoring overutilization, underutilization and inappropriate utilization using data and reporting systems to evaluate member and provider utilization patterns to identify opportunities for improvement and develop interventions to combat aberrant trends
- Adopting evidence-based, nationally recognized guidelines and reviewing criteria to determine if a requested procedure, treatment or device meets medical necessity
- Using provider profiling to identify opportunities to improve member health outcomes and quality of care by reducing variation in practice patterns
- Supporting data-driven population health management practices to identify and engage members with an intensity and focus of care coordination that aligns with their needs
- Serving as a gateway to care coordination activities by identifying members with unmet health care needs, chronic conditions, inappropriate utilization or a current episode of treatment

Our UM program will include integrated, interdisciplinary policies and procedures that meet NCQA standards and confirm the appropriate utilization of health care resources in the amount, duration and scope necessary to achieve desired health outcomes. Our program and its policies will be evaluated annually and updated as needed to improve UM activities and the clinical care and service provided to members.

Policies, Procedures and Processes

Our UM program will include policies, procedures and criteria for pre-authorization, quality, reconsideration, grievance and appeal mechanisms for providers and members to confirm appropriate utilization. Annually, we will review our UM program description, outlining our program functions, structure and accountability.

Following is an overview of the policies, procedures and processes we will include in our UM program:

Integrated user experience platform: Central to our UM program will be our web-based UM platform application, which connects UM with case, disease and health and wellness management functions, providing an end-to-end service delivery across the continuum of care. This platform will help us deliver a coordinated and integrated experience to members and providers. All clinical and nonclinical staff performing intake, inpatient coordination, outpatient coordination, coverage review, care management, disease management, complex medical conditions and health and wellness management functions will use this application.

The scope of activities conducted through the UM program will include the physical and behavioral health/substance use disorder services furnished to members, including, but not limited to, non-emergency pre-

service review, emergency admission review, discharge planning, case management and appeals/grievances processing. These functions will be performed across the continuum of service and care settings.

Our program will include end-to-end processes such as:

- **Intake/Notification:** At intake, and included as part of the admission notification, we will receive prior authorization requests from providers. Intake will support other processes, including referral into case and disease management programs, advanced notification and admission notification and prior authorization. We will build cases by collecting information about the member, provider, requested service, hospital or facility and network status. Providers can submit prior authorization requests for medical and behavioral health services 24 hours a day, seven days a week. We will receive requests through phone or electronic submission via our online provider portal, which will allow providers to verify approval, submit electronic referrals and get real-time online verification of membership. Our provider portal will allow for immediate response to prior authorization requests via our EMR-integrated decision logic tree.
- **Prior authorization:** When they receive a prior authorization request, our qualified and licensed clinicians, medical directors and other professional support teams will review clinical information provided by health care practitioners. Together, they will determine the medical necessity and appropriateness of care, avoid inappropriate use or duplication of services and identify members who may benefit from care coordination. Reviewers will not be rewarded for issuing denials, nor will they be incentivized to make decisions that result in underutilization.

Clinical coverage review (CCR) will include review of clinical information and benefit plans to determine benefit coverage for requested services in accordance with members' health benefit programs before delivery of the requested services.

We illustrate our high-level prior authorization process in the following figure:

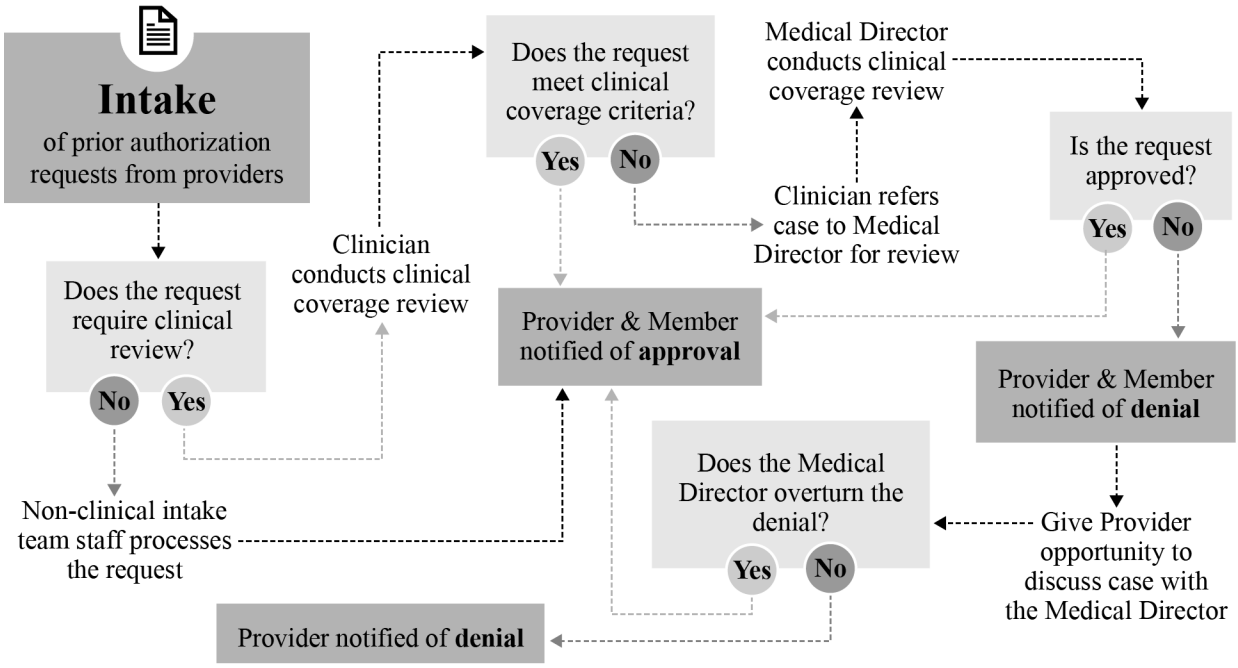


Figure 1. Our prior authorization process considers the four pillars upon which our programs excel: delivering exceptional provider and member support and services, improving the general population's health and reducing health care costs.

Nationally in 2021 we processed 1,784,577 standard Medicaid prior authorization requests with a TAT average of 2.39 business days and 96% compliance rate. We processed 80,694 expedited cases with a TAT average of less than 24 hours and 95% compliance rate.

We will make standard authorization decisions and provide notice in less than three calendar days or two business days following the receipt of needed information.

Physician consultation. Our medical directors will be available for peer-to-peer discussion with a member's treating physician to collaborate and discuss treatment options and plans, and to facilitate access to care or alternate care settings. Providers can arrange a peer-to-peer consultation by calling our toll-free number Monday through Friday from 8 a.m. to 5 p.m. local time.

Ensuring providers understand the prior authorization process. Providers will receive information about our prior authorization process in our provider manual, on our secure provider portal and in our provider newsletter. Our medical director, UM staff and provider advocates will deliver on-site UM educational sessions for providers, take part in the Division's provider workshops throughout the state and respond to provider questions and concerns. We will educate providers on our UM program, criteria and guidelines during initial provider training and update them whenever UM protocols, criteria or guidelines change. We will provide guidelines so providers know what we need for successful determination on the first submission and do not have to resubmit requests for authorizations.

When we identify providers who need help or have difficulties submitting authorization requests, our field-based provider representatives will conduct one-on-one training sessions with the provider, confirming the individual receives the education and support needed to follow the prior authorization process.

Hospice, inpatient care management, concurrent review and discharge planning. Unless the inpatient admission is an emergency, prior authorization will be required for inpatient, hospice, residential and higher acuity outpatient behavioral health services. We will perform concurrent review and discharge planning for inpatient admissions. Concurrent review and discharge planning will promote continuity of care and appropriate utilization, manage length of stay and facilitate collaboration among the UM clinician, care manager and inpatient facility and interdisciplinary treatment team (ITT). We will perform concurrent review and discharge planning for inpatient admissions and non-inpatient, high intensity behavioral health services. Concurrent review and discharge planning will promote continuity of care and appropriate utilization; manage length of stay; and facilitate collaboration among the UM clinician, care manager, inpatient facility and interdisciplinary team.

This team will be comprised of licensed clinicians who will provide the primary clinical interface with members, hospital staff and physicians to:

- Promote efficiency and collaboration with providers to determine a treatment plan based on correct guidelines
- Identify and prevent potential delays in care, tests and procedures
- Identify and address members' comprehensive health care needs, SDOH and preferences
- Facilitate prompt access to care and coordinate discharge planning services
- Facilitate alignment of the level of care (LOC) according to the member's physical or behavioral health condition
- Identify and refer members to an appropriate care management program for post-discharge follow-up

NICU and perinatal review. Our NICU UM team will consist of board-certified neonatologists and experienced NICU nurses who will determine appropriate levels of care and facilitate the safe and timely discharge to home or lower levels of care. Our perinatal UM team will include board-certified obstetricians and experienced maternity nurses who will enable evidence-based care for members using inpatient or specialized outpatient care during the perinatal period. These teams will collaborate with care management to support the needs of our members during and after discharge and partner with providers to support clinical outcomes, efficient resource consumption and payment for appropriate services. The teams will use nationally recognized decision support guidelines to determine levels of care and facilitate safe and timely discharge.

Retrospective review. We will conduct retrospective reviews to determine the medical necessity of treatment or services already delivered. We will follow the same process for conducting retrospective reviews as for prior authorization. We will consider retroactive eligibility and member and provider circumstances, including transition of care needs. When we receive retroactive eligibility and retrospective review requests for a member, we will not deny payment for medically necessary covered services due to lack of prior authorization or an absence of referral. To support the transition, we will facilitate transitions of care when a member transfers from one CCO to another, sharing information with the member, provider and new CCO. During the transition of existing care, we will honor the prior CCO's authorization for 90 days or until we contact the provider regarding prior authorization requirements.

Care management. Our integrated care management services will include transitional care management, disease management, complex care management, medical and behavioral care management and our 24 hours a day, seven days a week nurse line. The goal of integrated care management services is to improve our members' access to appropriate care, health status and satisfaction.

Organ Transplant Services. We will develop, implement and maintain a utilization management program that includes prior authorization and retrospective review of application requests for organ transplant services.

Medical claims review. Our medical claims review will provide clinical and coding accuracy support to claim operations. We will review appropriateness of medical services on a case-by-case basis after the service has been provided but before payment of services. Medical Claim Review (MCR) assesses clinical and coding accuracy support to claim operations. Selected claims will be triggered by payment systems and forwarded for pre-payment review to ensure adherence with medical, drug and reimbursement policies and specific benefit plan provisions that require clinical or medical coding knowledge or input to adjudicate.

Clinical appeals. We will have a full and fair process for resolving and responding to member or provider requests to reconsider a decision they find unacceptable regarding their care and service. Our dedicated medical directors in the grievances and appeals division will provide clinical input into the appeals process. Decision makers will be distinct from those making initial determinations.

Specialty case review. Across our company we employ many medical subspecialists. These licensed professionals will consult with our local medical directors to assist with rare cases. Board-certified and licensed physician consultants from specialty areas of medicine, surgery, chiropractic, behavioral health, substance use disorders and podiatry are examples. We employ specialty physician reviewers for transplant and complex medical conditions. These specialty reviewers will provide subject matter expertise to arm the Mississippi-licensed medical director with the information needed to render a decision.

External review services. If a specialty review or an independent review for an appeal or peer review is needed, we will request approval from the Division to secure a medical consultant through an external review organization. These specialists will assist the Mississippi medical director in rendering the decision. Board-

certified, licensed physician consultants from specialty areas of medicine, surgery, chiropractic and podiatry will be available to consult on individual cases.

A reviewing physician will not be permitted to perform a review on one of their patients, the patients of their partners, cases in which they have had previous involvement or cases in which they have interest. Specialties will include, but are not limited to, cardiology, gastroenterology, ophthalmology, psychiatry, chiropractic, internal medicine, orthopedics, radiology, dentistry, neurology, otolaryngology, surgery, dermatology, neurosurgery, pediatrics, urology, emergency medicine, OB/GYN, podiatry, family practice, oncology and pulmonology.

Post-service review. After services are provided and paid, we may conduct a review to assess the appropriateness of medical services on a case-by-case or aggregate basis.

b. Accountability for developing, implementing, and monitoring compliance with utilization policies and ...

Our UM program oversight will be led by the medical director and include the behavior health medical director, perinatal medical director and UM coordinator. This core group will be accountable for developing, implementing and monitoring compliance with utilization policies and procedures. These responsibilities will be facilitated through our quality management (QM) committee structure, which will include our Healthcare Quality and Utilization Management (HQUM) and Quality Management Committee (QMC). Accountability for compliance with UM policies and procedures will be a collaborative effort between our clinical leadership team, health plan leadership and key clinical functions, such as care management, pharmacy, QM, grievances and appeals, member services, provider services and health care economics. These teams will collaborate to realize the use of medical, behavioral health and substance use disorder resources in the amount, duration and scope necessary to achieve desired health outcomes for members while bringing salient information and support to our care teams and the providers serving our members. We will continue to make sure our UM structure includes mechanisms to assess the quality and appropriateness of care provided to members with special health care needs.

Development and Implementation

Our health plan medical director will be accountable for providing direction, clinical consultation and overall oversight for clinical programs and activities. These UM responsibilities will include:

- Implementing the UM program, including review and approval of the annual UM program description, evaluation, policies and procedures
- Identifying underutilization and overutilization and improving or maintaining acceptable UM performance
- Facilitating the implementation of provider-based disease management programs based on UM trends
- Serving as committee chair of our Provider Advisory Committee (PAC), HQUM Committee and QMC

The behavioral health medical director will be accountable for the clinical oversight of behavioral health UM to confirm quality of care and care advocacy activities are clinically sound. These responsibilities will include:

- Implementing behavioral health services within the UM program
- Providing clinical supervision, training and consultation with care managers
- Providing case review, peer reviewers and coverage determinations for behavioral health services
- Reviewing potential quality of care concerns

The perinatal health medical director will be accountable for clinical oversight and consultation on matters related to perinatal health. These responsibilities will include:

- Developing and implementing perinatal health policy through covered services to members
- Serving as a liaison between the health plan and providers
- Providing clinical consultation for referrals, denials, grievances and appeals
- Reviewing potential quality of care concerns

Our UM coordinator's responsibilities will include:

- Confirming application and adoption of the outpatient and inpatient medical necessity criteria
- Validating we conduct appropriate concurrent reviews and discharge planning for inpatient stays
- Analyzing, monitoring and implementing appropriate interventions based on the data, including those who need it because of over- and underutilization of services
- Monitoring prior authorization functions and making sure decisions are made consistently and based on clinical criteria while meeting timeliness standards

Monitoring Compliance

The HQUM Committee, a subcommittee of the QMC, will monitor utilization and quality improvement activities. This committee will conduct quarterly and annual reviews of national QM and UM policies and procedures, monitor and correct utilization variances and monitor for consistency of our decision-making through IRR reports. We will submit annual IRR reports to the Division. The committee will monitor clinical quality improvement and UM activities, including our care management and disease management programs. Additional responsibilities will include regular reviews of pharmacy use metrics, medical, behavioral health and HEDIS indicators. The medical director will chair both committees.

Our UM process will support the consistent application and monitoring of review guidelines by providing UM reviewers with a standardized set of tools and ongoing training to make medical necessity determinations of the requested service. We will review our standard prior authorization list at least annually and modify it to deliver the greatest value to our customers and members and reduce unnecessary burden on our providers. We will ensure the consistent selection and application of prior authorization criteria through the approaches outlined in the following table.

Approach	Description
Inter-rater Reliability (IRR) Testing	We will verify the consistent application of clinical guidelines through annual IRR testing of all licensed UM personnel, with the IRR score averaging 96.4% for physical health and 98.4% for behavioral health. We will conduct a formal retrospective audit to verify UM staff maintains compliance with established policies, processes and guidelines.
Formal Retrospective Utilization Management Staff Audits	Clinical auditors will perform audits on cases from each nurse and physician reviewer's caseload using a standardized tool that evaluates appropriate documentation of data and compliance using contractual time frames and processes. Each clinician reviewer and their manager will receive their individual audit results. Audit thresholds are 95%. Those clinicians falling below the threshold will complete a remediation plan that includes training on policies and procedures, guidelines and the application of criteria. All clinicians will receive a formal performance evaluation annually.
Case Reviews	The UM team will meet quarterly for case review and discussion to reinforce consistency in decision making throughout the year. The IRR review will be connected with the employee's annual review and objectives for the year. Managers of UM clinical staff will provide feedback to the team at large and to individual team members when the scores become available. The IRR score

Approach	Description
	results will be forwarded to the national training consultants to make them aware of future training needs. They will present the audit results to the appropriate health plan leaders and the Healthcare Quality and Utilization Management (HQUM) Committee at least annually.
Utilization Management Training	New utilization management staff will receive 6 – 8 weeks of onboarding training. The training will include a review of the decision-making hierarchy, benefit limitations listed in the Medicaid Service Manual and Medicaid contract, medical criteria listed in medical policy and other nationally recognized evidence-based criteria, verification of contract status and the new technology review process. New staff will be assigned to the appropriate preceptor (clinical or nonclinical) for their role. The preceptor will educate new employees on how to use the tools to support health plan decision making, tips to enhance the review process and the nuances of the review process. Staff will be tested through each level of training. Staff will be released from training once they demonstrate their ability to perform basic job functions independently. Both clinical and nonclinical staff will receive training on process updates through training meetings, one-on-one meetings with supervisors and email. Clinical staff will be educated on upcoming changes to medical policies monthly. Training meetings will be scheduled to clarify nuances of the review process for certain services if there is evidence the training is required for multiple individuals.

Our clinicians will be subject to supervision in addition to testing, auditing and committee review. The purpose of clinical supervision is to make sure all clinical staff maintain existing skills and develop new areas of competency. All clinical personnel will participate in scheduled clinical supervision or peer consultation at least once a month. A licensed or certified staff member assigned by the regional vice president or designee will provide clinical supervision.

Weekly opportunities will be scheduled for utilization management nurses to discuss and review cases while members are receiving inpatient care. The behavioral health care advocates, inpatient case manager (ICM), medical director, transitional case managers, complex case managers, social workers, discharge case managers, EPSDT coordinator and pharmacist will attend these rounds to provide support and education regarding multidisciplinary needs and allow for early identification of cases that could use collaboration and/or member outreach. We will conduct monthly pre-service prior authorization rounds to identify issues related to the prior authorization process, utilization metrics and guidelines.

c. Data sources and processes to determine which services require Prior Authorization and how often these ...

We will determine which services require prior authorization by considering cost-effectiveness and quality of care (whether there is potential for variance in care) and will require prior authorization for procedures where we see the highest variation in outcomes.

Data Sources

We will use our internal platform and utilization monitoring reports to monitor and track claims data, and our integrated user experience platform to monitor prior authorization activity, including denials, approvals and appeals overturn rates. We will regularly review trends and patterns of use to make sure our utilization management practices continue to deliver the greatest value to our customers and members.

To deliver the greatest level of value from clinical reviews, we will use our extensive experience to define a subset of documented elective services. For example, in a state of similar size and demographics, the prior authorization requirement for five codes for spinal surgery was removed when review utilization trends showed

a decrease in requests for these codes and the criteria for medical necessity was met in an overwhelming number of requests. This represented a decrease in variance and most likely indicated these procedures were being done at the appropriate time and in the appropriate place.

Processes

Our utilization review criteria are developed based on nationally recognized, scientifically based clinical evidence reviewed by our Medical Technology Assessment Committee (MTAC) and Operational Procedures and Standards (OPS) Committee. These committees report to the Medical Care Management Committee (MCMC) and evaluate and approve clinical protocols, criteria, guidelines and UM policies and procedures for use in our UM program. The MCMC includes physical and behavioral health medical directors and strategic leadership who meet quarterly to develop, evaluate and approve clinical protocols, criteria, guidelines and UM policies and procedures for use across our UM programs. Our MTAC and Clinical Policy and Operations Committees collaborate to review services requiring prior authorization using eligibility criteria, federal and state requirements, InterQual® criteria and behavioral health level of care guidelines (LOCGs).

The MTAC meets at least 10 times each year to develop new policies in response to emerging technology or new treatments based on scientific evidence. The OPS Committee meets monthly to review submissions of new, revised and updated policies and determine policies to retire.

Upon approval by the MCMC, the HQUM committee will review the list of services requiring prior authorization for acceptance and adoption. This review will be coordinated with the Division of Medicaid to make sure the list of services is appropriately aligned with state-specific or mandated guidelines, policies or regulatory requirements and the requirements of the MississippiCAN and CHIP contract. When appropriate, emerging patterns may indicate a necessary change in the list of services requiring prior authorization.

How Often Prior Authorization Requirements are Re-Evaluated

At least once a year, the MTAC and Clinical Policy and Operations committees review the standard prior authorization list against criteria, including whether the service is high cost, impacts many members and poses significant implications for safety. Reviewers identify whether there are evidence-based clinical guidelines for the health care service and whether providers demonstrate significant variation from those guidelines. Regardless of our review cycle, we will review new versions of clinical guidelines when they become available.

d. Process and resources used to develop utilization review criteria

Process – Committee Structure and Developing and Updating Guidelines

We develop our criteria for utilization review based on evidence-based nationally recognized standards and guidelines. Our MTAC and OPS committees assess evidence supporting new and emerging technologies, consider and incorporate nationally accepted consensus statements and expert opinions into the establishment of national standards, and review and approve clinical criteria within new or existing medical policies to be applied when performing a medical necessity review, when applicable.

Resources – Provider Input and Additional Data Input

Our Provider Advisory Committee (PAC) will be made up of medical, dental, behavioral health and pharmacy providers, and physical and behavioral health experts.

Our PAC will meet quarterly to review and accept nationally endorsed Clinical Practice Guidelines. As needed, the PAC may recommend modifying existing guidelines.

We work with the provider community to deliver consistent standards of care to improve patient care. We work with the AMA and major medical societies to develop programs and initiatives that simplify and streamline the health care system to reduce variation in quality and ultimately improve care across the country.

Internally Developed Clinical Policies
We will use internally developed, state-specific clinical policies to make determinations and guide length of stay expectations and levels of care in our medical management program. We will base our determination decisions on applicable state or federal regulations, and on the benefits outlined in the applicable plan documents.

Assessment of Evidence Supporting New and Emerging Technologies
Emerging medical technologies frequently lack well-established clinical evidence of safety and efficacy results published in peer-reviewed medical literature. As our clinical team becomes aware of emerging technologies or receives requests for services that may have been deemed unproven, we request a review by the MTAC, which assesses the evidence supporting new and emerging technologies. We incorporate the assessment of the MTAC and the clinical circumstances of the member to determine whether a new or emerging technology is medically necessary. As these technologies diffuse into the medical community, clinical evidence continues to accumulate. When such published evidence is sufficient, a medical technology previously deemed unproven may now be considered proven. Accordingly, the final decision about coverage may vary depending on applicable state or federal regulations.

e. Expected Prior Authorization clinical criteria by program area;

We will use internally developed evidence-based medical policies and InterQual clinical criteria to make coverage determinations and guide length of stay expectations and levels of care in our physical medical management program. Coverage will depend on applicable state or federal regulations and the benefits outlined in the applicable plan documents. For our behavioral health management program, and to make coverage determinations and guide length of stay expectations, we will use LOCUS/CASII/ECSII for behavioral health and ASAM for substance use disorders.

f. Process for regularly reviewing Prior Authorization requirements for their effectiveness and potential need ...

Our NMCM and HQUM committees will perform a comprehensive annual review of existing medical, behavioral health and substance use disorder policies to make sure they reflect local health plan needs. Our clinical leadership will monitor for changes in state regulations or changes in standards of medical care, which may warrant a need for updating criteria. We will add changes made to the Administrative Code or to our state-aligned contract, which may result in a change to our list of services requiring prior authorization, once they are reviewed and approved by the NMCMC and forwarded to our local Mississippi PAC and QMC for acceptance and adoption.

If a new version of the criteria is published before the annual review date, we will review criteria more frequently. In addition, our dedicated Mississippi UM team will meet at least monthly to review and discuss prior authorization requirements.

Description of Evidence-Based Coverage Decision Process

We review and revise clinical coverage policies to keep pace with advances in medical technology and changes in clinical practice. Our National Medical Care Management Committee (NMCMC) oversees the development, implementation and evaluation of the utilization management (UM) program. The NMCMC includes physical and behavioral health medical directors and strategic leadership. It meets at least 10 times annually to review and approve clinical policies, criteria and guidelines developed by the Medical Technology Assessment

Committee (MTAC). The NMCMC ensures adherence to practices of evidence-based medicine and establishes the principles for interpreting policies by:

- Maintaining a hierarchy of evidence quality
- Analyzing prevalence and variation in the use of new treatments and emerging technologies
- Assuring participation of authoritative stakeholders

Reporting to the NMCMC, our national MTAC meets at least 10 times each year to review and update existing policies and develop new policies related to emerging technologies or new treatments based on scientific evidence. This committee reviews clinical information to support the use of benefits documents for coverage determinations and to maintain clinical programs required for accreditation or regulatory compliance. The MTAC's activities include the following:

- Develop, review and approve evidence-based position statements on select medical technologies (i.e., device/service/technology/medically administered drug)
- Assess evidence supporting new and emerging technologies
- Review and approve clinical criteria within new or existing medical policies for use when performing medical necessity review
- Review and approve utilization review and Clinical Practice Guidelines to align with internally developed medical policies, including internally developed guidelines, externally licensed guidelines and specialty society guidelines

The MTAC works with local network physicians to develop clinical coverage policies. This committee identifies topics and technologies for review through requests from physicians and other health care professionals, reviews of current medical literature and annual review of existing medical policies. For any individual medical policy, policy staff will assess its consistency with national specialty society guidelines. Our MTAC staff presents documents and information to the MTAC for review. Our medical policies team conducts reviews of original medical literature and completes evidence-based technology assessments. To clarify complex clinical issues, the MTAC may invite additional subject matter experts into the review process.

Following MTAC and NMCMC approval, new and revised medical policies are posted on our Knowledge Library, an intranet-based knowledge management application available to all staff. We communicate required clinical coverage policies to our staff and health care providers through ongoing training, monthly medical policy update bulletins, webcasts, online learning modules and our internet and intranet sites.

In addition to de-novo guideline and coverage criteria development, the MTAC reviews and NMCMC approves adoption of a compendium of care guidelines from sources whose own development processes meet our robust evidence-based assessment procedures. For example, we review and adopt annual updates of the InterQual care guideline compendium. Health plans and provider groups widely use these care guidelines for their breadth of topics, depth and detail of criteria and strong evidence-based process used in their development. We adopt and use care guidelines from other respected guidelines/criteria development sources, such as the National Comprehensive Cancer Network (NCCN) and the U.S. Preventive Services Task Force.

We evaluate new evidence-based guidelines for emerging behavioral health technologies as they develop. We adopt the guidelines and standards of care developed by major professional societies, such as the American Psychiatric Association, the American Academy of Child and Adolescent Psychiatry, the American Association of Community Psychiatrists, and the American Society for Addiction Medicine, among others. We assure

coverage and authorization rule parity between behavioral health care services and general medical services. Providers can access a complete listing of the guidelines and criteria on our provider portal.

Health Plan Review and Adoption of Clinical Guidelines/Coverage Criteria

Our national utilization management committees, led by NMCMC, review our clinical guidelines and criteria at least annually, and more often as needed. Ad hoc reviews are conducted if a guideline has been updated or if new scientific evidence has been issued. Our national guideline process includes soliciting comments from national specialty societies and consulting specialists. After the national committee review, our local Quality Management Committee (QMC) will review, edit and recommend the adoption of the updated guidelines. The Mississippi QMC will address issues of local, cultural or linguistic diversity and variations in provider network capabilities. This will include obtaining input and recommendations from contracted providers in the Mississippi Provider Advisory Committee (PAC). We will communicate revisions and updates to providers, members and staff via bulletins, training classes and online resources.

g. Prior authorization processes for Members requiring services from non-participating Providers or ...

We will require a prior authorization request for routine and elective services provided by nonparticipating providers. This request must be initiated by the participating PCP or specialist who is seeking other services. Our standard process will be followed for both routine and expedited requests. The UM team will conduct a clinical review for medical necessity in accordance with the member's benefit plan and in compliance with state, federal, government and accreditation requirements. We will not require prior authorization for emergency services, including emergency inpatient psychiatric care, inpatient detoxification and crisis services provided by nonparticipating providers.

Identifying and Engaging Out-of-Network Providers

We will treat each member's circumstances individually, considering linguistic/cultural needs when locating a qualified specialist. Our provider network team will implement our provider recruitment process and attempt to contract with the out-of-network provider to continue to deliver these services as a network provider. If the team is unable to bring the provider into our network, we will improve access and minimize gaps in network accessibility as follows:

Short-term intervention: If a contracted provider is not available to meet member access and availability needs, we will enter into a single case agreement (SCA) with the out-of-network provider to make certain the member can receive needed care. Before execution of a SCA, our provider network team will validate the provider's licensure status, good standing and Medicaid status.

Continuity of care: Current members receiving care from a network provider may need to continue seeing that provider if that provider leaves our network. The Continuity of Care (CoC) policy will allow current members a transition period based on standard Transition of Care (TOC)/CoC requirements if the participating treating provider leaves the network. This policy will allow a newly enrolled member, including a member switching to another plan, a transition period for certain conditions and time periods before the member is required to transfer from an out-of-network provider to a network provider to receive network benefits under the terms of the member's benefit plan.

Out-of-network providers may contact our UM team or any of our care managers to request authorization for out-of-network services. Nurse reviewers can authorize referrals for out-of-network services based on approval criteria that consider local provider availability. When review staff cannot approve the referral, they will forward it to the medical director or a designated physician reviewer for a decision. Their review will consider the member's unique health needs when determining whether to cover out-of-network care.

In most instances, nonparticipating provider services will be authorized only if a required service or procedure is not available from a contracting provider or if capacity problems will prevent a timely service using contracting providers. All out-of-network services must be covered benefits. Members, or physicians on behalf of members, may request a referral with a nonparticipating specialist if (a.) the member is diagnosed with a condition or disease that requires specialized medical or behavioral health care; and (b.) we do not have a participating specialist with the professional training and expertise to treat the condition or disease; or (c.) we cannot provide reasonable access to a specialist with the professional training and expertise to treat the condition or disease without unreasonable delay or travel. A decision by a medical director to deny coverage or access concerning a request for referral to a nonparticipating specialist who meets all required qualifications will be an adverse decision. Behavioral health requests will use similar requirements, and decisions will be made by a Mississippi licensed physician.

Expedited Prior Authorization Process
Our expedited prior authorization process will comply with the requirements in Section 4.3.1.10, Notifications, including resolving the request within 24 hours of receipt.

If a provider indicates or the reviewer recognizes the standard time frame could jeopardize the member's life, health or ability to attain, maintain or regain maximum function, we will provide an expedited decision and notification within 24 hours following the receipt of necessary information. If the member or provider requests it, we may provide an extension of up to 14 calendar days.

h. The Offeror's approach to reducing the number of Prior Authorizations required

We will continuously monitor use pattern trends to determine the efficacy of our prior authorization requirements and identify how we can reduce them. This will include removing authorization requirements when an approval rate reaches an acceptable threshold and removing authorization requirements when an evidence-based disease and severity is documented. For example, in a state of similar size and demographics, the prior authorization requirement for five codes for spinal surgery was removed when review utilization trends showed an increase in the overall approval rate for these codes and criteria for medical necessity was met in an overwhelming number of requests. This represented a decrease in variance and most likely indicated these procedures were being done at the appropriate time and in the appropriate place.

We will continually review trends and patterns of utilization to verify our UM practices continue to deliver the most value to our customers and members and reduce provider abrasion. We may add review of services and procedures when medical necessity review delivers value (e.g., high-cost diagnostics) and remove services or procedures from review when it does not deliver value (e.g., hyperbaric oxygen treatment).

In Mississippi, we will use a variety of external sources and feedback from members, providers and other community stakeholders to evaluate our prior authorization policies, including:

- Review of member utilization patterns, including over- and underutilization of services and trends in prior authorization requests, including a focus on member demographics, including county, race and ethnicity, health care conditions and SDOH needs
- Input from our annual provider satisfaction survey
- Feedback collected from local stakeholders, including county representatives, as part of our formal committee structure and informal listening sessions
- Routine Evaluation of Prior Authorization Requirements Results in Updates to Better Support our Members and Providers

Recently, we purposefully reduced prior authorization requirements for over 300 services based on feedback from providers and our own detailed data analysis across all our markets. Categories affected were DME/orthotics/prosthetics, home health, nutritional and experimental/investigational.

We have an annual review process to make sure services meet various criteria, including whether services are higher cost, impact the most members, pose significant implications for safety and have adequate evidence-based guidelines available to form a basis for management and/or where there is significant variation from evidence-based practice guidelines.

Our National Medical Care Management Committee (NMCMC) and our local Healthcare Quality and Utilization Management (HQUM) and Quality Management (QM) committees conduct a comprehensive review of medical necessity and medical appropriateness guidelines to confirm the data is up to date and effective. Criteria may undergo review more frequently if a new version is published before the annual review date.

In addition, our NMCMC approves preventive service guidelines, medical policies and Clinical Practice Guidelines at least quarterly. After considering Mississippi-specific mandates and guidelines, the committee will collaborate to review services requiring prior authorization using eligibility criteria, federal and state requirements, InterQual criteria and LOCUS/CASII/ECSII for behavioral health and ASAM for substance use disorders. Once the NMCMC approves the list of services requiring prior authorization, our Mississippi HQUM will review it for acceptance and adoption for Mississippi members. We will coordinate this review with the state to verify the list of services is appropriately tailored to Mississippi-specific guidelines, policies or regulatory requirements and the requirements of the MHCP program.

We have created these committees and this infrastructure to make sure we can assess and respond to changes in medical evidence. This team of experts will monitor and detect the need for adjustment based on changes in practice as observed in our utilization data. We will use claims, cost data and approval and denial data to add or remove services to make certain we are meeting the needs of our members while addressing cost and efficiency. For example, services with low denial rates may be removed from the prior authorization list to improve efficiencies. Complex or high-cost services may be added to the review list. We will continually evaluate new and existing prior authorization services to make sure our criteria is cost effective and aligns with the Division and nationally recognized clinical guidelines to confirm clinical appropriateness.

Using Prior Authorization to Improve Access to Care

During the COVID-19 public health emergency, we removed prior authorization requirements for behavioral health and SUD services, including residential SUD services and extended existing approved prior authorizations for an additional six months. We use formal and routine review to adapt our prior authorization policies to meet the most pressing health care needs of our members.

We understand utilization management can be burdensome to providers, so we will continuously look for technologically advanced opportunities to streamline the process. Our prior authorization system will apply a decision logic tree to the service code requested to provide an immediate response to providers of approval or pending for more information. Our UM program will use our invaluable experience developing and continually evolving a health care service delivery system that provides diversified solutions to Mississippi-specific programs that care for the poor, the medically underserved and individuals with complex needs. We will operate and maintain our own UM program as a quality improvement measure rather than a cost control measure to improve health outcomes. Our UM program will reflect a commitment to delivering continuous innovations and an approach that reflects innovative thinking about UM as a proactive and constructive stream of activities.

The 2020 Council for Affordable Quality Healthcare (CAQH) study found the United States health care system has saved $122 billion annually by automating administrative tasks. We know our work is far from over, and

there are still significant cost savings available to health care professionals by continuing to reduce the administrative burden. We will launch our EMR-integrated decision tree questionnaire on our provider portal to help provide health care professionals real-time data and insights within the EMR workflow. This additional information can help eliminate blind spots in care, avoid billing surprises and foster co-decisioning. This virtual assistant will put personalized, real-time patient data, including clinical, pharmacy, labs, prior authorization, eligibility and cost information, directly in the provider's hands within the EMR at the point of care.

We will provide clear criteria and information on how and when to request prior authorization to our providers on our websites. We will provide an EMR-integrated tool that assists in determining services that require prior authorization, can request prior authorization, and communicates the decision, in some cases instantly. This tool will add real-time patient information, including diagnosis, medication utilization and other relevant clinical information, aimed at enhancing the patient–provider encounter and streamlining the providers' workflows.

i. How the Offeror will ensure that Prior Authorization does not delay treatment in an emergency

We will not require prior authorization for emergency services; these services are always covered, even if a non-network provider provides services. Covered emergency services include, but are not limited to, diagnostic tests, treatment, supplies, physician charges and facility charges. To maintain the stabilized condition and improve or resolve the emergency condition, we will cover post-stabilization care related to the emergency medical condition after the member is stabilized. We will follow federal mandates for post-stabilization care services, including financial responsibility for post-stabilization care services obtained within or outside our provider network.

j. Processes to ensure consistent application of criteria by individual clinical reviewers

We will verify the consistent application of medical necessity criteria through annual inter-rater reliability (IRR) reviews of licensed UM personnel. The IRR reviews will compare decisions among UM staff for uniform cases and then use statistical measures to assess consistency and identify potential sources of inconsistency. After completing the assessment, management will review the results and report them to our QMC for corrective actions, as indicated.

Review

We will conduct four IRR testing modules focusing on the following: InterQual Acute products, InterQual Prior Authorization products, InterQual Post-Acute Inpatient products and InterQual Behavioral Health products.

We will evaluate clinical staff on the following core competencies: knowledge of medical necessity criteria, variation in the application of medical necessity criteria and identification of potential avoidable or inappropriate service utilization.

Training and Remediation

We will expect clinical staff members to achieve a minimum score of 90%, and will provide training and retesting for those who do not score 90%. Clinical staff members will be allowed to retake the IRR test up to three times. If a staff member does not pass after the third IRR test, we will contact them for retraining and retesting. We will have a defined remediation process for those who do not pass or do not complete the testing. The IRR program lead will contact individuals and their managers and arrange retraining courses and retesting with the training team, as needed. We will identify opportunities for improvement in the determination processes and provide feedback at the individual level. The individual's direct supervisor will coordinate action plans for improvement. If the staff member does not pass the fourth and final retesting, the hiring manager will determine whether the staff member is suitable to remain part of the clinical staff.

The IRR review will relate to the employee's annual performance review and objectives for the year. This will help confirm employees are responsible for seeking success within their role and sharing the accountability for member care. When the IRR scores become available, managers will provide feedback to the team at large and to individual team members and then forward the results to the national training consultants to alert them to future training needs. At least annually, the test results will be presented to the appropriate health plan leaders and the HQUM Committee. We will provide summary data to our senior leadership and internal oversight committees. This monitoring and feedback will help UM staff continue to improve their skills and abilities and apply clinical review criteria in a consistent manner while still considering factors such as the member's age, comorbidities, complications, progress of treatment, psychosocial situation and, where applicable, home environment or ability of the facility to deliver services.

Audits
So that UM staff maintains compliance with established policies, processes and criteria, we will follow a formal retrospective audit process. Clinical auditors will conduct audits on cases from each nurse and physician reviewer's caseload using a standardized tool to evaluate appropriate documentation of data and compliance using contractual time frames and processes. Each clinician reviewer and their manager will receive their individual audit results. Audit thresholds will be 95%. Clinicians falling below the threshold will complete a remediation plan, which includes additional training on policies and procedures, and the application of criteria. As with the IRR, this audit will be applicable to the annual performance review of all clinical staff.

B. Methods

1. Describe the methods the Offeror will use to manage unnecessary emergency room utilization, avoidable ...

Our goal is to promote access to the right care at the right time, from the right provider and in the right place. We will use our catalog of monitoring and reporting tools to identify utilization patterns early and develop appropriate action plans. Part of the approach will be early engagement with our care management team (CMT) to identify and address barriers and risks that may contribute to high or inappropriate use of the ER, avoidable hospitalizations and readmissions.

Because our CMT will work with members in their communities, they will understand each member's circumstances and potential risk factors. This will allow us to deliver a range of interventions, which may help to avoid unnecessary ER and hospital use, such as member education and identification of environmental or social needs that may be a barrier to appropriate care, or arrangement for early follow-up with a PCP after an ER visit or hospital discharge. We will provide an array of health promotion tools and resources to engage each member in managing their health care, emphasizing wellness activities and connection to resources in the community. This will help address barriers to care and create member-oriented solutions leading to healthier populations.

Methods to Manage Unnecessary Emergency Room Visits

Care management is a fundamental component of our approach to managing unnecessary ER use for our member population. Key features of our comprehensive approach to minimize ER use will include:

- Improving access to PCP and behavioral health services
- Collaborating with providers to implement extended office hours using "physician extenders" such as physician assistants and nurse practitioner
- Providing 24 hours a day, seven days a week access to RN via our nurse line
- Reducing behavioral health crises through action plans with crisis diversion options
- Providing 24 hours a day, seven days a week access to behavioral health clinicians

- Providing peer support for members with serious mental illness or serious emotional disturbance through our crisis hotline

We will monitor health outcomes for members who are at risk for unnecessary ER visits and, in collaboration with their PCP, intervene when the member's health status, needs or living situation changes. When necessary, we will engage our interdisciplinary treatment team (ITT) to implement targeted interventions to address barriers to care, such as access to quality care or SDOH. We will provide members with education on alternative care options, such as urgent care centers or virtual visits, and we will actively engage members in our disease management programs to help them successfully manage their condition and minimize preventable ER visits.

Member Follow-Up Post Emergency Room Visit

We will assign members with high ER utilization to the CMT for targeted outreach and engage members following their ER visit through our transition of care process, reaching out to members within 72 hours of notification of discharge to:

- Review and reinforce ER discharge instructions
- Complete Health Risk Screening and address identified health care gaps
- Talk with members about ER alternatives, such as urgent care facilities, virtual visits, telehealth opportunities
- Support members in self-management methods and identify signs and symptoms that led to the ER visit
- Help members set an appointment with their provider within seven days of the ER visit
- Identify and address barriers to accessing care (e.g., transportation, childcare and other issues)
- Confirm members scheduled a follow-up visit and attended the appointment
- Connect members to community resources, support groups and peer support
- Assess the need to conduct a comprehensive reassessment and care plan update

Innovation and Emergency Room Use

Our culture supports our commitment to innovative delivery of member-centered care, collaborative community partnerships and good stewardship of the state's resources. To prevent unnecessary ER use, we will:

Provide Alternatives to the Emergency Room through Our Mobile Application: Our free member mobile application will help reduce potentially preventable ER visits and admissions by giving members a fast, convenient way to locate an urgent care facility 24 hours a day, seven days a week, rather than resorting to an ER. This application can connect members to a service navigator or nurse advisor using an optimized connection option. The service navigator and nurse advisor will provide member education and alternatives to the ER. The application will include phone number links, enabling the member to tap a link to connect to a provider.

Monitor Health Status through Remote Patient Monitoring: We will provide diabetic and hypertension home care management through remote patient monitoring care. This value-added benefit will be an app-based interactive program to remotely monitor blood pressure, blood glucose, food intake and insulin. As a part of this program, members will receive a free glucometer, unlimited blood glucose testing supplies and 24 hours a day, seven days a week live coaching and real-time nurse monitoring. Nurses will respond to alerts if a member's glucose is out of range, or the member has not tested as scheduled. We will send alerts to the member's PCP and their personal caregivers. The app will empower members to manage their care through access to an

artificial intelligence (AI) coach who will deliver specific messages based on the member's behavior, which will allow the member to make the connection between their behavior and actions.

Partner with EMS to Provide Treatment in Place (TIP): We will implement this collaborative approach to identify and treat member needs while reducing inappropriate ER utilization. This referral-based service will be available for members who are not in acute distress or in need of emergency services but need an in-person visit by a health care provider to address their current condition. Members may be identified for this service by clinicians, via the nurse line or by community health workers.

Upon arrival, the paramedic will conduct a thorough medical assessment and, if deemed necessary and appropriate, facilitate a telehealth visit with a physician, nurse practitioner or physician assistant.

Emergency Room Outreach Success Story

Mr. M is a 58-year-old male with an extensive medical history, including CHF, CAD, diabetes and anemia. Mr. M experienced frequent spikes and dips in his blood sugar, despite two changes in his medications to address these, which resulted in two ER visits when he fainted due to low blood sugar. He became anxious these episodes would recur and was prescribed a third medication. The new prescription was not on the preferred medication list and required pre-authorization before we could dispense it. The initial request was denied because it lacked a description of Mr. M's medical history with the original medications. Following several calls by his care manager, we arranged for peer review of Mr. M's new medication, and it was approved. With the new medication, Mr. M's blood sugar is well-regulated, and it has eliminated his anxiety and ER use.

Methods to Manage Avoidable Hospitalization and Readmissions

Transitional Care Management

We will use discharge planning to reduce avoidable hospital readmissions. Our inpatient CMT will coordinate care with our discharge care managers before members are discharged. Successful transitions of care will include member education and support and training self-management skills necessary to transition between the hospital and home. Some of these methods will include:

- Preparing an individualized discharge and care plan
- Providing medication self-management education
- Emphasizing PCP and specialist follow-ups
- Providing education to increase member knowledge of warning signs and degrees of complexity requiring care

Preventing Readmissions through Member Engagement and Education

Our approach to preventing readmissions will be centered around ongoing access and engagement with PCP and specialty care, educating and empowering members about disease self-management and addressing population health. Early identification of members at risk for readmission is key to the success of this approach and will be accomplished using various data tools including our hotspotting tool. Throughout the continuum of care, our care managers will play a crucial role in assisting the member with the overarching goal of optimizing health outcomes. These managers will bridge the gap in transition of care by supporting compliance with the discharge and care plans, medication adherence and PCP and specialist follow-ups.

Preventing Overuse and Readmissions through Telehealth

We have experience and a successful history of filling care gaps by implementing telehealth strategies for traditionally underserved populations in rural and urban locations. For example, we have partnered with federally qualified health centers (FQHCs) in various states to co-manage chronic diseases such as diabetes and

sickle cell disease via telehealth. We will broaden PCP access by using mobile device apps to facilitate interactive medical advice and by expanding telemental health services.

Across the states we serve, telehealth and remote patient monitoring services have seen high use rates during COVID-19, and we expect this increased use to continue, which is particularly important in rural areas where members may lack dependable modes of transportation for access to routine care. Findings indicate telemedicine users experience higher levels of satisfaction when medical appointments conducted through telehealth appointments better accommodate their schedules. We will commit to **$130,000 for the provision of both direct access to telehealth and telepsychiatry services and devices, such as tablets, to enable access to these services.**

By providing telehealth services, including telepsychiatry and telemental health services, we will increase accessibility to PCP and behavioral health appointments, which results in a reduction of health care disparities, unnecessary referrals, inappropriate ER visits, medical and behavioral health admissions and readmissions, and improve continuity of care.

Utilization Management through Primary Care Provider Visits and Assignments

Our UM and QM programs will share the priorities of reducing cost through quality care and appropriate utilization. One way we will collaborate to reach this goal is through Provider Peer Comparison reports.

Provider Peer Comparison Reports

Provider Peer Comparison reporting will allow us to monitor over- and underutilization of services. These reports will include claims data and preventive and condition management measures to indicate provider compliance with evidence-based performance guidelines. This process will allow the UM clinical staff and nurse consultants to build relationships with network providers and educate them about expectations relative to utilization and quality of care data.

The profiles will display data by case mix-adjusted member PCP panels and clinics by PCP type for multiple indicators, including discharges, hospital days and ER visits. In addition, the Healthcare Quality and Utilization Management (HQUM) Committee will monitor clinical quality improvement and UM activities, including provider over- and underutilization and whether results indicate a need for additional provider outreach. In another state similar to Mississippi, we recently enhanced these reports to include more measures and give providers a more comprehensive view of clinical quality performance.

During visits with providers, nurse consultants will use our HEDIS toolkit containing educational materials, including evidence-based quality performance guidelines for preventive and condition-specific care. When our analysis of medical records in another state similar to Mississippi showed providers were completing care, but incorrectly coding it to capture the services completed, we enhanced our toolkit by adding HEDIS coding information for preventive, ambulatory and disease management services.

Our UM methods will involve partnering teams with PCPs to reduce and eliminate unnecessary ER visits, hospitalizations and readmissions. Working as a care management team (CMT), our clinical specialists, internal medical, behavioral health leaders and PCP partners will make sure our members understand how important it is to see their PCP for post-ER and hospitalization follow-ups, particularly if the member has a complex array of health issues. By partnering with PCPs, we will reduce inappropriate cost, use of resources and time and improve quality of life.

Coordination of care is a vital part of ensuring appropriate utilization of services, particularly for our members who have experienced inpatient hospitalizations. Providing support as our members transition from hospital stays will be an important factor in preventing potentially avoidable hospital readmissions. This effort will

increase the efficiency of our health care systems and drive down costs; more importantly, it will promote the overall health and well-being of our members. The Quality Incentive Payment Program for Potentially Preventable Hospital Readmissions (QUIPP PPHR) will be a creative way to address this important issue. The success of this program will rely on building a strong collaborative relationship between our health plan and hospitals to make sure we meet the overall goal of delivery of the highest quality, most appropriate, cost-effective care for our members. This program will be centered around providing strong transition of care support and be built on discharge planning that requires that we work together to do the following:

- Create a discharge plan before the patient leaves the hospital in compliance with Medicaid policy
- Contact the patient within 24 – 48 hours of discharge
- Connect the patient with additional resources to enable follow-up care

Creating a Discharge Plan

For inpatient members and as part of our current TOC process, the discharge planning review will continue throughout the stay at the inpatient facility. Our care managers will work with hospital discharge staff to develop a comprehensive and unified discharge plan before the member's discharge from the hospital.

Contact Post Discharge

Our TOC process will include post-discharge outreach. Our care managers will work with hospitals to support this follow-up outreach between 24 and 48 hours after the member is discharged. We will prepare to follow up no later than 72 hours, which will add an additional layer of support for our transitioning members.

Connect

Once engaged with our ITT, we will be well-equipped to direct the member to the resources they need to make sure appropriate follow-up care is received. Early engagement post-discharge will enable us to identify barriers that may interfere with follow-up care, whether that be transportation issues or housing insecurity. We will use devices such as our SDOH resource directory and social care tools along with strong community-based partnerships to help members overcome barriers and get the care they need.

3. Describe how the Offeror will identify and address trends in over- and underutilization.

Identifying over- and underutilization and appropriate action planning will be a collaborative effort between our clinical and quality teams and UM. In addition, our fraud, waste and abuse staff will employ data analysis to identify meaningful underutilization and overutilization versus random variations.

Our QMC and HQUM Committee will meet quarterly to collect, monitor, analyze, evaluate, trend and report utilization data. This process will help assess the ongoing effectiveness of clinical care management interventions, monitor utilization patterns, identify opportunities for improvement and develop interventions to combat aberrant trends. Core components of our approach will include:

- Using clinical oversight and integration with QM
- Using UM tools and data analysis monthly (e.g., identifying gaps in care)
- Evaluating the efficiency and appropriateness of service delivery by adopting evidence-based, nationally recognized review criteria
- Identifying and resolving short- and long-term quality-of-care issues
- Ensuring a high-quality, clinically appropriate, highly efficient and cost-effective delivery system through provider profiling

- Maintaining our algorithm-driven system, which measures behavioral health and substance use disorder treatment effectiveness and detects high-risk conditions while treating problems early. This system helps reduce costly errors, identifies the over- and underutilization of outpatient and inpatient care and identifies undetected clinical risks, such as depression and substance use disorders.
- Linking our intelligent database with and receiving data from the clinical management system to allow reporting on operational performance. Our powerful claims-based predictive modeling tool helps us identify our most at-risk members related to medical, behavioral health and substance use disorder conditions, better coordinating their care and accessing necessary services. This predictive modeling identifies underutilization and the associated risks to our members.
- Viewing gaps in care using our integrated care management platform within provider practice management systems to increase provider involvement and compliance
- Allowing members to view their gaps in care using our secure member website or mobile application

Identifying Trends in Overutilization and Underutilization

We will identify and address trends in overutilization and underutilization through a monthly dashboard that provides a comprehensive in-depth analysis of all aspects of medical and behavioral health service utilization. Through these reporting features, we will continuously monitor local and national performance and develop strategic initiatives to combat aberrant trends.

Addressing Trends in Overutilization and Underutilization

Overutilization

Provider Peer Comparison Reporting Process: As mentioned, the provider peer comparison reporting process will be a collaborative effort between the QM and UM programs. This effort will monitor for over- and underutilization of services and educate providers about expectations relative to utilization and quality of care. The reports will compare case mix-adjusted member PCP panels and clinics by PCP type for multiple indicators, including discharges, hospital days and ER visits. The HQUM Committee will monitor all clinical quality improvement and UM activities to identify over- and underutilization and determines when results indicate we need to reach out to network providers.

The QM staffing model will include nurses who work with providers to improve quality outcomes for their assigned members. When discussing performance, field quality nurses will share provider peer comparison reports with providers during regular meetings.

During these visits, field nurses will share resources from our Quality Management Provider Education Program, including evidence-based quality performance guidelines for preventive and condition-specific care, descriptions of each HEDIS measure and required documentation needed to close identified gaps, coding references and best practice tips for gap closure. We will establish systems for tracking when members are due for services and work with providers to reach members and bring them in to see their PCP for care. Our goal is to improve member health outcomes by making sure providers render all needed preventive and chronic care services per established Clinical Practice Guidelines.

Underutilization

We understand the correlation between underutilization of wellness services and overutilization of ER and inpatient services. We will address this with incentive programs that target practices to improve compliance with annual wellness exams, including reward card incentives for adolescents who have completed preventive health care visits. We will host community wellness events that promote preventive care for different age

groups. In addition, we will conduct mail-outs and live outreach calls to encourage members to complete their wellness exams.

Another program, unique to our Behavioral Health and Substance Use Disorders programs, will align payment incentives with providers to strengthen provider partnerships and promote positive member outcomes. This program approach will improve behavioral health and substance use disorder members' health outcomes through their PCP and specialists' focus on appropriate and consistent use of necessary health services.

4. Describe how the Offeror will analyze pharmacy utilization patterns to improve care and reduce costs. In ...

Drawing from over 15 years of experience with pharmacy programs where a single pharmacy benefit administrator (PBA) or a state fee-for-service program manages the pharmacy benefit, our pharmacy team will monitor drug utilization patterns in multiple ways to improve care and reduce cost. We will adjust our utilization management infrastructure and processes to enable secure electronic data transmission and exchanges with states' PBA and other entities, and we will use processes already in place to incorporate pharmacy claims data for members into our data systems as frequently as it is received. We are prepared for the transition to the single PBA with a plan for data exchange and coordination of utilization reporting. We will use secure file transfer protocol (SFTP) and NCPDP formatted files for a secure, standardized pathway by which we will receive the claims extracts.

Following a quality assurance check to validate the integrity of the data received, the claims information will be fully integrated into our national data solutions, including our data warehouse, the retrospective drug utilization review (rDUR) analyzer, care and disease management platforms, member risk stratification and clinical profiling tools, and risk adjustment gap closure systems.

Our data warehouse will serve as a repository for medical and pharmacy claims and eligibility and authorization data. This sole source of truth for our clinical, finance, actuarial and HCE teams, coupled with its comprehensive scope, makes it invaluable for many business functions, including analysis of utilization management. To avoid overstating at-risk expenses in our financial analytics and projections, data received from external sources such as services carved out to fee-for-service Medicaid or delegated to other vendors will be tagged upon loading to the data warehouse.

As part of our population health management initiatives, our clinical teams will use pharmacy data to implement population, drug class or disease state-focused monitoring and remedial programs tailored to align with state priorities and areas of concern.

Improving Care and Reducing Costs through Quarterly Trend Monitoring

Our pharmacy-dedicated medical economics team will provide multiple trend reports to analyze pharmacy utilization patterns. In collaboration with our medical director, our dedicated pharmacy director will review these reports to identify areas of opportunity to implement pharmacy utilization management programs, including prior authorization, step therapy and quantity limits. This process will make certain members receive clinically effective medications that make the best use of the pharmacy benefit dollar. We have used these analytic tools successfully in other states, where they have used our feedback and recommendations to update their clinical and formulary program strategies and provide cost savings to the Medicaid program. For example, in a state similar to Mississippi we identified that approximately 40% of growth hormone utilization was for indications with no consensus in peer-reviewed medical literature regarding efficacy, safety or long-term consequence. Adoption of our recommendations ensured members were receiving safe, evidence-based treatment, and saved the state over $1 million annually. Examples of inappropriate or concerning trends to which we have alerted other state agencies include drug labelers with outlying unit costs, paid claims for non-

FDA approved products and pharmacy utilization patterns not supported by FDA labeling. Our pharmacy team will support the transition to single PBA by proactively identifying and recommending delivery and budget models that control costs, increase transparency and support providers, all while promoting access to needed medications for members.

While day-to-day management of pharmacy prior authorizations will be managed by states' PBAs, our pharmacy team will identify, monitor and highlight providers who appear to be outliers. We will engage outlier prescribers to address their adherence to the preferred drug list, compliance with prior authorization requirements or adherence to industry or peer norms for prescribing practices.

To promote transparent collaboration, we propose standing pharmacy coordination meetings to include representatives from the state, PBA and CCOs. This meeting structure will provide an ongoing forum for in-depth discussions and sharing ideas on tactical issues and long-term population health goals. Participants will review and explore enhancements to data feeds, including prospective and retrospective drug utilization review (DUR) findings, to improve care coordination programs' effectiveness and identify members and providers who may need additional support.

Identifying and Addressing Inappropriate Prescribing Practices

The safety and health of members is our highest priority. Our rDUR program will aim to prevent, identify and address inappropriate prescribing practices and member overuse or misuse of pharmacy services. By proactively identifying members who meet criteria indicative of potential abuse of prescription medications, we can refer members to our high-risk care managers for educational outreach, continued monitoring and referral for substance use disorder treatment.

DUR Retrospectives
During 2020, we completed 14 retrospective DUR programs in Medicaid states. The completed interventions resolved 16.4% of identified medication-related problems or gaps in care.

By identifying inappropriate prescribing patterns, we will offer targeted education to network providers on the most up-to-date clinical guidelines for managing chronic disease states. One example of our educational outreach was our promotion of the use of controller inhalers in members with asthma, which helped to initiate controller therapy in over 14% of identified opportunities in a state with similar size and demographics. Another example in another state was our promotion of the use of hydroxyurea to prevent complications in members with sickle cell disease, which helped initiate therapy in approximately 20% of members identified as possible candidates.

In the creation and implementation of new rDUR initiatives targeted to the unique needs of the Medicaid states and CHIP population, our dedicated pharmacy director will support the states' Division of Medicaid and PBA.

Opioid Prescriber Outlier Report

When reviewing utilization and medical history for members at risk for medication overuse or misuse, we will closely monitor controlled substance prescribing practices. Each prescriber will be benchmarked against their peers in the same specialty. The following table reflects a sample of metrics used to evaluate PCPs, including normal and outlier ranges.

Opioid Prescriber Outlier Report – PCPs		
Metric Description	**Typical Range**	**Outlier Range**
Quarterly total of opioid prescriptions	75-100	≥250
Members with more than one opioid prescription	13%-18%	≥25%
First fill compliance rate with CDC Guidelines	≥95%	<80%
Average daily morphine equivalent dose (MED)	40-60 MED	≥80 MED

As they are identified, our pharmacy director and clinical teams will be alerted to outlier prescribers. We will quickly engage outlier providers with direct outreach and education on established leading practice prescribing guidelines, including the CDC Guidelines for Prescribing Opioids. The Opioid Outlier Report will enable our team to perform focused analysis, by specialty or provider type, to identify errant prescribing and address the issue with prescribers. We will refer these prescribers to the Division, regulatory boards, provider quality review or FWA units, as appropriate. Through our comprehensive approach to ensuring appropriate opioid utilization, we have helped states increase their compliance to CDC Guidelines for Prescribing Opioids. In states with similar size and demographics, compliance increased from 77% in 2017 to 93% in 2021.

Antipsychotic Monitoring in Pediatrics Program

Developed in response to the SUPPORT Act's psychotropic drug use in children and adolescent monitoring and oversight, the Antipsychotic Monitoring in Pediatrics (AMP) program was developed in response to the SUPPORT Act's psychotropic drug utilization in children and adolescents' monitoring, oversight, intervention and reporting requirement. This program consists of retrospective drug utilization review and follow-up intervention as indicated. Inclusion for review will be based on a monthly analysis to identify children with concerning utilization, including children who are being prescribed multiple psychotropic medications, children with diagnosis of suicidal ideation, multiple ER and hospital visits or inappropriate antipsychotic prescribing based on FDA-approved labeling. Intervention will be conducted as needed in a one-on-on manner with the prescribing physician to discuss the issues of concern and provide education on behavioral health resources available. Results in one Medicaid state have shown 23% of one-on-one interventions in 2021 resulted in a positive outcome, specifically in instances concerning the member's antipsychotic use.

Improving Care and Reducing Costs through Pharmacy Adherence Programs

Although medications are effective in combating disease, their full benefits are often not realized because many patients do not take their medications as prescribed. We understand achieving medication adherence in Medicaid populations is particularly important — and challenging — due to the following dynamics:

Low-income subgroups disproportionately have educational, cultural and transportation barriers to accessing care and adhering to prescribed care.

Family support systems are important in facilitating medication adherence, but Medicaid subgroups often have fractured or unstable family dynamics that hinder adherence.

PCP connections within Medicaid populations are often not strong and lasting. Physicians familiar with their patients' clinical needs are valuable in initiating appropriate medication regimens and supporting adherence.

Housing instability and the lack of a phone can present barriers to effective communications that can support adherence.

Our approach to improving outcomes through medication adherence is multifaceted. We will implement a community pharmacist-led program to leverage the unique relationship between the member and pharmacist,

which will reward and reimburse pharmacists for improving outcomes. When signs of nonadherence are identified, we will implement a larger-scale medication adherence program that focuses on member education and early outreach.

Pharmacist-Led Intervention on Focused Population

To improve member adherence, we will engage the member's most frequently seen health care provider, the pharmacist. We will partner with Pharmacy Quality Solutions (PQS) to implement an outcome-based performance program in collaboration with state pharmacy providers, incentivizing pharmacists who provide enhanced pharmacy services, including adherence counseling for members who are or are at risk for noncompliance.

This program will provide the opportunity for in-year earnings with documented member engagement and additional year-end bonuses for improvements in medication adherence. Intervention documentation will be shared with care management to identify any barriers in care or trends in medication therapy for additional member follow-up, as needed.

Population-Wide Multimodal Member Engagement

We will use pharmacy claims data received from the state to identify members showing signs of medication nonadherence, for early engagement, helping members stay on track with their health and medications. In turn, this often will lead to better outcomes for members and lower overall health care costs.

Our large-scale and comprehensive medication adherence program will include the following:

New to Therapy Letter: When a member is newly diagnosed with one of the targeted conditions, we will send the member educational materials explaining their disease and the importance of taking their medication as prescribed.

Primary Medication Nonadherence Alerts: When a member does not begin their new medication therapy, we will notify the PCP and include suggestions and strategies to help keep them adherent.

Early Refill Reminder: Typically, three days before the refill date, members will receive a call reminding them to refill their medication. To refill, we will offer members the option of a warm transfer to their last dispensing pharmacy.

Late to Refill Outreach: To better understand our members and to improve their experience, interactive member calls will include a survey to identify any barriers affecting the member's medication adherence.

Low Adherence Outreach and Consultation: Consisting of provider- and member-targeted interventions aiming to increase members' medication adherence, providers will be notified when their patients are nonadherent to a targeted chronic medication, defined as Proportion of Days Covered (PDC) less than 80%.

When a member possesses a nonadherent PDC, they will receive calls and mailings. During outreach, we will ask members about any barriers affecting their medication adherence, so we can better understand them and take action to improve their experience. We will offer members the option to connect with a live clinical pharmacist for telephonic consultation.

Predictive Analytic Outreach: We will assign members a risk score indicating their likelihood of becoming nonadherent to their medications and target members who are considered high risk for interventions. We will outreach to members to encourage them to stay on track with medication adherence, and proactively collect information on any key adherence barriers.

Initial 2021 results from one of our Medicaid states highlights the success of the program. On average, 33% of members who are targeted due to nonadherence indicators are converted to adherent status after eight months in the program, with a post-intervention average PDC of 94%. We have implemented a comprehensive medication adherence program targeted toward members with diabetes, respiratory conditions and HIV.

5. Describe the process for ensuring medication continuity of care upon Enrollment and ongoing. In ...

Nationally, our pharmacy team has experience working within a single PBA model, collaborating with various states and PBAs to confirm our members have timely access to pharmacy services. We will fully engage with the Division to share best practices for promoting medication continuity of care in a carved-out pharmacy benefit.

Medication Continuity Upon Enrollment

Our process for ensuring medication continuity upon enrollment will begin by educating members on their pharmacy benefit. Our welcome kits for enrolling members will include information on using their pharmacy benefit, including how to locate a pharmacy in the PBA's network. To ensure medication continuity upon enrollment, as a contractor with access to pharmacy claim data for our members, we will collaborate with the state's PBA in the following ways by:

- Providing clear and direct communication with states and PBAs to fully understand the continuity of care process and collaborating to establish efficient methods to escalate and address concerns impacting a member's medication continuity. We have national experience leveraging this collaboration to establish innovative ways to limit provider and member disruptiveness in single PBA environments, including facilitating warm transfers from our provider call center to the PBA, operationalizing real-time access to pharmacy claim and prior authorization systems and updating third-party liability (TPL) in real time.
- Initial testing and ongoing validation that bidirectional data flows with states' PBAs are operational and monitored. To ensure correct point of sale adjudication by the PBA, this process avoids disruption in continuity by ensuring a robust data exchange by providing historical prior authorization and pharmacy claim data. To make sure the states' PBAs have access to all relevant attributes for an efficient point of sale and prior authorization process, we enhance the process by providing medical claim data, including medical drug utilization and diagnosis code history.
- Initial and ongoing monitoring of real-time pharmacy claims to ensure any barriers to our members accessing pharmacy services are identified and escalated to the PBA for resolution. We have identified and helped to proactively resolve issues including discrepancies in member eligibility loads and TPL validation through real-time claim monitoring in single PBA environments.

Care Coordination and Integration

We will train our care coordination staff and transition coordinator on our end-to-end processes to achieve pharmacy continuity of care and seamless pharmacy transitions for new members. Our care coordination staff will work with integrated pharmacy support staff to coordinate care so that members who are changing pharmacies will have continuous access to their needed medications.

Ongoing Medication Continuity

Based on our experience with pharmacy carve-out transitions, we know strong partnerships with states and PBAs are key to providing medication continuity of care. To promote continued access for maintenance medication and avoiding point-of sale rejections, we will share our leading practice approaches using communication and collaboration with the PBA. To make sure members have uninterrupted access to their medication regimens, we will leverage proactive member and provider communications, and clinical programs

that focus on medication adherence and reconciliation post discharge. Examples of ways we will promote medication continuity of care on an ongoing basis include the following methods and approaches:

- Collaboration with states and PBAs on ways to promote continued access to medication, including sending system alerts to providers when existing prior authorizations are expiring for select maintenance medications.
- Ongoing identification of unresolved pharmacy claim rejections for further follow-up with members, providers and states' PBAs to help navigate the resolution process.
- Timely resolution of escalated issues received by our member and provider call centers. We will enact processes so that our call center can coordinate with internal and external entities to provide a warm transfer. This ability will provide a seamless process to resolve pharmacy services-related calls, or to help with misdirected calls.
- Analysis of pharmacy claim extracts to identify members who are at risk for nonadherence for inclusion in our Medication Adherence Program. This program will focus on early engagement and staying connected to understand any barriers our members may be experiencing and help them stay on track with their health and medications. The program will include member education on the importance of taking medications as prescribed, and provider alerts when primary nonadherence is identified.
- Coordinated and proactive member and provider notification of changes impacting the pharmacy program, including prior authorization and preferred drug list changes to allow members the opportunity to discuss these changes with their provider, and make sure providers know ahead of time about changes impacting member care. Network provider newsletters will include reminders for pharmacy providers to offer a three-day emergency supply of medication if the medication is non-preferred or requires prior authorization to avoid disruption in the continuity of medication therapy.
- Monitoring inpatient members and intervening when needed to verify appropriate medications are prescribed and reconciled with pre-admission drug regimens, ensuring medication continuity post-discharge.

[END OF RESPONSE]

4.2.2.6 Information Technology

A. Claims Processing

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 ...

Our systems diagram outlines each component of our claims processing system and the supporting systems used to ensure compliance with contract requirements. The diagram is provided in **Att. 4.2.2.6-1 Systems Diagram**.

b. How each component will support major functional areas of the Mississippi Medicaid Coordinated Care ...

Our managed care information system is built on our highly configurable core transaction processing system, which provides eligibility, enrollment, claims processing, benefits configuration, capitation, reporting capabilities and the source data for our encounter submissions. A systems diagram showing the components of our claims processing and supporting systems can be found on the following page.

Our suite of systems is employed across our Medicaid contracts and supports critical program functions, including member and provider management, plan and reference data management, care coordination and utilization management (UM), claims and encounter processing, third-party liability (TPL), financial management, program integrity management, quality improvement, analytics and reporting and data exchanges internal and external to our organization.

Claims Management

Our claims processing platform is the core of our MIS architecture. We have extended and interfaced the platform to support all required capabilities and interfaces based on a well-known and widely used commercial processing platform. Supporting components in our architecture are interfaced using a variety of approaches tailored to the situation. Interface approaches include real-time streaming, web service APIs and traditional batch file exchanges across a wide array of X12 and FHIR formats.

Systemic Edits Identify Claims Issues

We capture the claim received date and assign a unique claim number for incoming claims. Many data edits are applied to incoming claims to validate the data is compliant, complete, accurate and appropriate under the terms of the contract. Claims with invalid data points are rejected or denied as appropriate, and those with valid data are adjudicated. Claims are subject to several systematic edits to identify unanticipated claim billing patterns or potential questionable billing practices before, during and after the claims processing review. Our retrospective audit system randomly samples processed claims once claims processing completes. Claim auditors then access the selected claims within our audit system and review them to determine processing accuracy. With a knowledge base containing up-to-date code sets, the editing tool can apply local exceptions. Further, it screens for unbundled codes; up-coded, invalid and duplicate codes; code fragmentation; member age; member gender; place of service; pre- and postoperative intervals; and modifiers. We manage provider reimbursement policies through our editing process.

Coordination of Benefits for Claims with Third-Party Liability

Our TPL subsystems work in conjunction with our claims and utilization review subsystems to continually mine for TPL and to apply COB edits, making sure Medicaid is the payer of last resort. We have comprehensive edits in place to coordinate with a variety of payers, such as auto insurance and employer-sponsored health insurance carriers. The system pends the claim for manual adjudication when our community transaction system encounters a claim flagged for possible subrogation and TPL. Our claims examiners coordinate benefits with the primary payer's EOB in the manual adjudication process. We pay in full any copayment, coinsurance or

deductible required by the primary payer, up to allowed amounts, regardless of whether the claim is from a network or out-of-network provider.

Member Management

The member eligibility, enrollment and disenrollment files we receive from the Division will be passed through our secure file exchange gateway to our enrollment processing system the day we receive them. The enrollment processing system performs format validations for HIPAA compliance and adherence to business rules. Records passing validation are pushed to the claim platform via real-time API to appropriately enroll, disenroll or update member records. We will use the Division's member categorization to identify available benefits. Members are assigned unique member numbers, which we use on member-specific materials and for member-related processing.

The claims platform, upon finalization of member record updates, will pass the finalized updated records to downstream applications, vendors and repositories via real-time API, batches and streaming. Data will be shared simultaneously with these other systems, such as the 270/271 transactions with claims clearinghouses, our call center IVR system, member and provider portals and our Medicaid analytic reporting tool. Enrollment and eligibility updates will be shared with subcontractors and downstream operations such as ID card fulfillment and care coordination activities.

Encounter Submission

Our encounters system facilitates reliable reporting built on sound, accurate data to bring workstreams together to manage encounter data in the required formats. Drawing data from our claims processing system, our encounter data submission and reporting system initiates submissions, tracks responses and provides error correction and resubmission of encounter data.

We load adjudicated claims into the encounter system to make sure the full population of claims is available for submission and use when measuring the claim or paid dollar submission completeness and timeliness of encounter submissions. Encounters are flagged within the encounter system and matched to the 277 response files to reconcile their status, measure acceptance rates and identify reject reasons for each submission. The encounters team monitors reports to confirm all data is sent and accepted, validates the claims system reconciles to the encounter submission reports (including financial fields) and verifies the financial fields of a claim match the financial fields of adjudicated encounters.

Financial Management and Accounting

Our claims and finance subsystems will be interfaced and configured to facilitate prompt payment to providers, reconcile payments with the Division and support our accounting systems. We will send each provider a comprehensive standard Provider Remit Advice (PRA). Transactions will be fed from our claims system to our enterprise resource management platform. All financial transactions are auditable according to generally accepted accounting principles and supported by Sarbanes-Oxley, SSAE 16 and other controls.

Care Management and Coordination Systems

We will gather quality measures, prior authorizations, clinical and claims data and data from providers or subcontractors through our UM program and our care management and coordination systems. We will continuously monitor and manage overutilization and underutilization of services using automated workflow, reporting, dashboards and scorecards developed from data gathered and analyzed by our analytic reporting tool. Our tool will link with and receives data from our clinical management system, which provides an integrated, single solution for managing service authorizations for physical and behavioral health services. In recent years, we have introduced a social resource referral application in other states to help us address and respond to a

member's SDOH needs. We use various data sources to identify member SDOH needs and make referrals to community services with a closed loop back to our care platform.

Providers can submit and view prior authorization requests for new or continuing medical or behavioral health services via telephone, our secure provider portal, direct EMR integration and EDI, all of which integrate to our care platform. Providers can view HEDIS gaps in care using these same channels. Members can view their gaps in care using our member website, our mobile application or the care management member portal.

Provider Enrollment and Network Management

We maintain our single national repository of provider information, which is a database housing information on providers who have contractual relationships with us and our affiliates. These data are the source of truth for populating our provider directories and automatically updates daily into our claims processing platform and in near real time to the common services connected across our information technology (IT) landscape.

Each provider record in our claims platform contains relevant identification numbers, including Medicaid provider number and National Provider Identifier (NPI). We audit new contract data to make sure provider contracts are set to pay according to the benefit design, eligibility and reimbursement policies. All member claims, authorization and clinical service management processing (where a provider reference is required) is linked back to the unique provider record. Provider relationships with members (e.g., health home and PCP) pertinent to claims processing are noted within our claims and provider payment subsystem. We ask providers to update and attest to their demographics periodically via our secure provider portal.

Reporting Systems

Our integrated reporting and data analytics solution will enable us to achieve maximum plan effectiveness and meet the Division's reporting requirements. We integrate data into our data repositories from sources external to our core operations systems, including provider and encounter data from our vision and dental ancillary vendors, and pharmacy encounter data. Developing these composite data sets enables quality analysis, such as HEDIS and others, and supplements the medical management of the members. We are continuing to invest in the next generation big data technology while we build on the latest database technology to bring noticeable performance benefits to all reporting and analytics users. This provides us with a future-ready data platform primed for continued business growth and enables timely, data-based decision making across the business.

2. Describe modifications or updates to the Offeror's claims processing system that will be necessary to meet ...

We do not anticipate the need to modify or update our claims processing system, based on the RFQ requirements and the model contract provided. Our system's architecture accommodates scalable expansion, allowing us to quickly introduce routine upgrades as needed while providing the latitude for us to plan for significant increases in computing needs without risk or material operational impact. Our advanced, scalable MIS platform, shared across our national Medicaid customers, integrates physical and behavioral health, pharmacy (when applicable) and social service support in compliance with applicable state and federal regulations. Our shared platform allows us to drive economies of scale in both staff and infrastructure, enabling our core systems to stay current and maintained. We will use the following tools and processes during contract implementation and post implementation to confirm claims process accurately and to assess any opportunities for modifications or updates to our system.

Pre-Implementation Approach

We will work with the Division before implementation in the following ways to confirm our systems are up to date and functioning properly:

Tested project management approach: We use a framework of governance and project management to actively monitor and track implementation progress and validate the quality of our deliverables meets contract requirements. We implement a continuous improvement process to evaluate implementation performance while maintaining close communication with the Division's stakeholders.

Stringent needs assessment and system configuration: While our systems are configured for and successfully process claims, we will perform any needed system configuration and testing to make sure claims are paid accurately. We produce a standard needs assessment to identify benefit requirements to configure our claims system and supporting applications to meet contract requirements.

Intensive testing: We will have a highly specialized team who will test the configuration via intensive unit, systems and end-to-end user acceptance testing and work with providers to perform a series of test scenarios in a test environment to make sure our system is properly configured. Claim edits and reimbursement policies will test our system configuration against the Division's reimbursement policies and our reimbursement policies to validate accurate claims adjudication.

Post-Implementation Approach

We will monitor claims to immediately identify any problems post go-live. We will monitor and manage a wide variety of performance indicators, such as auto-adjudication rate, pend rate and denial rate, to verify compliance with regulatory and contractual requirements. Using the information gathered during our testing processes, we continue to identify and remediate any issues encountered.

Claims go-live, post-implementation processes: We will have a stringent process for post-implementation, including auditing claims to confirm correct processing. We will quickly identify and remediate issues and monitor key metrics using our daily claims remediation call, including auto-adjudication rates and denial rates.

Innovations and Enhancements to Our System

We invest $3.5 billion annually in technology and innovation across our IT portfolio, showing our commitment to making sure our systems are up to date and facilitating innovation. Our significant innovations and enhancements include:

Upgrades to Claims Platform: We upgrade our claims platform twice per year to the most recent, leading-edge version, maintaining support and compliance.

Technology Modernization: We continuously invest in multiple functional areas to improve automation, advance real-time transaction processing, advance quality, reduce infrastructure cost via cloud deployment and benefit from other modern technologies.

Machine Learning: We are broadly experimenting with machine learning algorithms across operations areas. Examples include efforts to increase and improve provider and member matches on submitted claims; identify fraud, waste and abuse; and proactively identify and address claims denials likely to be turned over on appeal to reduce end-to-end provider abrasion and increase speed to payment.

Claim Pre-Determination: We have developed a portal feature so providers can file professional services claims for a pre-determination and estimate of payment, in real time. These pre-determination claims are checked for many of the same edits and conditions a finalized claim undergoes, allowing providers to submit, edit and resubmit to facilitate proper submission and payment of the final claim.

Virtual Card Payments: We implemented a "virtual card payment" for providers who are not paid via electronic funds transfer to reduce paper checks, reduce administrative burden and improve speed to payment. With virtual

card payments, the total dollar amount of a claim's payment is loaded onto a single use, virtual card a provider can immediately redeem on their existing credit card point of sale terminal.

Provider Portal Enhancements: We continue to improve our provider portal experience by simplifying the way providers do business with us, including ongoing surveys to continuously improve usability and accessibility. Examples include the ability to modify claims address and payer display for delegated members, customization and personalization enhancements, and enabling health care professionals to access self-service tools and relevant policies, forms, training materials and other content quickly and easily.

Interactive Claim Edits: Electronic data interchange (EDI) and portal claim submissions have many of the actual claims platform edits and reviews applied to them upfront in real time, providing immediate feedback over EDI and the portal for which claims will be rejected or may deny. Claims flagged for rejection or denial are held for several business days to allow providers to resubmit with corrections.

Health Information Exchange: We are dedicated to enabling the electronic sharing of clinical data to facilitate the quality of care for our members. Nationwide, we connect to hospital direct submitters, health systems, HIEs and ADT and data aggregators. We are intaking clinical records from external sources with better speed and better quality, allowing the care managers and care teams to react expeditiously.

Interoperability: We have developed a long-term strategy to support bidirectional, standards-based information exchange before and beyond the CMS Interoperability mandates, and we are building this capability to enable bidirectional collaboration and real-time coordination of member treatment plans. We have real-time integrations deployed across several major EMR vendor platforms.

Our Ability to Modify Our Systems

We will receive the full support of our local and national resources to remain proactive and responsive to the Division as we identify system modifications. We will partner with the Division to work emerging system changes through application configurations or our software development process. Our approach will include communicating early and often with the Division regarding the process. We will follow a disciplined software modification planning and implementation process, including defining requirements, confirming change compatibility, assessing impacts and identifying and mitigating risks.

Examples of Modifications

We have experience continuously refining our managed care information system to meet new requirements and enhance the support of services delivered to our members. We have completed several projects in similar states using this method, including the following:

- To date we have completed several projects to support the CMS 21st Century Cures Act:
  - 21st Century Cures Act – Provider, a requirement to validate provider Medicaid registration with each state before claim payment
  - 21st Century Cures Act – Electronic Visit Verification (EVV), a requirement to electronically verify home health care visits before clams payment
- We updated a number of applications to support the CMS Medicaid Managed Care Rule initiative, requiring the collection and directory display of additional provider data elements to provide members with better matching criteria for their health care.

3. Describe the Offeror's claims processing operations including:

3a. The claims processing systems that will support this program;

Our claims processing system is a customized, market-leading, highly configurable commercial platform with scalability to meet our current and future demands. It is extended and interfaced with a wide range of applications. We process claims using the comprehensive Strategic National Implementation Process, using their electronic data interchange (EDI) guidance, and we comply with applicable claims processing requirements. Our team adjudicates and pays claims using the same processes, tools, systems, edit checks and timelines regardless of whether a claim was submitted in paper or electronic format. Our team subjects claims to further validation and edits for member eligibility, provider contracting and prior authorization upon completion of initial validation edits. Our system determines whether the claim can be auto-adjudicated and, if the claim criteria indicates auto-adjudication, uses built-in logic to automatically process and price the claim according to claim type. Claims that cannot be auto-adjudicated and require special intervention outside the normal claims processing cycle are diverted for manual adjudication, which follows standard operating procedure guidelines.

Our claims routing engine delivers claims to the appropriate claims processing platform based on each member's demographic data and corresponding eligibility information. This allows claims data for various programs to flow through the same channel, verifying appropriate routing for provider-submitted claims. Before the claim even enters our adjudication process, we employ our proactive claims optimization tool, which scans EDI claims, identifies certain claims to deny and returns the claims to providers pre-adjudication via a standard 277CA report. Our claims optimization tool notifications include clear instructions on how to repair errors and resubmit, along with access to supporting documentation regarding the triggered alert.

3b. Standards for speed and accuracy of processing and measures to ensure standards are no less than the ...

Using our advanced infrastructure for claims adjudication, our claims team consistently meets or exceeds federal and state prompt payment requirements while maintaining the highest levels of accuracy and quality in claims processing. This operational experience provides the foundation for successful claims management and administration for our members and providers. A dedicated auditing team monitors claims processing accuracy. We use multiple quality audits and programs to verify adherence to claims processing standards, including pre-disbursement review, post-disbursement review and prevention, and root cause analysis and resolution.

The claims payment and accuracy metrics we track include dollar accuracy rate (DAR), claim payment accuracy (CPA) and overall accuracy rate (OAR). Nationally, in 2021, our DAR was 99.95%, our PAR was 99.99% and our OAR was 99.84%, highlighting our commitment and capability to deliver payment and accuracy performance results.

3c. The Offeror's process for dealing with discovered compliance issues through an expedited process;

While each compliance issue is unique and requires different levels of remediation, we strive to identify and solve any issues immediately. We have a number of tools and processes in place to remedy any compliance issues that may arise during the contract period, including the following:

Claim Analytic Tool

This tool uses data collection and analysis to monitor denial volume, denial rates, claim receipts and cash flow to then elicit the appropriate response. The system alerts us to the risk of claims denied in error and to fluctuations in claims receipts and cash flow paid to providers. Once claims are in our system for adjudication, we use our claims analysis platform to systematically analyze and identify claims anomalies on a macro level before providers experience significant claims disruption. The platform uses data collection and analysis to alert our analysts when there are statistical trends requiring intervention and resolution before it becomes an issue.

In 2021, we had 27,791 alerts from our claim analytic tool and found 7,185 of them warranted action. These actions ultimately resulted in rework savings of $1,617,888.

Claims Rules Software

Our claims rules software enables claim edits based on configurable business rules that are quick to modify and deploy. Edits range from provider validation to CPT code-based rules.

Claims Optimization Tool

Our claims optimization tool electronically identifies “certain to deny” claims before adjudication, alerting and educating providers by delivering prompt and clear notifications on resolving claim errors. This pre-adjudicated claim editing capacity allows us to autodetect claims with potential errors. Our claims optimization tool delivers provider feedback within 24 hours of claims submission. Using our secure provider portal, providers can correct errors, reducing the complexity and provider concerns resulting from claims denials.

Workforce Management

Our internal claims teams have integrated rigorous processes and controls to actively monitor the physical and behavioral health claims inventory. Claims requiring manual intervention are assigned to staff based on a designed hierarchy to afford maximum efficiency and support the complexities inherent to the manual intervention to process the claim.

Provider Relationships

Provider agreements will address provider claims responsibilities, including the responsibilities of providers to submit appropriate information and documentation. We will follow policies and procedures for payment issues and reconsiderations that can be amended based on the contract and review by the Division. We will work with providers through our provider services team to achieve satisfactory resolution of claims disputes.

Our Investigation and Solution Group

If a claim undergoes proactive accuracy and built-in adjudication system checks and there is still an issue with the claim post-adjudication, our investigation and solution group (ISG) reacts quickly to resolve escalated issues for providers. This includes supporting reconsiderations and disputes with a standard to resolve these issues in 20 days or less. The ISG is a single-point tracking and monitoring team for our provider services staff to engage with for claims issue escalations and makes complex provider issues transparent, enabling rapid remediation. The ISG merges and streamlines data from claims, enrollment, clinical episodes of care and utilization history and provides a complete view of provider concerns, root cause analysis and resolution.

In a similar state, our plan’s ISG enabled the reduction of the claims payment turnaround time to 11.80 days — down from 14.41 days and 12.72 days in previous years.

3d. The Offeror’s process for and timeframe to correct programming errors and timeline for correcting any ...

While we strive to correct any errors as soon as they are identified, our goal is to correct any programming errors or misprocessed claims within 30 days. We have systems in place to allow us to stop claims from incorrectly processing. This allows the claims team to analyze the issue, pend any claims and make sure there are no additional claims deficiencies. We built our Claims Quality Assurance program upon a set of quantifiable measures to continually verify we are processing and paying claims on time and accurately. Our sampling methods are designed to the relevant algorithms in each of our deployed audit programs. For post-disbursement reviews, we extract a stratified sampling by dividing claims into eight categories, called strata, based on the dollar amount paid; a fixed number of claims are randomly selected for review; and the number of claims

selected per strata is based on the percent of paid dollars per strata. We use a suite of analytic solutions, which identify outlier, aberrant or suspicious transactions, providers and members using various statistical models.

Working with Providers

We recognize a key component of timely and accurate claims payment begins with the providers, and we will create policies and procedures to guide providers through the billing requirements and make this information available on our public provider website and portal. We will make it easy for providers by making sure any employee, no matter what department they are in, can directly assist or guide providers to the most appropriate resource who can assist them through our "no wrong door" policy. Notably, assigned and designated staff from our Mississippi-based provider support team will be available for requests from providers to discuss claims status and issues and help resolve barriers.

Our provider service model for Mississippi will include local dedicated staff who focus on the transition of Mississippi providers new to managed care. All providers joining our network will be assigned a dedicated advocate who will serve as their single, primary point of contact, provide face-to-face support related to orientation and answer any questions related to new managed care administrative processes. Following contractual requirements, we will follow established policies and procedures for handling claims inquiries and disputes with the resolution process, including at least two levels for providers to dispute the nature of medical necessity. Teams such as claims, authorizations, medical directors, service and provider relations will facilitate a comprehensive review and resolution of any escalated case, where applicable,

Corrective Action

As part of our documented analysis, we track, escalate and resolve deficiencies by analyzing the issue and determining root cause, generating and obtaining approval of a documented approach to resolve the issue, developing and testing a solution and implementing and monitoring the corrective action post-implementation.

In addition, the claims leadership team reviews audit findings, financial performance metrics and control charts weekly. These reports include monthly quality metrics by platform and by claim processing location.

3e. The process of identifying and addressing deficiencies or contract variances from claims processing ...

Identifying Deficiencies and Variances

As described, we have a pre-implementation and post-implementation approach to our managed care contract to issue resolutions, including using the following tools and processes: a tested project management approach, stringent needs assessment and system configuration, intensive testing and post-implementation claims go-live processes.

Our claim analytic tool supplements our claims audit efforts by identifying areas of risk in the claims process. As mentioned, the tool alerts us to the risk of claims denied in error and to fluctuations in claims receipts and cash flow paid to providers to give us an end-to-end view of the claims process and expand our vision to additional areas, which can improve provider satisfaction with claims payment.

Addressing Deficiencies and Variances

Our claims team analyzes the data and develops a plan to correct the variance and monitor ongoing performance when we detect a deficiency or contract variance. We develop corrective actions if our analysis identifies a systemic problem, and if the issue is broad enough, we incorporate the change in our member or provider manuals and newsletters. Consistent progress measurement and internal resource sharing are supported by a weekly performance review, the results of which are shared monthly with our leadership team.

We gather information at key provider touchpoints to determine root cause of issues and resolution. We identify deficiencies or contract variances resulting from retrospective review, post processing review of claims data, operational meetings and an analysis of identified issues.

Other claims management activities that improve the provider experience, reduce administrative burden and minimize complaints include:

- Using post payment trend monitoring for denials, change in payment trends and population-based changes to derive policy and system change
- Removal of DRG coding audits when a provider has 95% quality rating or higher in a quarter
- Pre-denial provider outreach call for key claims
- Data-driven EDI edits to afford care providers an opportunity to repair claim data as applicable before the claim processes through the adjudication system

With every provider-specific claim issue, our claims educator will work directly with contracted and non-contracted providers to quickly resolve issues and to give focused attention and education to providers. Our claims system auditors will verify provider contracts are loaded correctly. This ongoing collaboration will help to keep our claims payment accuracy rates high and in compliance with the contract.

Examples of Addressing Deficiencies and Variances

We identify deficiencies or variances through provider inquiries or through our claim denial trends, which are captured and reviewed daily. The issues are researched against system configuration and provider contracting to identify and remediate the root cause. The following examples from similar states demonstrate our commitment to facilitating accurate claims payment and remedying any deficiencies or variances during our payment process:

- Provider timely filing limits were set up incorrectly in our system. Our team was persistent in having provider files updated with correct timely filing limits and corrected history claims. Our team overrode timely filing denials until corrections were completed to remedy this.
- Lab codes were being denied, showing they were not covered in error. Our team corrected this edit and applied service rule overrides until configurations were completed.
- We were asked to blend network behavioral health claims with out-of-network medical claims. In response, we reprocessed all claims and paid to alternative group IDs to prevent as many denials as possible.

B. Technological Systems

1. Describe how the Offeror will leverage its technology to ensure it produces a consistently effective Care ...

Our suite of clinical tools will promote collaboration between the member, care manager and the interdisciplinary treatment team (ITT), our field-based care teams and the member's providers and other organizations. These tools will share practical member data and identify potential changes to each member's needs and health risk so the member's care team and ITT can implement timely, targeted member interventions based on data. Our member engagement programs will provide members tools to promote healthy lifestyles and help them appropriately access care.

Our system will facilitate the delivery of timely, integrated and coordinated services and supports across varied populations and delivery systems. It will support the ongoing management of the member's care and help manage the member's care as they experience changes in health status or changes in care settings. Our system will allow the care manager and ITT to collaborate on relevant care needs to support the member's optimal health; develop a treatment plan to meets the member's needs, goals and desired outcomes; monitor the

member's progress toward achieving their goals; and identify acute events (e.g., hospitalization) so the member's care manager and ITT can coordinate relevant and timely member interventions.

Sharing Data across the Care Team

An interdisciplinary care management approach is central to our clinical model. We will enable collaboration among the member's care manager and ITT using our secure, cloud-based care management platform. This platform will provide a timely flow of workable member information and care management tools to enable the member's care manager, medical, behavioral and specialty providers and community-based organizations (CBOs) to work together to coordinate and monitor the member's care.

Our care management platform will provide single sign-on access to information and provider-facing capabilities, identifying the provider's members who have gaps in care and providing access to the member's plan of care. Our platform's integrated health record will include member information and a listing of the services and supports the member is receiving. The platform will allow providers to store attachments and capture notes and allow the care manager and ITT to conduct assessments and view findings, view and update the member's treatment plan, review the member's progress toward achieving their goals, confirm the member's adherence to their treatment plan, monitor for acute events through ADT alerts and act to prevent an escalation of the member's utilization and more. It will help engage members in their health care by providing a variety of tools to communicate with their care management team, track the completion of goals in their treatment plan, keep track of appointments in their calendar and complete assessments.

Data Housed in Our Care Management Platform

Our care management platform will provide the mechanism for the member's ITT to collaborate and develop a treatment plan to meet their needs, goals and desired outcomes; monitor the member's progress toward achieving their goals; and identify acute events so the ITT can coordinate relevant and timely member interventions. Our care management platform will facilitate the delivery of timely, integrated and coordinated services and supports across varied populations and delivery systems.

Our platform will maintain information about the member's care and services in their care management record, providing a comprehensive view of their needs and goals and the services and supports being delivered to meet their needs and help them achieve their goals. The care management record will include information such as:

- **Member Info:** Details such as member demographics, primary and secondary insurance, primary address and other addresses; member identifiers, such as member Medicaid and Medicare IDs; names and contact information of the ITT members; and programs for which the member is enrolled and the member's status in the program.
- **Member Health:** Member medical information; member service dates and outcomes, including those manually entered or visits based on claims data; diagnosis summary; ADT alerts and messages; managed conditions; pharmacy data and medications, including types and dosages and medication adherence; health indicators; and appointments.
- **Member Gaps in Care:** Advanced analytics and evidence-based medicine tools integrate medical data with data to identify risk and stratify members' needs and connect members to a variety of programs.
- **Member Treatment Plan:** Provides access to a shared, dynamic, coordinated treatment plan integrating medical, behavioral, social and functional issues and data and freely and frequently shares vital member information across the team.

- **Member Activity Record:** Details the record of activities performed for a member and scheduled activities yet to be performed. This tab includes the ability to capture notes, upload documents and distribute health-related articles. It serves as a repository for signed consent forms and disenrollment agreements.

Supporting Care Management Activities

Our system will provide a dashboard for authorized members of the care team with four major panels — My Members, My Calendar, My Alerts and Requests Received — with features that encourage engagement and support integrated care management. Users will have access to a full range of secure communication and collaboration tools to interact with other users, both internal and external. For example, if members need care manager support, they can use the member portal to contact their care manager, or a member of the care team may receive an online request from another care team member to take a specific action for the member.

Our system will support ongoing treatment planning, management and coordination across a continuum of services and settings by providing access to this information from a single source. The care team can track the member's progress online against the treatment plan using several key features, such as an audit log highlighting updates and changes to the treatment plan, filtering by particular domains (e.g., mental health), alerting based on updates or changes and member input.

Our system will enhance the PCP's ability to develop and share treatment plans and co-manage high-risk members requiring multiple specialists and care providers. Our system will support a variety of nationally-recognized valid and reliable assessment tools to trigger care events in the treatment plan and facilitate alerts to other members of the care team. The care manager can assess a member's needs using our system while maintaining our structured clinical care management and care management processes.

System Interoperability and Data Exchange

Our care management platform will automatically exchange member and authorization data with our community transaction system based on authorization transactions processed in our utilization management system. Our utilization management system will provide prior authorization status, treatment plans and Health Risk Screenings to providers through our online provider portal.

Our clinical and operations teams will use our managed care information system applications to access and update data to perform a variety of functions. These functions will include enrollment and eligibility processing, care management, provider network management, encounter data reporting, claims processing, member services, reporting to the Division and our internal teams and data analytics to monitor key metrics and trends across various dimensions through regular performance reviews.

Our clinical team will perform care management using our authoritative source of service authorization data and member data (e.g., member eligibility) and provider data. Our acute care managers will have access to our utilization management system to view pertinent member utilization data.

Electronic Medical Record Interoperability

Our EMR-integration capabilities will deliver providers integrated access to real-time data programs to streamline provider access to payer member information from directly within their EMR workflows, enabling providers to offer faster, higher-quality service to their patients. Using our tool, providers can check pharmacy and medical benefits, coverage and cost information; review gaps in care; search for high-quality, lower cost providers for referrals; manage prior authorizations and more.

Our Social Determinants of Health Resource Directory and Social Care Tools

We will use our SDOH resource directory and social care tools social support network to refer and connect members to supportive services in their local communities. Our SDOH resource directory and social care tool will be a web-based tool, easily accessible by laptop or tablet to help care managers and community health workers connect members to free (or reduced cost), relevant and available social resources, such as food, housing, legal resources, employment assistance, energy, support groups, childcare and clothing. Our integrated, secure, HIPAA-compliant, web-based care management platform will facilitate the coordination of the member's care by sharing vital member information with the member's care manager and ITT and providing a suite of tools to monitor each member's progress toward achieving their goals and making certain the member is experiencing improved health outcomes.

Our care management platform will facilitate the delivery of timely, integrated and coordinated services and supports across varied populations and delivery systems. It will support the ongoing management of the member's care and help manage the member's care as they experience changes in health status or changes in care settings. Our care management platform will allow the care manager and ITT to collaborate on relevant care needs to support the member's optimal health; develop a treatment plan to meets the member's needs, goals and desired outcomes; monitor the member's progress toward achieving their goals; and identify acute events (e.g., hospitalization) so the member's care manager and ITT can coordinate relevant and timely interventions.

A unique feature of the tool we will implement is its closed loop model, which allows the member, community-based organization or our employees to update the status of the member's SDOH resource referral. Our SDOH resource directory and social care tool's easy-to-use database of available community resources will include:

- The ease of navigation allows the user to search for resources by ZIP code and/or type of support needed.
- The tool uses an algorithm to search public websites and sources to identify community resources.
- Information on services, contact information, intake requirements, service hours and languages spoken.
- The platform allows the user to email or text the referral information directly to member.

2. Describe how the Offeror will leverage its technology to measure the success of Quality Management ...

At the core of our QM program is the analysis of data to monitor and improve the delivery of care, member safety and service. We will identify where we should focus improvement efforts by routinely analyzing key indicators to measure the processes and outcomes of care rendered to our members. We will track any state required HEDIS measure by race, ethnicity, gender, geographic location and member language as available. Our reporting development is flexible and will center around priority focus areas for the Division. Our technology tools have helped to drive improvement in numerous quality management programs. For example, in a similar state for a Medicaid population, there was a focus on improving antidepressant medication adherence. Use of the following tools, along with provider and member engagement, resulted in a 10.11% improvement in the acute phase management and 8.84% improvement in the continuation phase management from 2018 to 2020. In addition to using certified HEDIS software, we will benefit from the following tools and technologies to support quality improvement:

Performance Tools	Purpose
Member Touchpoint Tracking Tool	Our member touchpoint tracking tool is a data engine used to house and track member touchpoints for quality programs. This includes the data sent to a vendor or internal department to deploy a program and the outcomes of the program for an individual member. The data can be used to orchestrate when and how a member is outreached based on outcomes and when they received outreach for other programs.

Performance Tools	Purpose
Care Opportunity Management Tool	Our care opportunity management tool is an online tool to help providers identify, address and manage open care opportunities for members. Our care opportunity management tool can assist providers in identifying members who have had a recent hospital stay so they can provide appropriate and timely post-discharge care.
Provider Scorecard and Gaps in Care Report	The provider scorecard helps providers identify members who have gaps in care related to preventive health care and monitor for select medical conditions. These care gaps align with HEDIS performance measures and state-required performance measures such as wellness exams, immunizations and medication adherence requirements. Addressing open care gaps will help providers achieve positive health outcomes for their patients and adhere to evidence-based Clinical Practice Guidelines.
Analytic Reporting Tool	Our analytic reporting tool and analytics tool set contain claims information, member data, provider data, authorizations, subcontractor data and predictive modeling.
Member Survey	We conduct a member survey from February through June of each year by a certified vendor and measure members' experiences with us during the prior six months. The survey team analyzes and trends the results annually with review by the QMC to identify trends and opportunities for improvement and make recommendations to improve member experiences.

Further, we will measure quality initiatives through the following:

- **Retrospective Reporting:** We will partner with our certified HEDIS auditor to ensure our success in the generation of HEDIS rates pass auditor review. These rates are submitted to NCQA and to the state in compliance with state regulations and NCQA accreditation requirements. We will assess the final rates to determine where performance has improved, declined or plateaued.
- **Prospective Quality Metric Reporting:** We will track year-to-date performance and assess our performance retrospectively. We will view this information at the health plan, provider and member level to (1) inform where our QM Work Plan may need to be modified and (2) provide targeted information if additional interventions are needed to address performance gaps, monitor performance and drive member-specific communication about care opportunities. These efforts will include:
- **Performance Monitoring:** The QM team will have access to reports that are updated at least twice a month with year-to-date performance on HEDIS and state custom measures. The QM team will view performance at not only the product or reporting population level, but by a variety of membership segments such as geography, gender, age and race-ethnicity. The ability to view performance by these membership segments will allow for the identification of any unwarranted variation and informs differential intervention strategies to promote equity and drive overall improvement.
- **Member-Level Information:** Members who have gaps in care will be identified using certified HEDIS software. We will use this information for direct outreach activities to set up a needed appointment or support member incentive programs.
- **Provider Reporting:** Provider performance reports, including the practice's patients with care gaps, will be generated twice a month. Providers can access these reports through our online provider portal. Our field staff will visit larger practices and review these reports with the provider office staff and collaborate to close those gaps and verify members receive required services.

Addressing Health Care Disparities

Eliminating health disparities and addressing SDOH inequities is at the core of our population health approach. The mission of our population health management program is to help build a more equitable, accountable and

community-integrated delivery system to improve the experience of care, reduce costs and reverse the intergenerational effects of structural racism that have and continue to affect the health of our members.

To further segment populations for targeted population health intervention, we will use our sophisticated predictive modeling tool, which uses advanced analytics to identify and stratify populations. The tool applies more than 300 clinical and nonclinical rules, enabling our clinical team to understand member risk, protective factors and future predicted clinical and cost outcomes. We developed an Impactable Care Model (ICM) to take clinical risk factors a step further by looking at member utilization and care patterns through the lens of Impactable Factor registries to pinpoint opportunities where we can act. Our population health team will use the ICM to analyze disparities for targeted action or quality improvement. The model's diverse functionality will enable our teams to stratify, segment and sub-stratify our members by numerous characteristics to help identify member cohorts for heightened engagement. Specifically, we can look at clinical risk factors, filtering by member characteristics such as race and ethnicity to identify patterns and significant disparities by racial and ethnic subpopulation. This will help us advance health equity by confirming the most appropriate resources are allocated to the highest need members and subpopulations.

3. Describe how the Offeror will leverage its technology to effectively analyze utilization and create ...

Our UM program will be supported by evidence-based, nationally recognized health care policies and clinical and review criteria, which influence care decisions to support the delivery of appropriate care in the most appropriate setting at the appropriate time. Our technology, coupled with our UM team, will contribute to our successful ability to analyze utilization and make sure utilization is appropriate.

Utilization Management and Quality Improvement Subsystem

We will gather quality measures, prior authorizations, clinical and claims data and data from providers or subcontractors through our UM program. We will continuously monitor and manage overutilization and underutilization of services using reporting, dashboards and scorecards developed from data gathered and analyzed by our analytic reporting tool. Our analytic reporting tool will link with and receive data from our clinical management system, which will provide an integrated, single solution for managing service authorizations for physical and behavioral health services. Our UM system will be the system of record for medical service authorization data and coordination of behavioral health services. We will use member and authorization data based on authorization transactions processed in our clinical management system and passed back to our community transaction system for claims management and clinical system for care management activities.

Providers can submit prior authorization requests for new or continuing medical or behavioral health services via several methods, including telephone or through our secure provider portal. Providers can submit authorization requests, verify approvals, submit electronic referrals and obtain real-time verification of membership through the provider portal. Providers can view gaps in care using our clinical management system, the secure provider portal within the provider's practice management system, and with any 270/271 EDI integration.

Our clinical management system will support medical and behavioral management business functions, including intake, coverage review and inpatient care management. The platform will support transitional, emerging risk and high-risk care management, disease management, complex medical conditions and health and wellness management functions, providing clinicians a complete view of each member on a single technology platform. Nurses, health care managers and wellness advocates can view members holistically, allowing them to prioritize their conversations and interactions on the opportunities that have the greatest benefit to the member based on their specific needs and situation. Our clinical management system will use an intelligence system that

mines data to identify health improvement opportunities to arm nurses and coaches with opportunity scoring, gaps-in-care intelligence and predictive analysis, including identification of populations with emerging risk.

Using Data to Improve Appropriate Use of Service and Cost Efficiencies

We will integrate and assess medical data, behavioral health claims, pharmacy claims and lab test results using our multidimensional, episode-based predictive modeling tool and our analytic reporting tool. These tools will allow us to develop and produce reports, dashboards and scorecards and conduct clinical, quality, UM and care management analyses to monitor and evaluate medical and behavioral health utilization and care management. Our health care economics team will perform utilization reporting and analysis to identify overutilization, underutilization and inappropriate utilization, understand the clinical and utilization events affecting a member's health risk and evaluate the ongoing effectiveness of clinical care management interventions. They will use it to identify opportunities for improvement in the way we deliver services to members, identify care management and care coordination opportunities, evaluate the efficiency and appropriateness of service delivery and monitor outpatient practice management outcomes.

We will base our determination of which services require prior authorization on whether our management will result in better quality and increased efficiency. We will use our internal platform and monitoring reports to monitor and track claims data and our integrated user experience platform to monitor, track and trend prior authorization activity, including denials, approvals and appeals overturn rates.

We will perform continual internal monitoring for trends in utilization patterns. This continuous monitoring will allow us to stay alert to changes in utilization trends. For example, in a state similar to Mississippi, we recently removed five codes for spinal surgery when, after reviewing utilization trends, we found criteria for medical necessity were met in an overwhelming number of requests for these codes. This was a strong indicator these procedures were being done at the appropriate time and in the appropriate place.

4. Describe how the Offeror will leverage its technology to measure the efficacy of Population Health ...

Eliminating health disparities and addressing SDOH inequities is at the core of our population health approach. The mission of our population health management program is to help build a more equitable, accountable and community-integrated delivery system to improve the experience of care, reduce costs and reverse the intergenerational effects of structural racism that have and continue to affect the health of our members.

Using Diverse Data to Understand Health Care Needs of Our Population

Understanding and addressing SDOH are critical components of our overall mission. Our program design and approach will be supported by case management, quality management and service navigators. Our model will include capacity building among our staff, routine SDOH screenings and supports in care management activities and population-level identification of SDOH trends for our members and their communities. These teams, along with our behavioral health advocates, community health workers and care managers will hold recurring meetings to discuss member and community SDOH concerns, share new SDOH-related resources and job aids, reinforce SDOH resource and referral tool use and training, discuss the SDOH screening process and potential improvements and share successes and challenges with member Health Risk Screening completion. These teams will collaborate during the weekly rounds meeting, during which staff will hold in-depth discussions about members of heightened concern and HEDIS trends throughout the state. The unified work across these teams illustrates our proactive, collaborative approach, which will lead to improved SDOH issue identification and support before reaching a point of crisis. Using insights on health condition, behavioral, environmental and psychosocial risk factors at the member and community level will help our teams understand the populations we serve. This includes demographic characteristics, SDOH needs and contexts in which members live.

Using Innovative Data Tools to Identify Subpopulations

We will use insights from data to segment our population, assess disparities and identify members and subpopulations for targeted action. In Mississippi, we will use tools to enable our team to identify opportunities to develop interventions for emerging needs, including:

HEDIS Dashboard: Our customizable Quality Measure Dashboard will break down member-level detail for HEDIS measures by race and ethnicity, age, ZIP code and county. The ability to analyze disaggregated data easily will provide us the opportunity to view where and among which populations lower rates are concentrated.

Index of Disparity: We will use the Index of Disparity to assess differences among groups. The formula can be used for a variety of subpopulations, including racial and ethnic groups, income levels, education levels and primary language and can be applied to any measure.

Our platform will include a series of engines that synchronizes claims data with evidence-based medicine guidelines to identify engagement opportunities for proactive changes in care, provider, medication and lifestyle. The platform will generate optimal health opportunities, disease monitoring gaps, medical and behavioral management considerations, medication adherence and interaction alerts, treatment choice options, lifestyle enhancement opportunities and money saving tips.

As one of the key analytical engines in our analytics platform, we will offer a multidimensional, episode-based predictive modeling and care management analytics solution allowing our nurse care managers to use clinical, risk and administrative profile information to provide targeted health care service to members. Among myriad capabilities, our solution will identify individuals who are not obtaining appropriate preventive care and screening and who are at risk for developing costly and debilitating health conditions.

C. Innovation

1. Describe what innovative technological methods, if any, the Offeror will utilize in the delivery of services ...

We will use multiple innovative methods and tools that enable access and delivery of care services. We will strive to support members by improving access and navigation in members' care journey and enable providers to provide access to care. We will continue to offer innovative technology that can improve member experience and outcomes. Examples of these innovations include:

Supportive Websites and Applications

Member health dashboard: We will deploy our member health dashboard for provider and member use, and continue to enrich its data. The integrated dashboard will include individual members' health records, with a detailed view of claims, prescriptions, problems, opportunities and gaps in care. Members can find care, connect to a virtual care provider available for non-emergency medical care, locate urgent care clinics and find network providers or specialists and pharmacies. Members can talk with a RN 24 hours a day, seven days a week, who can answer any health questions they may have. It will provide tools allowing the PCP to view or complete assessments, view and modify treatment plans, monitor the member's health status, determine whether the member is achieving their goals and identify any gaps in care.

Virtual visits: App-initiated virtual visits with an ER provider to support on-demand care. Our program will enable members to initiate a virtual visit from their home with an ER physician, board-certified and licensed in Mississippi. This innovative, chat-first workflow will enable barrier-free access to care in 90 seconds or less while engaging members via their preferred communication channel.

Independent living transitions program for younger plan members ages 14 – 26: A gamified website targeting foster and transition age youth to provide them with educational tools and resources to assist in development.

Our platform will take the overwhelming transition process and break it down into bite-sized, manageable steps and connect foster youth with the support and guidance they need.

Behavioral health member portal: Behavioral health-focused member portal with educational tools, information, self-help programs, resources and multimedia. It will provide information on health and wellness to help them manage behavioral health issues and other chronic diseases. This will include Personal Empowerment Programs available for several prevalent behavioral health conditions, including depression and substance use disorder.

Care management platform: We are improving the ability in our care management platform for members to search and display benefits. We will better capture and represent race, ethnicity, language preference, disability status and gender for use by our downstream applications. The platform will engage members in their health care by providing a variety of tools to communicate with their care management team, track the completion of goals in their treatment plan, keep track of appointments in their calendar and complete assessments.

Wearable Technology

Remote patient monitoring: The Bluetooth-enabled devices facilitate the collection of biometric data and provide qualitative feedback to questions about member health and needs. We will equip members with diabetes, heart failure or COPD with evidence-based, end-to-end remote care management to support active self-management of chronic conditions. Participation in the program will provide members access to video educational tools to support further engagement in health. Results from our monitoring program in comparable states include readmission reductions over 65% and adherence and **satisfaction levels exceeding 95%.**

Virtual pregnancy monitoring program: Remote monitoring for high-risk condition management focusing on chronic conditions, such as diabetes and high blood pressure, deploying a digital educational app with remote patient monitoring capabilities for high-risk members to modernize prenatal care, reduce access barriers further exacerbated by COVID-19 and prevent adverse outcomes.

Virtual diabetes and hypertension management: Through this program we will offer remote monitoring and expert coaching to support members with diabetes and hypertension.

Virtual Support for Members

Chatbots: Our artificial intelligence (AI) chatbot is built with standard operating procedures (SOPs) and platform APIs to automate and support functions our customer service and claims operations personnel perform. The chatbot will automatically look up SOPs and populate data and directions to screens for staff when required. **This automation will improve the efficiency of our staff in assisting our members and providers and accuracy of data entries during calls and claims processing.**

Text programs: As an enterprise, and with members' informed consent, we deliver communications to members through a variety of channels, including text. Examples of text alerts include health care reminders, benefit and plan information, program and services information and appointment scheduling. Text programs include texting will support targeting specific gap-closure opportunities and two-way SMS messaging designed to engage high-risk members, connect to community resources and increase treatment plan adherence.

2. Describe what innovative technological methods, if any, the Offeror will utilize in development and ...

We aim to be a strong, supportive partner for providers, offering data to support care, flexibility in the service delivery model and training to support providers and reduce administrative burden. In addition, our technology facilitates adequacy and accuracy in our network. Our innovations in our network development help make sure

we are offering a comprehensive provider network for all members. Examples of innovations include the following:

Provider Support

An EMR tool to deliver providers with integrated access to real-time data: We created our EMR tool to streamline provider access to payer member information from directly within their EMR workflows, enabling providers to offer faster, higher-quality service to their patients. Using our technology, providers can check pharmacy and medical benefits, coverage and cost information; review gaps in care; search for high-quality, lower cost providers for referrals; manage prior authorizations and more.

Provider training platform: We will offer a customized training program for staff and network providers based on requirements using local knowledge, proficiencies in other states and considerable access to training resources. Our trainers will deliver education through many methods, including classes, online resources, face-to-face assistance, lunch and learns and written materials. We will use this platform for on-demand and live classes and work with community-based resources to provide local training to providers.

Provider portal enhancements: We continue to improve our provider portal experience by simplifying the way providers do business with us, improving ease of use and expanding capabilities. Common administrative functions are available directly from the site, alongside the related content from our provider manual and bulletins. Workflows are simple and straightforward, with enhancements for usability and accessibility.

Care management platform: We will deploy our care management platform and make the system and its data available to providers who are engaging in the care management of members. This system will allow us to integrate key data regarding a member's care into a comprehensive electronic record, including acute care, preventive care, chronic disease management, medical, behavioral health and substance use disorder, social and long-term services and supports. This will allow the member's care team to view, update and communicate with each other regarding the member's medical needs. In addition to our clinical platform, a database of community resources will be available to select provider partners, helping them to meet the social service needs of their patients. The member's care management team can view important member information, such as member information, member treatment plan, member health, member gaps in care and member activity records.

Closed-loop care transitions platform: We will offer an end-to-end post-acute care management platform that connects different providers to enable transparency and improve member outcomes. This innovative tool will interface to providers' EHR, enabling transparency and real-time analytics, without changing the providers' workflow.

Provider toolkits: We will use our website to educate care providers and provide them with the tools they need related to medical and behavioral diagnoses within geographic areas (e.g., depression) or the specific populations they serve.

Network Adequacy and Accuracy

Telehealth solutions: Our telehealth solutions are integral to our efforts to promote the appropriate use of health care services, improve access to care and deliver needed services to members. We will continually assess the impact of our telehealth initiatives on their ability to reduce inappropriate utilization, improve the member experience and health outcomes and give providers the ability to deliver value-based services.

Cloud reporting: We will use cloud reporting to map the travel distance between the ZIP code of the member's residence and providers' service locations. Provider accessibility (time and distance) will be measured by the geographic distribution of providers by specialty. Our provider-to-member ratio analysis will provide insight

into the number of providers, by type, and the location of the required specialties, to meet and exceed contracted access standards and calculate network sufficiency.

Provider network visibility tool: Will provide competitive analysis of network access strength and identify available providers for recruitment, allowing us to strategically recruit providers.

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

Our overall goal is to support the Division's goal of improving the lives and health of Mississippians with a continuously evolving plan to offer members and providers our best service and resources. We do this by delivering innovative solutions such as:

Health Information Exchange: We are dedicated to enabling the electronic sharing of clinical data to facilitate the quality of care for our members. We have extensive experience engaging with industry leaders related to clinical data management and exchange. We engage with the five major EMR vendors and platforms and over 1,200 hospital EMRs to exchange clinical data, and we contract with major release of information vendors to acquire clinical records.

System Monitoring Tool: Our system monitoring tool uses transaction baselines and alert thresholds to proactively identify and address system bottlenecks. This tool has enabled us to avoid unnecessary escalation to address application issues, while improving application availability and claims processing speed.

Interoperability: Our managed care information systems are fully interoperable and fluidly exchange information to allow us to deliver services to our members. Similar data elements have equivalent names and data types across systems to ease maintenance and provide flexibility for growth. Automated data exchanges occur nightly, weekly or multiple times a day, depending on the business purpose and need for the data.

State Data Dashboard and System Access: We are committed to transparency and accountability of our operations by providing the Division access to systems and information when it is needed. We will facilitate authorized remote connectivity to our systems and data, including subcontractor data, through our secure, HIPAA-compliant processes. Users granted access to the Division's reporting group will only have access to Mississippi-related data based on the Secure Group, provisioning and Tableau permission settings.

D. Continuity of Operations (Question is revised per Amendment 5)

1. In an appendix no longer than ten (10) pages, describe the Offeror's proposed emergency response continuity of operations plan ...

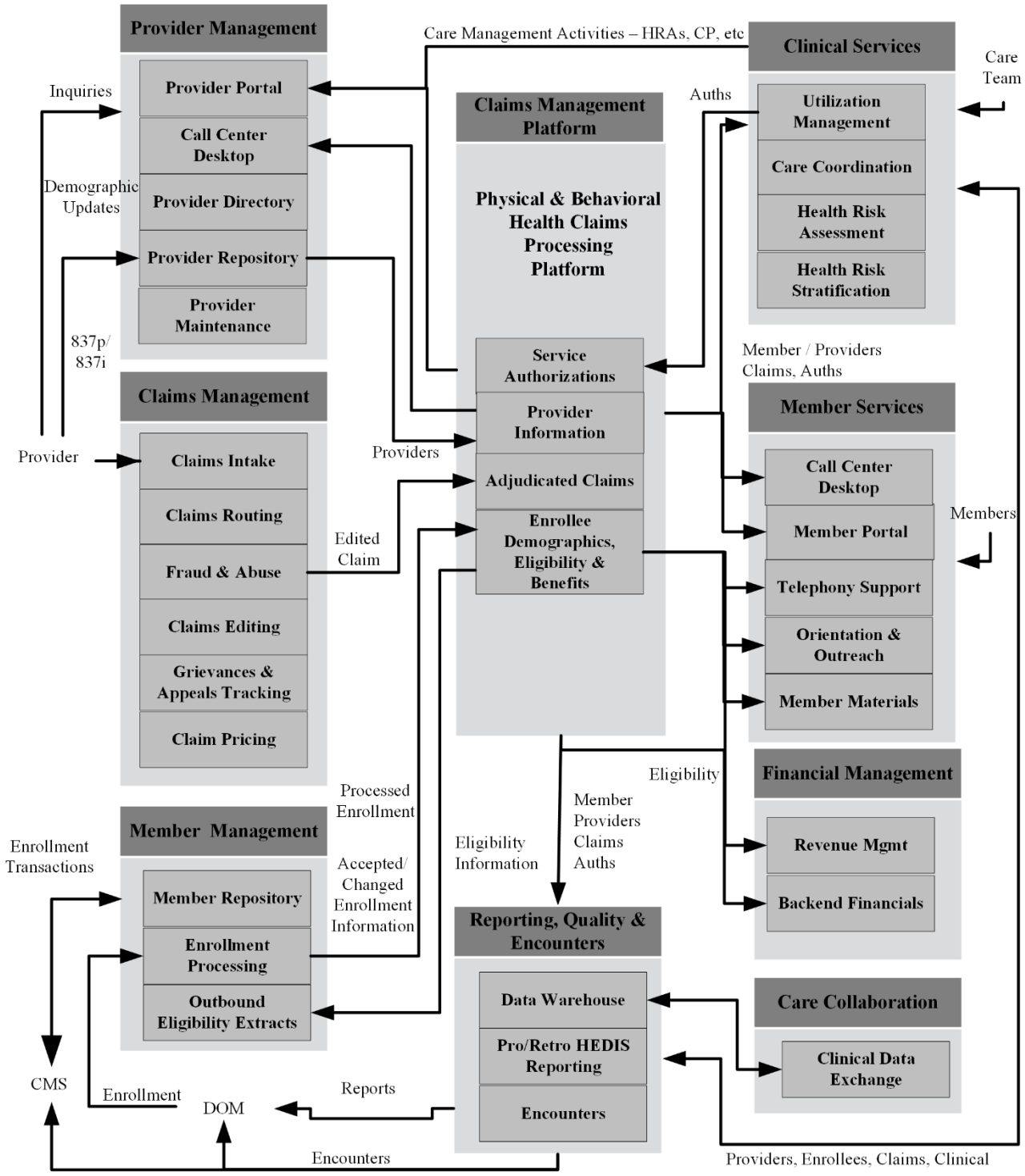
Our proposed emergency response continuity of operations plan is provided in **Att. 4.2.2.6-2 Proposed Continuity of Operations Plan.**

[END OF RESPONSE]

Att. 4.2.2.6-1 Systems Diagram

ATTACHMENT 4.2.2.6-1 SYSTEMS DIAGRAM

The following system architecture depicts the interconnectedness of our MIS architecture.



Att. 4.2.2.6-2 Proposed Continuity of Operations Plan

ATTACHMENT 4.2.2.6-2: PROPOSED CONTINUITY OF OPERATIONS PLAN

1. In an appendix no longer than ten (10) pages, describe the Offeror's proposed emergency response continuity of operations plan. Address the following aspects of pandemic preparedness and natural disaster recovery, including:

a. Employee training;

All recovery team members will be educated on the business continuity plan (BCP) as part of our training program. We will train and provide orientation for new business continuity team members. Refresher training will be required for other team members annually. A variety of training methods will be used specifically for business continuity and disaster recovery:

Employee Orientation and Training	Training Method
Enterprise Resiliency and Response Overview	A self-paced, computer-based training (CBT) to provide employees with the necessary information for addressing emergencies that may occur.
Event Management Computer-Based Training	Used to provide business continuity team members, event management team members and disaster recovery team members with the knowledge necessary to respond to business disruption events.
Business Continuity Plan Development Computer-Based Training	Used to provide business continuity team members with the knowledge and tools necessary to develop and maintain a successful business continuity plan.
Enterprise Disaster Recovery Overview Computer-Based Training	Used to provide employees who have direct or indirect responsibility for business applications and anyone who has disaster recovery responsibility or would like to learn more about disaster recovery.
Structured Plan Walk-Through	Used to train and refresh team members on their roles and responsibilities, refresh awareness of plan documentation and recovery steps and prepare the team for the annual business continuity or disaster recovery plan exercise.
Business Continuity Annual Exercise	Used to reinforce and enhance the competence of the business continuity planners and recovery team members to confirm recovery team members are familiar with the business continuity plan content, understand their roles and responsibilities during an event and are better prepared to respond effectively.
Disaster Recovery Annual Exercise	Uses a variety of methods, including tabletop and functional exercises to demonstrate team members' familiarity with plan content along with their abilities to recover applications. Validates infrastructure, policies and procedures to confirm they can support a successful recovery.

b. Essential business functions and responsible key employees;

The event management team, an enterprise-wide team consisting of local leadership, provides a consistent and reliable approach for communication and engagement between required parties necessary to manage a major event. Local health plan subject matter experts will manage business recovery actions within their functional teams. They will use the event management team, at the corporate level, to engage, communicate and make decisions between teams more quickly and reliably.

Our local business continuity team leadership will include:

- **Executive sponsor:** Accountable for verifying the recovery strategy and associated tasks align with the operational recovery time objective. Responsible for making and authorizing critical decisions for determining how to effectively manage a disaster.
- **Business continuity lead:** Accountable for development, maintenance, testing and execution of the recovery strategies defined in this plan. Responsible for content management, including maintenance and support of the business continuity plan.
- **Customer communications lead:** Responsible for developing communications for critical customers regarding the impact and remediation efforts for the affected business functions.

- **Vendor communications lead:** Responsible for developing communications for critical vendors regarding the impact and remediation efforts for the affected business functions.
- **Chief information officer:** Responsible for understanding the health plan's technology needs, the Division's contractual requirements, needs and preferences regarding information technology (IT) systems and for confirming they are addressed with appropriate resources.

Our business continuity strategies include leveraging resilient or redundant operations performed in geographically dispersed locations across the U.S. work-at-home personnel and abundant locations spanning the United States. Our employees are well-equipped to work from home or other remote locations as needed and have strong experience doing so due to the COVID-19 pandemic.

c. Contingency plans for covering essential business functions in the event key employees are incapacitated or the primary workplace is unavailable;

Our plans address natural and human-caused or fabricated disasters and are used in conjunction with the Event Management and Disaster Recovery process. The plans focus on critical business functions and planning for the worst-case scenarios so we can react quickly and efficiently.

The business continuity plan includes a variety of strategies to effectively respond to loss or complete interruption of the following four scenarios:

Business Continuity Plan Elements	Loss Description and Action Plan
Loss of Facility	Complete interruption of facilities without access to its equipment, local data and content. The interruption may affect a single site or multiple sites in a geographic region.
Loss of Critical Resources	Complete interruption with 100% loss of personnel within the first 24 hours and 50% loss of personnel long term. The interruption may affect a single site or multiple sites in a geographic area.
Loss of Critical Systems	Complete interruption and access of critical systems and data located at our various data centers for an extended period.
Loss of Critical Vendors	Complete interruption in a service or supply provided by a third-party vendor.

All strategies focus on maintaining resilience in our operations and mitigating impact to our customers in a timely fashion. High-level strategies include relocating staff to alternate facilities, offloading critical work to alternate sites and providing access to staff to be able to work from home. We achieve recovery from anything less than complete interruption by implementing appropriate portions of the plan. If our local offices become inaccessible or disabled, depending on specific circumstances, our affected staff will use other Mississippi offices connected to our internal network with full access to systems, or staff will access our systems securely from their homes via our internal virtual private network.

d. Communication with staff and suppliers when normal systems are unavailable;

Critical vendors and subcontractors will be defined in the BCP, and the plan will document the recovery actions required for the loss of all the critical vendors. The vendor's recoverability will be assessed to determine whether they have sufficient business continuity plans to maintain critical services. A variety of communication delivery methods will be used to communicate our business continuity plans. Plans include a call tree for contacting critical recovery team members and employees to make sure they receive up-to-date information on the disaster and actions they should take.

We will communicate with members and health care practitioners during a crisis using all mediums that are available and pertinent. Based on the impact and severity of the event, we will use a variety of communications options, including member and provider portals, member service and provider services centers and media

communications. In addition, we will keep our Division contacts informed on the status of our continuity of operations by providing information within the first hour after the disruption.

e. Plans to ensure continuity of services to Providers and Members, including the Recovery Time Objective for major components;

The public health event management team will convene to discuss the situation and define necessary actions, deployable resources and specific time frames and touchpoints for monitoring to confirm continuous communication and care continuity for members and providers.

Each disaster is unique, and we will customize our response based on needs and the services we provide to members in the impacted area. The following are potential activities that may be included as part of our efforts:

- We may temporarily modify prior authorization requirements to assist members in accessing needed health care.
- We may make our crisis counseling line available to the community to provide mental health support.
- Our medical directors review care management and disease management files to identify members at most risk due to disease severity or fragility enabling priority outreach from care management staff.
- Our compliance team proactively searches for any regulatory orders related to the event to verify we are addressing all regulatory requirements.

Recovery Time

We will use a variety of recovery strategies to align to the defined criticality of the application. Business critical applications, as defined by the business impact analysis and subsequent BCP, will be given the highest priority and generally have a 72-hour or less recovery time objective, meeting the Division's recovery requirements.

f. Security and privacy requirements;

We manage and support an information privacy and security program with established enterprise policies and controls that are comprehensive and aligned with applicable regulatory obligations, customer considerations and industry practices.

Privacy Compliance

Our Enterprise Privacy Compliance Program protects the privacy of health, medical, enrollment and personally identifiable information (PII) or protected health information (PHI) obtained through an individual's participation in our health plans.

The Enterprise Privacy Compliance Program consists of the following core elements and associated responsibilities:

- Policies and Procedures: Maintaining and updating business-specific policies and guidelines for privacy compliance of business operations that involve the management, use and disclosure of PHI
- Incident Management: Detecting, investigating, mitigating and developing corrective action plans for any privacy-related incidents
- Notices and Communications to Individuals: Distributing notices and other communications to individuals, informing them of their rights to access, amend and restrict access to PHI and any other disclosures regarding confidentiality and privacy practices to individuals
- Website Privacy Statements: Maintaining and updating privacy and security statements posted on our websites designed for individuals, providers and customers
- Individual Rights Processes: Maintaining and updating individual rights processes to access, amend and restrict access to PHI and accounting for PHI disclosures

- Complaints: Receiving, overseeing and resolving individual complaints regarding fulfillment of individual rights as outlined in state and federal laws and regulations
- Reporting: Providing summaries of privacy compliance status and performance requirements to leadership
- Monitoring: Monitoring ongoing reporting of privacy compliance status and performance metrics through electronic and manual processes, and providing summaries of privacy compliance status and performance requirements to executive leadership
- Internal Audit: Preparing for and responding to annual privacy internal compliance checklist survey in preparation for internal audit of selected processes and operations approved by our board of directors

Security Compliance

We use an expansive array of network, security monitoring and encryption technologies to protect our environment and maintain the confidentiality and integrity of our data. We routinely test and validate our systems' security and deploy leading security practices to stay apace with evolving cybersecurity threats and risks.

Firewalls, Virtual Private Network and Physical and Logical Separation of Processing Systems

Access to our network and systems is limited through use of multilayered firewalls, VPN, demilitarized zone (DMZ), security middleware and separation of processing systems. Our information technology provides dedicated connectivity to a highly reliable and secure nationwide voice and data wide area network (WAN) to connect health plan locations to the metropolitan area network (MAN) at our corporate headquarters. The corporate infrastructure provides secure access to applications, network storage, telephony and internet. Local area network (LAN) infrastructure within the health plans provides workstation connectivity to local shared devices such as servers and printers, in addition to connectivity to the WAN.

Network-Based Intrusion Detection Technologies

The Enterprise Information Security infrastructure services security team uses two network-based intrusion detection technologies to identify the potential risk of security breaches:

- Intrusion Prevention System (IPS): Allows for "detect" and "deny" action
- Intrusion Detection System (IDS): Allows for a "detection" action

The IPS and IDS systems include real-time alerts and provide detection and prevention of known attack within the scope of network-based protocols.

Encryption and Data Protection

Our policy on encrypting nonpublic data in transit and at rest follows a risk-based approach. Encryption and key management vary by technology platform and application.

- **Encryption Algorithm:** Encryption varies by environment, but key systems use AES 256 encryption, which is FIPS 140-2 certified.
- **Full Desktop Encryption:** Generally, information classified as protected does not reside on a user's desktop or laptop, and customer data is stored on secure servers residing in our secure owned and managed data centers. Full-disk encryption is included as part of our workstation configuration.
- **Encryption of Backups:** In our infrastructure environments, our strategy is to encrypt data at rest without regard to its content or type at the storage media (device) level on both disk and tape.
- **Key Management:** Encryption key owners are responsible for the protection and management of public and private encryption. Key deployment and storage need to be processed in a secure method.
- **Antivirus and Malware Protection:** All our computing devices that access our information technology systems must have an actively running antivirus or Critical System Protection software.

g. Testing plan, which should be provided to the Division on an annual basis within 30 days of the request.

Our business continuity plans are tested annually by program staff using a variety of test techniques, including tabletop, structured walk-through, large- or full-scale and emergency response. We publish and monitor a formal exercise report, identifying any gaps, issues and enhancements through testing, for remediation. When the remediation plan is complete, the appropriate executive leadership certifies it. The Program Steering Committee monitors the certification, which occurs annually. We will provide our testing plan annually within 30 days of the request.

We operate a comprehensive data protection framework to protect customer and member data. This framework includes applied technology, security operations and services to reduce the risk of data breaches. Our disaster recovery plans are tested annually using a variety of techniques. In addition, we review all data security controls as part of our annual Sarbanes-Oxley (SOX) audits and subject to regular audits. Our business continuity, disaster recovery and emergency management standards are reviewed regularly to align with industry practices, including BS 65000 standard, NFPA 1600, ASIS security standard and ISO 22301. We review the program against each new standard and evolving professional practice. An independent third party evaluated our resiliency capabilities in 2020 as optimized and indicated we align with or exceed industry peers in 10 of the 10 assessed categories, indicating a high level of maturity.

[END OF RESPONSE]

4.2.2.7: Subcontractual Relationships and Delegation (Unmarked)

A. Services to be Subcontracted

1. Describe what services the Offeror will plan to subcontract if chosen as a Contractor.

2. Describe the Offeror's relationship to any potential subcontractors for each service the Offeror plans to ...

Services to be Subcontracted and Subcontractors to Fulfill the Roles

We will have access to an array of technologies, innovations and intellectual capital to enhance health care in Mississippi by creating a more efficient and effective health care delivery system, controlling costs across all modalities and reducing health disparities across all populations. We are committed to providing the highest quality of care, services and support to our MississippiCAN and CHIP membership. While we will deliver most of our services to our members and providers through our own employees and resources, we will subcontract certain services when the subcontractor has a particular expertise and experience in furnishing those services. Our organization will work alongside both owned affiliates and outside non-affiliates with whom we have built strong, well-established relationships; in short, we are offering a highly functional and well-established team. Our six affiliate and two non-affiliate subcontractors are well versed in our business practices, have established relationships with our leadership teams and will be fully integrated into our health plan operations. We will maintain complete accountability and oversight for each subcontractor's performance.

1. Behavioral Health Solutions

We have worked with this subcontractor for nine years.

This subcontractor has over 30 years of experience managing and administering mental health and substance use services. They hold URAC and NCQA accreditation, partnering with more than 140,000 clinicians and 5,000 care facilities nationwide, offering one of the nation's largest, specialized managed behavioral health networks. They serve 6 million Medicaid, uninsured and dual-eligible members in 28 states. They deliver services aligning with recovery principles and address precursors to health (e.g., housing, employment assistance programs) to help empower members with the knowledge needed to make informed decisions about their care or the care of family members. Services to be provided include behavioral health utilization management and case management; 24 hours a day, seven days a week call center for members and providers to address routine, urgent and emergent call needs; behavioral health network management and development; behavioral health provider relations; behavioral health claims administration; and quality management.

2. Dental Services

We have worked with this subcontractor for 12 years.

Our dental services subcontractor has over 35 years of experience serving all populations within the Medicare and Medicaid states, including children, adults, seniors and those with special needs and in long-term care. They provide dental coverage to over 24 million people nationwide through a network of more than 405,000 dentist access points and manage Medicare programs in 46 states and Medicaid plans in 16 states. Services to be provided include dental benefit administration and management services, to include third-party administration; provider network development and maintenance; provider credentialing; customer service; oral health education; oversight of claims adjudication and payment; utilization review and management; fraud, waste and abuse services; quality management; claims encounter and reporting services; and ongoing account management.

3. Non-Emergency Transportation Services

We have worked with this subcontractor for six years.

Our chosen subcontractor for non-emergency transportation (NET) for the MississippiCAN program and CHIP has provided services since 1995 and has grown to serve more than 100 contracts in 29 states, serving 10

million members annually. Services to be provided include NET services to and from Medicaid-covered medical services for both MississippiCAN and CHIP members.

4. Pharmacy Care Services

We have worked with this subcontractor for 12 years.

Our subcontractor has evolved from a traditional pharmacy benefit management model to a pharmacy care services organization. With 33 years of experience serving a broad spectrum of internal and external customers, including public and government entities, managed care organizations, Medicare and Medicaid plan sponsors, employer groups, and third-party administrators, they serve approximately 5 million members nationally through 60 Medicaid programs in 26 states. We recognize that the Division aims to use a single PBA to administer payment of pharmacy claims, medication prior authorizations and pharmacy network management for MississippiCAN and CHIP. Therefore, services for which we propose using this affiliated subcontractor include enhanced clinical pharmacy services, retrospective drug utilization reviews and medication adherence programs as allowed by the Division.

5. Radiology and Cardiology Management Services

We have worked with this subcontractor for 14 years.

Our radiology and cardiology management services subcontractor provides health care management services to more than 4.6 million managed Medicaid members from 20 different health plans. Services to be provided include management services for outpatient advanced radiology and cardiology benefits, targeting utilization and quality. Through the program, advanced radiology modalities include magnetic resonance imaging (MRI), magnetic resonance angiogram (MRA), computed tomography (CT) — including contrast and three-dimensional identity (3DI), positron emission topography (PET) and nuclear medicine. The cardiology modalities include echocardiogram, stress cardiogram, diagnostic catherization and electrophysiology implants.

6. Rehabilitation Therapy

We have worked with this subcontractor for nine years.

Our rehabilitation therapy subcontractor has supported the Medicaid state since 2005; they are serving approximately 7 million members nationally through 47 Medicaid programs in 25 states for network and utilization management programs. They contract with a national network of chiropractors, physical and occupational therapists and speech pathologists. Today, they manage nearly 43 million members across a wide spectrum of products and programs, including employer-sponsored, Medicare and Medicaid populations. Services to be provided are network access and utilization management activities for chiropractic care; physical, occupational and speech therapy; and complementary alternative medicine.

7. Subrogation, Payment Integrity and Fraud/Waste/Abuse

We have worked with this subcontractor for 10 years.

Our subcontractor is one of the largest health care information, technology, operational services and consulting companies in the world, serving four out of five hospitals in the United States and more than 100,000 physician practices and health care facilities, serving 31 state Medicaid and Health and Human Service agencies and over 300 health plans. They process over 1.5 billion claims annually with more than a 99% accuracy rate. Services are tailored to the state government payers, including data and analytics technology, claims management and payment accuracy services, and strategic consulting. Services to be provided include data analytics, technology and operational services, to include payment integrity services for data mining; recovery; fraud, waste and abuse; and coordination of benefits and subrogation.

8. Vision Services

We have worked with this subcontractor for five years.

Our vision services subcontractor specializes in vision care benefits administration for government-sponsored programs. With over 20 years of experience in the public sector, the company administers vision benefits for more than 8 million members nationwide, including 6 million Medicaid members. Population types cover Medicaid — including expansion membership, CHIP, dual eligible, D-SNP and TANF. Services to be provided are routine vision and eye care benefit administration services, to include provider network development, credentialing and education, provider customer service, eligibility and benefit maintenance, reporting (ad hoc, state-mandated and client specific) and claims processing.

B. Subcontractor Oversight

1. Describe the Offeror's Subcontractor oversight program. Specifically describe how the Offeror will:

a. Provide ongoing oversight of the Offeror's Subcontractors, including a summary of oversight activities, ...

Ongoing Oversight

Accountability and responsibility for full contract and program compliance is a core organizational belief, goal and imperative, and our subcontractors are an extension of this core belief. We designate account directors within our subcontractor partner organizations who will serve as our key points of contact for each contract, which will provide targeted responsibility and accountability with direct subcontractor access to key personnel. We will monitor and manage the ongoing performance of Mississippi subcontractors through the mechanisms described below. These mechanisms will facilitate our oversight of the subcontractors and allow us to evaluate performance, especially with respect to MississippiCAN and CHIP contractual requirements.

Sign-off Authority: Notifications of any changes to a subcontract that materially affect the subcontract will be approved by our chief executive officer and will be provided to the Division 30 calendar days before the execution of the change amendment.

Monitoring and Governance: Internal functional area leaders, quality and compliance committees and executive leadership, together with the subcontractors' staff performing the services, will regularly monitor subcontractors. This consistent governance oversight helps verify subcontractors are meeting performance metrics and their staff, policies and resources are appropriate to meet the requirements of their agreement. Results of these monitoring activities will be reported in the DVJOC, Service Quality Improvement Subcommittee (SQIS) and compliance committee meetings, which include our executive leadership.

Delegation and Vendor Joint Oversight Committee: The DVJOC will oversee the development and implementation of an effective and efficient delegate oversight program to meet and exceed our regulatory and contractual obligations. The DVJOC's focus will be on the qualifications and performance of delegated vendors to provide coordination of behavioral health, physical health, dental, vision and transportation benefits. In addition to reviewing the overall relationship between us and vendors at a local and national level, the responsibilities of the committee include the following:

- Review clinical, quality and operational performance metrics of delegated activities against plan-level targets as outlined by established service level agreements.
- Discuss any necessary or ongoing corrective action plans, remedial actions or areas for opportunity.
- Discuss any ongoing, open or significant issues related to member challenges or specific states and collaborate on opportunities for new strategic initiatives.

Dedicated Staff: We will designate accountable relationship owners from the MississippiCAN program and CHIP in the appropriate functional area to work with specific subcontractors. The local relationship owner works with regional and national relationship owners to perform this oversight.

Scorecards: We will use itemized scorecards during governance meetings to monitor vendor performance against contract requirements. Vendors and the Division are provided with scorecard results.

Statistics and Reports: Subcontractors will be required to report key performance indicators (KPIs) daily, weekly, monthly or quarterly as applicable. These reports allow us to monitor and evaluate subcontractors and indicate action steps for improvements well before a small problem has a chance to evolve into a large problem. Review of these statistics will occur in monthly DVJOC meetings.

Surveys: We will perform annual member and provider surveys to gain feedback on the service of subcontractors. Our member services center performs ad hoc surveys if a caller elects to participate in a survey after their call is completed.

Organizational Infrastructure Supporting Subcontractor Oversight

Our chief operating officer and delegated services manager will oversee our DVJOC and will be accountable for oversight of all subcontractor functions for MississippiCAN and CHIP. Our chief compliance officer will make sure we submit all subcontracts to the Division for approval. Our contracts will comply with Medicaid, state and federal regulations.

Our DVJOC will meet monthly to monitor performance metrics, quality and contract compliance of subcontractors. The DVJOC will report any identified delegated vendor issues to the delegated vendor manager and through our SQIS. Our vendor management team will work with the subcontractor through the resolution of any identified issues. In addition, our Healthcare Quality and Utilization Management (HQUM) Committee will monitor all clinical quality improvement and utilization management activities within our organization, and our SQIS will track metrics for compliance of subcontractors. This will include extensive review of our care management and disease management programs and review of utilization metrics from pharmacy, HEDIS indicators for behavioral health and grievances and appeals.

Types of Reports Required from Subcontractors

We will receive monthly utilization and encounter reports from our care management, disease management, dental, transportation and vision subcontractors. In addition, we will receive monthly reports regarding fraud, waste and abuse; subrogation; and third-party liability activities. All required records and timelines for delivery will be outlined in each service level agreement (SLA) with the subcontractor. Our delegated vendor manager will confirm all required data is received from our subcontractors as scheduled.

b. Ensure receipt and reconciliation of all required data including encounter data;

We have an established process to verify all required data, especially encounter data, is received from our subcontractors as scheduled. Our vendor management team will employ validation edits and use lag reports in this data collection and monitoring process. Once received, the team will evaluate third-party data for accuracy and completeness through a stringent verification process confirming files are not duplicates and primary dates-of-service or claims postdates fall within expected ranges. Additional validation edits will include original input filenames, expected received date, actual received date, insert date, batch load ID, number of claim header and detail records, number of claims accepted into encounter data management system and number of claims failing initial edits. Our team will obtain corrections from our subcontractors and confirm completion of reconciliation reports from our finance group and the subcontractor; they will participate in the subcontractors' defect management program. Through contractual agreements, we will require subcontractors to submit all encounters for services rendered to our members. All subcontractors will be required to submit zero pay claims, including COB claims or claims covered under capitation, which process through our claims system and are subject to the same edits and validations as fee-for-service claims. We will have several mechanisms in place to safeguard the submission of timely, accurate and complete subcontractor encounter data, including operating agreements, dedicated encounter staff, statistics and reports and audits. Our subcontractor agreements will obligate providers to submit timely and accurate claims. Payments will be contingent on the subcontractor meeting all contractual obligations, including the claims submission guidelines in our provider manual.

c. Ensure appropriate utilization of health care services;

To monitor appropriate utilization of health care services, we will conduct subcontractor oversight activities:

- **Monthly DVJOC Meetings:** We will require a monthly meeting to review compliance, performance measures, audit results, corrective action plans, improvement planning and reports, and early detection and resolution of operational or other potential issues.
- **Quarterly Review Meetings:** During the quarterly SQIS and HQUM Committee meetings, data will be reviewed, and suggestions made by the team to improve the utilization or to continue to monitor the trends.
- **Annual Subcontractor Review:** Annual audits of each subcontractor with staff who directly oversee vendor operational areas will occur to review all aspects of their performance over the year and to monitor the results of any corrective actions taken. These reviews comprise an examination of metric compliances and misses, complaints and grievances, and claims. We will conduct a formal annual review meeting with each subcontractor and the delegated services manager to review the results of the audit. The results of this review will be made available to the DVJOC, QSIS, QUM, executive leadership and to the Division.
- **Formal Contracting:** We will execute formal contracts with all our subcontractors, including those affiliates within our broader organization.
- **Regular Reporting:** We require at least monthly reporting on performance metrics.

d. Ensure delivery of administrative and health care services meets all standards required by this RFQ;

We will develop performance standards through SLAs and enforce those agreements up to and including subcontractor terminations. In accordance with the SLA, the DVJOC will monitor and manage subcontractor performance through the mechanisms described above. These mechanisms will facilitate subcontractor oversight and allow us to evaluate performance, especially with respect to contractual requirements. We will rely on the SLA, which incorporates a description of required functions and service levels, the process by which we assess performance, the recourse if service standards or expectations are not met (including revocation of delegation or imposing other sanctions if the subcontractor's performance is inadequate) and the authority of our executive team to drive change. This agreement will be put in place with the subcontractor and will comply with the Division's requirements. We will require all subcontractors to submit monthly or quarterly reports and statistics to demonstrate their compliance with the SLA and program effectiveness. Key performance indicators used to monitor our subcontractors will include provider service levels, call center statistics, claims timeliness, claims accuracy statistics and encounter submissions. Subcontractors will present these metrics at our local SQIS meetings and the DVJOC. The DVJOC can provide feedback, recommendations and escalate issues as needed to senior leadership. The DVJOC will help conduct an annual review of all subcontractors to verify subcontracted activities comply with the contract, RFQ, NCQA and federal regulations.

e. Ensure adherence to required Grievance policies and procedures;

We will confirm every subcontractor is compliant with the complaint and grievance requirements of this contract by clearly outlining our policies and procedures, which align with the contractual requirements, in each subcontractor's SLA. We will keep them up to date on any changes or revisions to the contract as they occur. As with all other aspects of the subcontractor's performance, we will monitor their performance in regard to complaints and grievances and take corrective action if required.

To confirm adherence with our grievance process, we have an enterprise-wide internal auditing team for member complaints and grievances. These auditors conduct a monthly sample of appeals, state fair hearings, claims disputes, scanning and data entry for internal staff and subcontractors alike. They use the information retrieved from these samples to confirm compliance with policies and procedures and supporting regulatory requirements. A formal process is then taken to identify, track, address and correct adherence issues through adjustment and satisfactory completion. The subcontractor audit findings help us identify trends and training needs, improve the consistency of the appeals and claims dispute processes and ensure subcontractor

compliance with policies and procedures. The results are reported to executive management and discussed in team meetings. Any continuous noncompliance issues related to grievance policies and procedures are addressed during our monthly DVJOC meetings, and corrective action plans are instituted to enable resolution and prevent further nonconformity.

f. Address deficiencies or contractual variances with the Offeror's Subcontractors, including an example of ...

All vendors will be required to be fully compliant with our performance standards for each data set reviewed and will agree to implement our required corrective action plan as we deem necessary. All exceptions must be approved by the DVJOC. Our vendor review process will verify appropriate oversight measures are taken; the results of this review process guide the DVJOC in their determination process, including whether to amend or terminate a vendor's agreement. If the DVJOC determines the reports or audit results demonstrate deficiencies, corrective action plans will be completed and tracked until the issues are resolved. However, as we remain accountable for all subcontracted functions, we retain the right to terminate any or all functions where our monitoring identifies significant deficiencies. If we identify a lapse in performance, our oversight will include placing the subcontractor on a corrective action plan, more frequent monitoring activities, up to and including termination. Our goal is to resolve any subcontractor issue internally well before it reaches the state level.

During our monthly DVJOC meetings with our dental team in a state similar to Mississippi, we discovered a trend in missed call center metrics. A new telephone system had been implemented through a third-party vendor, and the initial management tool was not sufficient to support the call center operations and meet required SLAs. We discussed the deficiency with local leadership, and remediation efforts were immediately identified, outlined and assigned. The call center was transitioned in-house, additional agents were hired and trained and call center reports were tracked by both vendor and our internal leadership daily to improve performance. Remediation efforts are ongoing, but call center metrics have improved drastically, and our heightened quality controls are functioning as they were designed.

g. Also include acknowledgement of the requirement to perform annual quality review of Subcontractors, ...

We acknowledge the requirement to perform annual quality review of subcontractors, which will be included 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 ...

Affiliated subcontractor costs will be charged to each regulated entity for services provided to our members. Affiliated business partners will evaluate their services and complete surveys annually to categorize the costs into expense categories. The allocation determinations made through this survey will be loaded into a service matrix, which houses all intersegment services and their expense category percentages. These expense categories will be reviewed and approved by internal management. Non-affiliated subcontractors will be evaluated on a case-by-case and service-by-service basis. A Medical Loss Ratio (MLR) Steering Committee will be established to evaluate arrangements monthly and decide whether certain services qualify based on 45 C.F.R. § 158.150 criteria. The MLR Steering Committee decisions will be documented and archived in MLR Decision Documents.

[END OF RESPONSE]

4.2.2.8 Financial and Data Reporting (Unmarked)

A. Financial Reporting

1. Describe the Offeror's approach for supplying data as determined by the state to satisfy the requirements ...

42 C.F.R. § 438.5 (c) requires states to provide all the validated encounter data and audited financial reports that demonstrate experience for the populations to be served by the managed care organization to the actuary developing the capitation rates for at least the three most recent and complete years before the rate period. We are equipped to supply the data to the Division of Medicaid to satisfy this requirement.

Encounter Data Validation

Achieving Operational Excellence

The foundation for supplying accurate encounter data is to have powerful and functional platforms to capture and process transactional data. We have systems in place to process member and provider data that becomes part of the encounter data, including member eligibility, provider information, claim and other demographic data elements. Processed data is stored in our data warehouse, from which we will pull our encounter data and supply to the Division. Our encounter submission is tracked within our internally and strategically developed encounter management system. It initiates submission, tracks response and provides error correction and resubmission of Medicaid encounters. The system is adaptable to meet the Division's encounter requirements as they evolve over time.

Our encounter validation processes help us achieve the highest possible acceptance rates. **Nationally, we have a greater than 98% overall initial acceptance rate.** Data that is rejected undergoes rigorous research and analysis with remediation, allowing the encounter to be accepted upon correction and resubmission. Our encounter, finance and actuarial teams remedy any errors and validate the completeness and accuracy of data provided. **Our final acceptance rates exceed 99% in every state with many states above 99.5%.**

Our data warehouse has the capability to store multiple years of detailed transactions to enable trend analysis and full drill down from aggregate data to detailed data, in cases where further research and investigation on any issue is deemed necessary, either internally or by the Division. We will confirm we are providing accurate data through our financial audit reporting and record maintenance policies, as described herein.

The investment we make in the processing and capturing of transactional data will allow us not only to supply the Division with accurate encounter data for capitation rate setting, but to perform data analytics in other areas, such as quality improvement, utilization trends and care management patterns to effectively help members achieve their best health outcomes.

Financial Audit Reporting

We will comply with the requirement to submit an annual audited financial report specifying our financial activities under the contract within six months following the end of each calendar year.

An independent Certified Public Accounting firm will prepare the report using Statutory Accounting Principles as designated by the National Association of Insurance Commissioners (NAIC). We agree to work with the Division regarding the format and contents of the audit.

Our accounting and finance teams will operate in accordance with generally accepted accounting principles and sound financial practices, demonstrating economic viability, regulatory compliance and prompt and accurate payments to providers. Our accounting system will verify costs applicable to the program are clearly identifiable, and records related to services and expenditures made under this contract will be maintained.

Maintaining Financial Records

We agree to maintain records that fully disclose the extent of services provided to individuals under the contract for seven years or for the duration of contested case proceedings, whichever is longer. We will follow strict financial and medical record procedures and require all contracted providers and subcontractors to maintain detailed and organized financial and medical records at all times. These procedures will support and permit effective and confidential patient care and quality review, administrative, civil and criminal investigations and prosecutions. Our financial and medical record keeping policies and practices are consistent with 42 C.F.R. 456 and NCQA standards and related state and federal laws for medical record documentation. We will have well-established internal policies and procedures to verify compliance with the medical record documentation standards articulated in this contract, Mississippi law and applicable federal laws and regulations.

2. Describe the Offeror's approach for the timely completion and reporting of the Medical Loss Ratio (MLR) ...

We will provide the medical loss ratio (MLR) report to the Division for each reporting quarter by the 60th calendar day following the end of the reporting quarter in the format and manner prescribed by the Division. We will provide the MLR report each reporting year by April 1 of the year following the end of a reporting year in the same manner. We will implement policies and procedures to validate the accuracy and timely filing of all MLR reports in compliance with the reporting requirements, which exist in all other Medicaid states. General ledger data will be obtained from the accounting system, and subcontractor data will be obtained directly from vendors or the vendor database. Information will be processed and reported on the MLR report in accordance with the reporting requirements specified by the Division. The report will be subsequently reviewed, analyzed and approved before its submission.

Computation of Medical Claims Cost

Medical claims costs and non-claims cost will be computed in accordance with 42 C.F.R. § 438.8 and 438.74.

Medical claims cost will include the following when applicable: 1) direct claims paid to or received by providers; 2) sub-capitated payments equal to third-party vendors' actual costs; 3) unpaid claims liabilities, reserves for contingent benefits and changes in other claims-related reserves; 4) withhold from payments made to network providers; 5) recoverable claims for anticipated coordination of benefits; 6) claims payments recoveries received due to subrogation; 7) changes in other claims-related reserves and reserves for contingent benefits and the medical claim portion of lawsuits; 8) the amount of incentive and bonus payments made or expected to be made to network providers; 9) the amount of claims payments recovered through fraud reduction efforts, not to exceed the amount of fraud reduction expenses; and 10) any additional items provided in MLR requirements.

Amounts deducted from the medical claims cost will include the following when applicable: 1) overpayment recoveries received from network providers and 2) prescription drug rebates received and accrued.

Medical claims cost will exclude the following when applicable: 1) non-claims costs; 2) amounts paid to the Division as remittance under 42 C.F.R. §438.8(j); and 3) amounts paid to network providers under 42 C.F.R. §438.6(d).

Computation of Non-Claims Cost

Non-claims costs will include the following when applicable: 1) expenses for administrative services that are not incurred claims, expenditures for activities that improve health care quality or licensing and regulatory fees or federal and state taxes; 2) expenses for administrative services that do not constitute adjustments to capitation payments for clinical services to members or expenditures on quality improvement activities; and 3) the following expenses for administrative services: a) cost-containment expenses not included as an expenditure related to a qualifying quality activity; b) loss adjustment expenses not classified as a cost containment expense;

c) workforce salaries and benefits; d) general and administrative expenses; e) community benefit expenditures; and f) any additional items provided in MLR requirements.

B. Data Reporting

1. Encounter Data

a. Describe the Offeror's approach for collecting, validating, and submitting complete and accurate encounter ...

Data is the foundation for evaluating our performance, quality improvement activity, utilization patterns and access to care and determining future premium payments. Accurate, timely and complete encounter data submissions will be evidence we are fulfilling our responsibilities to the Division. We will subject new claims to a series of reviews to confirm we have data needed to process the claim and produce accurate encounters. Our approach will use innovative technology at each stage of the claim adjudication process. We will use a combination of promoting electronic data interchange (EDI) claim submission, our proactive edit tool, early detection tools and provider outreach programs to make sure we overcome obstacles associated with claim processing delays and errors to pay claims accurately and on time. We will have an organized encounter data collection, processing and reporting system in place, including elements noted in the Division's Model Contract and provisions applying to contracted providers and subcontractors.

Our encounter data submission and reporting system will enable us to analyze medical, behavioral health and capitated and subcontractor encounters, member and provider data to identify deficiencies in the quality and completeness of subcontracted provider data. We will perform scheduled reviews of claims for accuracy of transaction processing.

Collecting Encounter Data

We will retain all required data elements in claim history for use in creating the encounter submissions. Our encounter system will extract adjudicated claims data from the claim adjudication system using the claims extract program, which sweeps the claims database and collects all adjudicated claims date-stamped since the last encounter extraction. This process will verify claims previously extracted are not loaded again, preventing duplicates within the system. Claims from our subcontracted providers will feed directly into our encounter system. Capitated providers will be required to submit zero pay claims, which will process through our claim system and be subject to the same edits and validations as fee-for-service claims.

Validating Encounter Data for Timeliness, Accuracy and Completeness

Our encounter management system will perform automated edits and HIPAA validations on claims to confirm the accuracy and completeness of encounter data. Our system will apply data validations to confirm HIPAA 837 or National Council for Prescription Drug Programs (NCPDP) required fields are present in the correct format and meet the Division's encounter submission requirements. We will comply with CMS and HIPAA standards for electronic submission, security and privacy, and we will verify our subcontractors adhere to these HIPAA standards. Claims that do not pass the edits and validations will receive an error, and the encounter management team will send them for research. The team will collaborate with functional operating teams or subcontracted providers to resolve and submit the pended encounters.

Submission

Compliant HIPAA-formatted encounter files will be submitted to the information system intermediary weekly at a claim and line level per the Division's requirements. All claims will be included in our encounter file submissions. An alert will be sent to information technology to research the issue if files fail during generation. Information technology will then resolve the issue, restart the generation process and notify the encounter management team when files have been submitted to the Division. Our encounter management team, which will be comprised of a director of operations, an associate director of operations and a business analyst who works

and resides in Mississippi, will continuously monitor encounter requirements and seek opportunities to improve encounter data quality.

Monitoring Completeness

We will compare the dollars loaded and submitted from our encounter management system to our financial reports each month to verify completeness and accuracy within our encounter program. The encounter management team will use a variety of reports to monitor timeliness, accuracy and completeness, including:

- Submission Statistics Report: We generate this report after we receive responses for submissions indicating the number of claims submitted and number accepted. This allows us to track 100% of our unresolved encounter submissions.
- Encounter Error Trending: We analyze error trends to identify incomplete or inaccurate data.
- Contractual Requirement Report: This report allows us to internally monitor interim and final compliance with each weekly and monthly metric.
- Financial Reconciliation Reporting: The encounter management team validates the financial fields of a claim (e.g., health plan paid) and reconciles with the fields of encounters.

Managing Non-Submission of Encounter Data by a Provider or Subcontractor

We will require providers to submit encounters for services rendered to our members. Providers must submit zero pay claims, including coordination of benefits (COB) claims or claims covered under capitation, which process through our claims system and are subject to the same edits and validations as fee-for-service claims.

The encounter management team will verify we are receiving claim data from our subcontractors using monthly validation edits and lag reports to monitor encounter data from providers and subcontractors. The verification process will confirm the file is not a duplicate and primary service dates or claim postdates fall within expected ranges. We will validate original input filename, expected received date, actual received date, insert date, batch load ID, number of claim header and detail records, number of claims accepted into the encounter claims processing system and number of claims failing initial edits. We will monitor rejection volumes to identify providers who need additional education by our provider relations advocate team or claims coding staff.

Corrective Actions or Assessments

Our team will quickly reach out to providers to identify root causes when trends emerge, work to remediate the problem and track progress through resolution. Remediation may involve providing education to providers, implementing a corrective action plan or re-contracting to a fee-for-service method. The final step is termination if there is no resolution.

Subcontractor Oversight

We will require subcontracted providers to submit their encounter data directly to us, and in turn, we will integrate the data into our encounter system for data validation, encounter submission file creation and response reconciliation. We will monitor external subcontractor and affiliate subcontractor partner provider encounter data performance using the same reporting as all other encounters. We will share any encounter rejects related to eligibility, provider demographics or claim payment policy with the subcontractor to identify short- and long-term solutions to correct errors and prevent future encounter rejects. The encounter management team will have ongoing working communications with the subcontracted providers to confirm issues are resolved timely. All subcontracted providers must be fully compliant with our performance standards for each of the data sets reviewed or partially compliant with such standards and agree to implement our required corrective action plan.

Other Key Components of Encounter Completeness Plan

Our completeness plan comprises the sections mentioned above and the error correction and continuous improvement initiatives described herein.

Error Correction

The encounter management team will continuously review encounter reject reports in which like rejects are stratified by claim type, service type and provider to identify trends to resolve each reject promptly and to prevent future rejects. Research to arrive at resolution and prevention plans will include reviewing claim images, provider billing requirements and any other available encounter requirement documentation. We will have several successful methods of resolution and prevention, depending on the size and scope of the issue and provider, including offering targeted provider education and implementing claim edits.

Continuous Improvement

We will continuously review encounter requirements and processes for opportunities to improve encounter quality. We will review pended and denied encounter reports for the top issues experienced and perform internal root cause analyses. We will develop mitigation plans for the short term to correct identified issues before the next submission. We will identify and develop edits for the long term to improve future results. We will monitor encounter rejections to identify providers who need additional claim billing education.

2. Health Information System Data

Our comprehensive, integrated reporting and data analytics solution will enable us to maximize plan effectiveness, meet the Division's reporting requirements, empower providers and provide care for our members. It integrates medical, behavioral, pharmacy, financial, demographic and socioeconomic data to produce the reporting and analytics needed to conform to the state's requirements.

Our existing management information system (MIS) serves Medicaid plans and supports millions of members across the United States. Our system is fully compliant with all applicable federal and state regulations. Our reporting and data analytics solution integrates claims data, member data, provider data, authorizations, external subcontractor data, predictive modeling information and HEDIS® gaps in care results for our members. Our suite of systems is employed across our Medicaid plans and supports critical program functions, including member and provider management, plan and reference data management, care coordination and utilization management (UM), claims and encounter processing, third-party liability (TPL), financial management, program integrity management, quality improvement, analytics and reporting and data exchanges internal and external.

Our integrated reporting and data analytics solution will enable us to maximize plan effectiveness, meet the Division's reporting requirements, empower providers and care for our members. It will integrate medical, behavioral, pharmacy, financial, demographic and socioeconomic data to produce the reporting and analytics needed to conform to the Division's requirements, including predictive analytics; provider information support; fraud, waste and abuse; and the management of utilization and medical outcomes.

a. Describe the Contractor's approach to maintaining a health information system that collects, analyzes, ...

i. Utilization,

Data analysis will drive our UM program by identifying areas for improvement and priorities, such as a reduction of admissions, inpatient bed days, readmissions and nonurgent ER visits. We will continuously monitor and manage overutilization and underutilization of services using reporting, dashboards and scorecards developed from data gathered and analyzed by our data warehouse tools.

Collects

The UM system's consolidated, scalable workflow management tool will manage program queue prioritization, assignment, enrollments, alerts, activity tracking and referrals. We will collect member clinical and health information and load it into our UM system where will be shared with the larger care coordination community. Our UM system will provide an integrated, single solution for managing service authorizations. Prior authorization management is a core component of our UM system, and we will equip providers with the ability to submit prior authorization requests for new or continuing medical or behavioral health services via several methods, including telephone or through our secure provider portal. Our data warehouse links with our utilization system, allowing for greater data use and capability.

Analyzes

Our UM system will provide a wealth of data that will be analyzed to support medical and behavioral management for our members and for utilization trending for risk stratification. The data collected will be used by our population health, quality and care coordination teams to identify gaps in care, identify under- and overutilization of services, identify targeted interventions of specific populations and articulate utilization patterns of services and provider types.

Integrates

Our utilization data will be shared across UM, care management and quality management systems. This will help us easily communicate gaps and act in a streamlined way. Utilization management will be integrated with the data warehouse, clinical and quality platforms and care management platforms. Our comprehensive clinical platform will synchronize multiple health care management data points and deliver personalized health management solutions. It will encompass processes to identify and segment populations; execute clinically comprehensive, highly personalized health management programs; engage and activate members and providers; and monitor and measure outcomes. It will work in conjunction with our other clinical care management programs to offer a total population solution to health management. We will execute on the concerted delivery of care management through this platform by synchronizing vast and complex data streams with evidence-based medicine rules and value-based opportunities.

Coordination with Care Management

Our UM program will serve as a gateway to care management, disease management and health promotion activities. It will work hand in hand with our care management program to identify members who have needs by**:**

Advancing Population Health Outcomes

- Supporting our evidence-based identification and stratification process identifying members' social, behavioral, medical and functional circumstances and needs, their level of health risk and the focus (e.g., social, behavioral) of their needs
- Providing our care teams and providers with tools, reporting and predictive modeling gives them the ability to monitor members for indications their health status, needs or circumstances have changed
- Determining the medical necessity and appropriateness of care to avoid inappropriate use or duplication of services and make certain members receive the appropriate services and supports to close care gaps

Validates

We will gather quality measures, prior authorizations, clinical and claims data and data from providers or subcontractors through our UM program. The data warehouse will link with and receive data from our clinical management system, the UM application, which will provide an integrated, single solution for managing service authorizations for physical and basic behavioral health services. Our monthly dashboard will provide an in-depth analysis on all aspects of service utilization. We will continuously monitor local and national performance

through these reporting features and develop strategic initiatives to combat aberrant trends. Our leadership will evaluate and adjust the UM program to promote efficacy and impact.

Our department managers and directors will regularly review and analyze reporting, dashboards and scorecards to verify we provide appropriate care and services to our members in a cost-effective and cost-efficient manner.

Reports

Our monthly dashboard will provide an in-depth analysis on aspects of service utilization. Reporting capabilities will include:

- **Monitoring unnecessary emergency room utilization through advanced data analytics and reporting.** Our health care economics team will integrate and analyze medical, behavioral and pharmacy claims, social determinants data and lab test results. They will use data analytics and reporting tools to produce a suite of reports, dashboards and scorecards, helping our clinical leadership team monitor utilization.
- **Emergency room escalation report** will identify hospitals with the propensity to admit members from their ER to observation or inpatient level of care compared to peer hospitals across Mississippi.
- **Our utilization management tracking report** will help our leadership team perform quarterly trend reviews identifying outliers, trends and changes by broad category of service to determine areas of concern.
- **Provider peer comparison reports.** We will share with providers their utilization rates on select measures annually and how they compare with their peers through provider peer comparison reports.
- **Inpatient utilization (medical management) reporting.** These reports will provide a snapshot of monthly inpatient authorizations; a breakdown of inpatient authorizations based on member age groups; inpatient authorization data by programs; grouping of inpatient authorizations based on total length of stay; inpatient days and admits by facility and month; and the top 20 diagnosis codes for inpatient authorizations.
- **Inpatient utilization dashboard.** Will present days and admits per 1,000 and average length of stay based on inpatient authorizations from our UM system. It will include views by health plan, case type, length-of-stay groups, member age bands, facility and top 20 diagnoses.

Dashboards and Scorecards

In addition to standard reports, users can use predesigned templates and drill down features to analyze high-level trends pinpointing potential root causes. This will help our management understand business performance and develop effective action plans addressing changing business needs. Our team will produce several standard scorecards and dashboards using analytics tools such as:

Our health care economics team gathers quality data, prior authorizations, clinical and claims data and data from providers or subcontractors and continually reviews and analyzes this data so we can detect and correct utilization variances against targets and national standards, such as HEDIS.

- **Variant Day Analysis Hospital Benchmarking.** Supplies weekly, monthly and quarterly data that compares inpatient admissions, length of stay, admission and readmission diagnoses and ER utilization to professionally recognized standards of care and performance metrics
- **Utilization Management Scorecard.** Compares prior year data against current year goals for UM metrics, admits, days and average length of stay based on inpatient authorizations from our UM system
- **Medical Experience Tracking Report.** Helps us perform quarterly trend reviews that identify and quantify areas of concern within our health plan operations, and identifies outliers, trends and changes by broad category of service to determine areas of concern

ii. Claims, Grievances and Appeals,

Claims

We recognize and accept the significant accountability to confirm claims are paid timely and accurately and support providers in delivering quality care to our members. We will use a variety of tools to manage the timeliness and accuracy of our claims payments and reduce provider administrative burden.

Collects

We will require providers to submit claims on the appropriate claim form. We will capture claim received date through our claim processing system and assign a unique claim number for all incoming claims. Many data edits will be applied to incoming claims to validate the data is compliant, complete, accurate and appropriate under the terms of the contract. Claims with invalid data points will be rejected or denied as appropriate, and those with valid data will be adjudicated. We will extract encounter data from our claims platform and load the data into our encounter system database. We will require claims files from all of our external vendors so we can submit encounter data to the Division for all covered services.

Analyzes

Our local claims department will retrieve claims detail and performance indicators, such as timely payment, denial rate and auto-adjudication rates, from our analytic reporting tool as part of the monthly process, enabling us to audit and improve quality processes to promote accurate and timely claims processing. Daily monitoring of claims process efficiency will confirm performance to requirements and provide opportunities to improve automation. We will compile the results monthly and compare against contractual performance requirements. Our national team will review the results with local health plan leaders once the information is compiled to compare baseline performance to current results, identify trends and detect improvement opportunities.

Integrates

Our encounters team will use our integrated systems to process and translate provider-submitted claims into standardized encounter files. The team will use network database data from our system to process encounter data submissions. Our managed care information system applications will work in concert with our claims system to provide care coordination, encounter data submission capabilities, online provider and member support solutions and reporting and analytics capabilities. Our reporting and data analytics solution will be integrated with our systems, allowing our reporting team to develop and produce analytical and client reports based on data processed by our clinical, claims, encounters and care management teams.

Validates

Our claims audit process will include pre-adjudication, pre-payment review and post-payment review, all of which incorporate root cause analyses and rapid deployment of solutions to improve accuracy and avoid service dissatisfaction among providers. We will document audit review outcomes and evaluate them for trending, reporting and continuous improvement and maintain them according to our provider requirements.

We will employ mechanisms like machine learning in our payment integrity activities to promote cost avoidance and cost prevention. Our claims teams consistently meet or exceed federal and state prompt payment requirements using our advanced infrastructure for claims adjudication while maintaining the highest levels of accuracy and quality in claims processing.

Reports

Our suite of claims reporting will include the following comprehensive reports:

- **Claims Trend Report:** Reports claim cost and utilization per month and quarter by category of service

- **Claims Processing Turnaround Time Report:** A month-to-date report updated daily, reflecting the turnaround time results for claims processing
- **Monthly Claims Status Report:** Reflects a six-month view of month-end claims inventory, monthly productivity results and average claims turnaround time and payments
- **Claim Payment Timeliness Report:** Reflects the month-end claim inventory and timeliness results
- **Claims Payment:** Count of Finalized Claims, Daily Pend Report, Pend Claims By Provider Detail, Coordination of Benefits Monthly Summary, Health Plans High Dollar Claims, Claims Aging Days Out, Service Date Quarterly Stats, Top Diagnosis, Year Over Year Trend, Claims Detail Reports, Multiple Claims Summary Reports, Multiple Pended Claims, Multiple Daily Claims Audit, Multiple Duplicate Claims Audit, Claim Payment Turnaround Time, Aging of Unpaid Claims, Claims Processor Activity and Pended Claims Report

Grievances and Appeals

We strive to avoid grievances and appeals by delivering high-quality, responsive and culturally competent services and communications to our members. We have significant experience processing member grievance, appeal and state fair hearing programs that verify the appropriate and timely processing and resolution requirements when a member does not agree with our decision.

Collects

Our staff will maintain, record and store grievances and appeals activity using our grievances and appeals database, including policy-mandated time frames for member contact and grievance or appeal resolution, which will allow us to perform tracking and trending activities.

Analyzes

Our system's security protocols will allow staff and managers at various levels and departments to have read, write or update permissions to individual data elements and modules. Our system will allow our grievances and appeals staff to create a case file to track the disposition of the grievance or appeal from receipt to resolution.

In addition, our grievances and appeals staff will use our tracking system to assist with generating member and provider communications; identify open, outstanding or urgent grievances and appeals requiring resolution and to query and review a specific member's grievance and appeal history; track staff compliance with resolution time frames; provide grievances and appeals data to our quality management department to assess member satisfaction; identify opportunities for improving the member experience and identify and resolve any potential quality-of-care issues; and develop customized reporting and inquiry capabilities on multiple data elements.

Integrates

We view grievances and appeals as an opportunity to understand trends, allowing us to make continual improvements to the way we provide care and services. Our grievances and appeals governance team will collaborate with other internal departments, such as compliance and QM, to monitor the reasons members are filing grievances or appeals and our handling and resolution of grievances and appeals.

Validates

Tracking cases confirms adherence to communication time frames, providing a better member experience in the processing and conclusion of their issues, assuring the member we are addressing their concerns quickly. Retaining records of cases and activities provides the opportunity to create reports that may identify discrepancies in systems or procedures that, when remediated, improves the member's experience or eliminates the issue altogether. Our staff will maintain, record and store grievances and appeals activity using our grievances and appeals tracking system.

Reports

We will provide records of grievances and appeals upon request by the Division. We will provide standard management reports to track our resolution time frames and provide ad hoc query functionality. Our system will provide us significant flexibility to add or remove data fields, as specified by the Division, and to provide reporting capabilities based on multiple data elements, filters or sorting options. We outline the key tracking, trending and reporting data elements in the table herein:

Key data elements maintained by our grievances and appeals tracking system	
Member Grievances	**Member Appeals**
▪ Date grievance was received ▪ Member identification information ▪ Individual recording the grievance ▪ Nature of the grievance ▪ Disposition of the grievance ▪ Corrective action required ▪ Priority status (expedited status) ▪ Staff assigned for disposition ▪ Date of resolution ▪ Date of member notification of disposition	▪ Effective date of the action ▪ Date the member or representative requested the appeal ▪ Identification of the individual filing ▪ Member identification information ▪ Date an appeal filed orally was followed up in writing ▪ Nature of the appeal ▪ Disposition of the appeal ▪ Priority status (expedited status) ▪ Staff assigned for disposition ▪ Date of member notification of disposition

iii. Disenrollment (for other than loss of Medicaid eligibility),

Collects

It is rare we receive notification from a member or a parent or guardian, outside the annual open enrollment period, of their intent to disenroll from the health plan. If we receive a request, we will work in collaboration with the member, parent or guardian and seek interventions to resolve the issues that are influencing the disenrollment request. If a member or a parent or guardian contacts us to request disenrollment, we will work to resolve the issue through appropriate and individualized interactions as described below:

Request Received via Member Services Center	▪ Service navigators "own" the issue from initial point of contact to resolution. They will diligently work to identify any barriers to continual enrollment and resolve the issue. ▪ We will use Division-approved prepared questions when assisting members to determine whether a specific issue is driving their desire to disenroll. We will ask if the available option changes the desire to disenroll when we have an option or remedy available. ▪ The service navigator can provide a thorough solution to the matter, regardless of complexity, using specialized assistance from a team of experts, including clinical and behavioral health staff, pharmacy and others. ▪ Our efforts will focus on educating a member or a parent or guardian on the plan benefits and continuity of care. Simultaneously, the service navigator can respond to the individual needs of the member or family, and we will encourage them to remain as a MississippiCAN or CHIP member.
Request Received via Care Manager	▪ The care manager will work with the family for at-risk members assigned to a care manager to resolve issues prompting them to contemplate disenrollment. We will confirm continuity of care for all our members, in particular those members in our care management program, and work with the care team to overcome any barriers and resolve the issue.
Request Received via Community Health Worker	▪ Community health workers (CHWs) will intervene and provide successful resolutions to discourage disenrollment. Our CHWs will personally connect with members and their parents or guardians, providing the education and resources they need to access timely and appropriate care. Through personal interactions, they will be able to understand issues members may be facing and identify solutions to overcome the problem.

	▪ If needed, the CHW may engage additional care management resources to further assist with clinical needs.
Request Received via the Division	▪ If a member's family requests disenrollment for cause (e.g., not all related services are available within our network), a service navigator will contact them to identify any barriers and resolve the issue. ▪ If we are unable to address the member's needs satisfactorily and the family still wishes to disenroll, we will acknowledge the request and assist the member and their family with filing the request in writing to the Division.

Analyzes

We will take immediate steps to understand why the intervention to prevent disenrollment has concluded and a member or their family continues to seek to disenroll from the plan voluntarily. Our member engagement specialists will conduct a state-approved disenrollment survey within five business days of the member's disenrollment.

Disenrollment Survey Results
Less than 12% of disenrolling members reported dissatisfaction with our health care services in a state similar to Mississippi in 2021.

The survey will specifically ask the member or parent or guardian to share with us length of membership, how often they accessed medical care, how satisfied they were with the service they received, their primary reason for disenrolling from the plan and their experience compared with similar services from other medical payers.

Integrates

Geographical trend charts identifying where disenrollments are occurring will be developed from the survey results quarterly. These results will guide strategies identified by two strategic teams, a member retention team and a CAHPS task force team. These teams will use the results from the survey to improve MississippiCAN and CHIP member experience.

Member Retention Team: The member retention team, comprising community outreach staff, will use disenrollment survey results, among other data sources, to develop a strategic work plan about issues affecting member retention.

CAHPS Task Force: The CAHPS task force will review the disenrollment survey results and recommend interventions for implementation and program improvement as needed. Our task force will use trend data to provide targeted outreach and education efforts about the top disenrollment drivers, review survey results to identify and correct member issues and serve as a problem-solving entity for effective operations.

Results Driven by Member Feedback Tools

We will put these results into action as we continue to learn from our national Medicaid, Medicare and CHIP membership through tools such as the disenrollment survey. Examples of initiatives sparked by member feedback include increased promotion of our nurse line so members are more aware of the availability of these services; expanded efforts through our "closed loop" initiative by deploying care managers to contact members who are having difficulty accessing services and identifying regions with elevated disenrollment requests; and enhanced local community outreach about benefits and available services.

Validates

We will use Division-approved prepared questions when assisting members to determine whether a specific issue is driving their desire to disenroll. We will ask if the available option changes the desire to disenroll when we have an option or remedy available. The service navigator can provide a thorough solution to the matter using specialized assistance from a team of experts, including clinical and behavioral health staff, pharmacy and others, regardless of complexity.

Reports

We will collect, compile and deliver disenrollment survey results to the Division quarterly.

iv. Member Characteristics,

We will receive member characteristics through our enrollment and eligibility processes. This information will be stored in our system and is used across the enterprise, as described herein.

Collects

We will process electronic data transmissions received from the Division daily, weekly or monthly, including any additions, deletions and modifications to the program's enrollment. We rely on our secure file exchange gateway for data file exchanges. The gateway will provide a mechanism for internal entities and external business customers to exchange data files, such as 834 (enrollment and eligibility) and 837 (encounters) via scheduled integration with job automation and control services, including transmission validation.

Analyzes

We will use our community transaction system to process enrollment automatically. It will enable off-cycle enrollment and error correction. We will process the enrollment data to add, delete or modify membership records with accurate begin and end dates. Our system will maintain a history of changes, adjustments and audit trails for current and retroactive data. It will use logging, journaling and audit tables to maintain a record of changes to transactions and data within each application. Our platforms actively store seven years of historical information, including membership, eligibility and claims data. Our COB extension will allow us to store members' additional insurance information, which we will integrate into the claims processing application to provide proper claims adjudication.

Integrates

We will implement critical interfaces to exchange enrollment and eligibility information appropriately and securely, including:

- Accepting Division eligibility files in HIPAA-compliant formats.
- Providing membership information to our internal systems, such as our clinical management system.
- Providing data to our analytic reporting tool for reporting and performing data analytics.
- Securely submitting new member data to the ID card and member welcome packet fulfillment center.
- Confirming membership information is available to our member portal following receipt of the enrollment file.
- Confirming membership information is available on the secure provider portal.
- Providing membership information to applicable partners following receipt of the 834 enrollment file.

Validates

Our community transaction system will programmatically load and reconcile member enrollment files and reports on discrepancies. In addition, our system will provide automatic error alerting triggering error correction processes and procedures for manual correction by our eligibility team. Our eligibility team will examine the load reports and address issues from the member roster load to verify there are no remaining discrepancies or errors upon receipt of the daily, weekly and monthly enrollment file from the Division.

Reports

To maintain data integrity, we will:

- Compare the membership files received against our community transaction system, membership records monthly and look for changes in name, gender, group number, phone number, address, birth date, effective date and Social Security number.
- Generate a batch input file for electronic update into our system.
- Produce an exception report identifying member information not meeting electronic update criteria.
- Review exception reports daily and make corrections, as needed.

v. Provider Characteristics,

We will manage our provider information to allow for system maintenance supporting our regulatory reporting requirements, care management navigators, downstream users such as call centers, provider engagement and accurate claims adjudication.

Collects

Provider Enrollment, Credentialing and Network Management

Before the provider contract effective date, participating providers will undergo a careful review of their qualifications, including education, training, board certification status, license status, hospital privileges and malpractice sanction history. Once a provider's credentials receive primary source verification, we will further verify the provider's data by comparing it with the state's provider database.

Quality Management

We will collect provider-level data using the following methods:

- **Provider-specific Data Sharing Arrangements.** We will implement one of our most successful strategies for collecting provider data using provider-specific data sharing agreements. This will include structured data, electronic medical record data, flat files, Consolidated-Clinical Document Architecture and bidirectional data exchange.
- **Provider Medical Record Audits.** Our field-based registered nurse consultants will support PCP offices to audit and gather data from providers' electronic and paper medical records. These audits may occur via remote access to providers' electronic medical record systems through data sharing arrangements.

Analyzes

We will continuously monitor key metrics and trends across various dimensions through monthly performance reviews. We will use standard reports, in addition to root cause analyses, if a trend varies from the norm or expectation to identify the cause of such variations. We will review facilities, physicians (PCPs versus specialists), ancillaries (e.g., durable medical equipment, lab and surgical) and pharmacies; drill into key types of services as appropriate (e.g., inpatient – medical or surgical, outpatient – ER, radiology and therapies); analyze key trends by provider within these categories and identify outliers for potential opportunities; and apply best practices or remediate key providers.

A discovery and design session will occur between the local reporting team and subject matter expert report owner upon receipt of a regulatory report request to consider a technical assistance call with the Division. Our local and national reporting teams will work together to construct and test reports for review by the functional operation leader and report owner to assess for completeness and accuracy.

Our Mississippi network and operations teams will perform quarterly comprehensive network analysis validating we maintain compliance with network access standards, including:

- Monitoring the linguistic competencies of provider offices compared with languages spoken by members

- Evaluating data on practitioners and provider denials
- Analyzing HEDIS provider data
- Analyzing, identifying opportunities and recommending interventions to address provider satisfaction
- Recommending topics for provider communications
- Profiling network providers and benchmarking them across the health plan to identify utilization outliers.

Integrates

Our network development plan is an all-inclusive strategy whereby we will continue to offer participation in our network to providers whom we identify as providing high-quality care in a cost-efficient manner throughout Mississippi. We will use a multipronged, innovative approach, in addition to the traditional measurement of our networks, by bringing in feedback from our stakeholders and providers. We will collaborate with teams across the health plan and in the community. We will engage in the following activities to measure and regularly verify, in real time, our networks are meeting our members' needs:

- **Community Engagement.** We will partner with local groups to help us identify community-specific network gaps and give us the perspective of local providers on changes and updates to the operations of our networks.
- **Input from Frontline Staff.** Our best sources of information related to the network will be from our locally based frontline staff, provider advocates and service navigators. We will implement online tracking tools for frontline staff to log network opportunities quickly and efficiently. We will receive real-time information about member access needs and address these needs quickly with our locally based frontline staff.
- **Member Advisory Group.** Our Member Advisory Group will be comprised of members, their advocates and critical community-based organizations representing our members and providers. Our quarterly Member Advisory Group meetings will offer members the opportunity to discuss trends in their communities, network issues, cultural needs and potential barriers to care related to language, health care and policies. Information gathered will be shared with the network teams to resolve gaps and inform network growth and expansion. The teams will review issues and questions, conduct outreach to resolve the issue and then add it to the agenda for the next Member Advisory Group meeting.

Validates

We will audit all new contract data ensuring provider contracts are set to pay according to the benefit design, eligibility and reimbursement policies. The provider file will be submitted to the credentialing committee for further review if there are sanctions or issues with licensure. We will only award contracts to providers after we verify they meet the applicable credentialing and licensure requirements.

Reports

We will synthesize the data we collect through the methods described to produce flexible, provider-specific reporting. Our suite of provider performance reports will include:

- **Provider Incentive Reports.** We will distribute reports throughout the year for providers participating in our provider incentive program, including provider progress against measures covered under the program and identifying care opportunities needed to achieve established quality goals.
- **Provider Profiles.** We will produce quarterly provider profiles used to compare provider performance against national and local state weighted averages and benchmarks.
- **Provider Scorecards.** We will use monthly provider scorecards demonstrating providers' performance year over year and compare it against national and targeted benchmarks. We will tailor the measures included in

the scorecard to each provider type and the measures most important to the specific provider and the Division's priorities.

- **Peer Comparison Reports.** This report will provide physicians with workable information to deliver better care, better health outcomes and better fiscal outcomes by analyzing claims data to identify variation from peer benchmarks and alerting providers whose data varies from expected practice patterns.

vi. Care Management Utilization,

We have a multifaceted approach comprising an oversight structure, policies, processes and data analysis tools to evaluate member and provider utilization patterns so we can improve our health plan operations. Our clinical leadership team will iteratively monitor and analyze key metrics identifying utilization trends and the effectiveness of provider practices, hospitals and clinical programs. We will continuously verify our clinical programs are making a positive influence in terms of quality of care, member experience, member outcomes, member quality of life and the cost of care through this analysis.

Collects

Core to our approach to identifying members' social, behavioral, medical and functional needs and their care management services tier is having the right data inputs, innovative tools to synthesize and interpret data and the clinical expertise and local relationships to provide a 360-degree view of each member's circumstances. Our tools will identify key drivers common to our members who require clinical intervention, such as special health care needs, high-risk pregnancy, unmanaged complex medical or behavioral conditions or acute social determinants, such as homelessness.

Our identification process will integrate findings from the initial health risk screening (HRS) and comprehensive health assessment (CHA) and the results of our monthly predictive modeling analyses and our hotspotting tool to understand each member's social, behavioral and medical needs, circumstances and level of health risk.

Analyzes

Our team will routinely review aggregate data at the population level by disease condition and by risk level and at the member, provider and facility level to identify opportunities for improvement in the quality of care, member experience, member outcomes, quality of life and cost of care rendered to members. This will allow our leadership team to develop more meaningful action plans by reviewing overarching trends and breaking them down into the underlying driving forces.

We will develop corrective action plans if our analysis identifies a systemic problem, such as education for care managers to use during member interactions or provider outreach through field-based registered nurse consultants. We will use the information we collect to stratify our members based on risk and provide interventions to encourage their participation in our care management programs.

Integrates

Our clinical and operations teams will use our managed care information system applications to access and update data to perform a variety of functions. These functions include enrollment and eligibility processing, care management, provider network management, encounter data reporting, claims processing, member services, reporting to our health plan and national teams and data analytics to monitor key metrics and trends across various dimensions through regular performance reviews. Our clinical team will perform care management using our integrated user experience platform, member data and provider data. Our acute care managers will have access to view pertinent member utilization data.

Validates

Our integrated clinical leadership team will be comprised of our care management, quality management and UM leadership teams. The clinical leadership team will provide oversight of functions that are integral to delivering timely, appropriate and high-quality health care services to our members. The team will continuously monitor our health plan operations through our integrated quality management and UM committees, which will collect and analyze data from a variety of sources to evaluate the ongoing effectiveness of clinical programs, monitor utilization patterns and identify trends and identify opportunities for improvement.

The team will routinely review aggregate data at the population level by disease condition and by risk level and at the member, provider and facility level to identify opportunities for improvement in the quality of care, member experience, member outcomes, quality of life and cost of care rendered to members.

Reports

Our health care economics team will gather quality data, prior authorizations and clinical and claims data from providers or subcontractors and continually review and analyze this data so we can detect and correct utilization variances against our targets and national standards, such as HEDIS. The team will develop reporting, dashboards and scorecards using utilization analytics tools and reporting to help our leadership team analyze our performance. Some examples include:

- **Regular Care Coordination Reporting.** Will provide core outcome metrics reports monthly, quarterly and annually to continuously refine and improve our care coordination strategies
- **Data Variance Analysis.** Will review weekly, monthly and quarterly reports that compare inpatient admissions, length of stay, admission and readmission diagnoses and ER utilization to professionally recognized standards of care and performance metrics
- **Emergency Room Escalation Report.** Will allow us to identify hospitals with the propensity to admit members from their ER to observation or inpatient level of care compared to peer hospitals at both a state and national level
- **Maternity Scorecard**. Will focus on maternity-related care, including maternity and care management delivery outcomes, the antepartum average length of stay, admits and days per 1,000, NICU admits and days per 1,000 and care management volumes by care level

vii. Clinical Data, and

We will use systematic processes and data analytics to understand our members' circumstances and needs, their level of health risk and the focus of their needs. Our comprehensive suite of clinical tools will promote collaboration between the member, care manager and the interdisciplinary treatment team (ITT), our field-based care teams and the member's providers and other organizations.

Collects

We will collect a variety of clinical data from a combination of our claims, UM, quality management, care management, Rx and behavioral health systems. Our managed care information systems are fully interoperable and fluidly exchange information to allow us to deliver services to our members. Our care management system will automatically exchange member and authorization data with our community transaction system based on authorization transactions processed in our integrated user experience platform.

Analyzes

Our clinical adherence program will create a culture of process improvement in daily operations; it will promote improvement and transparency, member advocacy, integrity and fiscal responsibility in the provision of care. It will provide our Mississippi leadership team with a clinical operations scorecard measuring overall program,

manager and care manager compliance with our policies and Mississippi-specific care management requirements, such as required clinical competency testing results, timeliness and appropriateness of decisions on prior authorization and notification of adverse actions, treatment plan execution and documentation, plan of care execution and documentation and metrics specific to certain member populations.

We will perform an end-to-end process review validating the accuracy and comprehensiveness of supporting clinical systems and processes that support adherence to community-based care management requirements using the scorecard analyses.

Integrates

Data will automatically feed to our reporting, care management platform and data analytics solution daily, biweekly and monthly from a variety of systems. This data will include claims information member data, provider data, authorizations, external subcontractor data and predictive modeling information from our predictive modeling and care management analytic solution. In addition, our analytic reporting tool will capture geographic information, diagnosis and level of care, disease management categorizations, provider contracts, revenue capitation by rate cell, claims and encounters for each service category, service authorizations by day, actuarial reserving completion factors and risk stratification scores by member.

Our clinical and operations teams will use our managed care information system applications to access and update data to perform a variety of functions. Our systems will work in unison to provide our clinical teams with predictive modeling and risk stratification. We will use this information to create clinical profiles for our members, risk scoring, total spend and other valuable data points.

Validates

We will perform an end-to-end process review using our scorecard analyses to validate the accuracy and comprehensiveness of supporting clinical systems and processes that support adherence to community-based care management requirements. The review will include oversight and monitoring of clinical operations, case reviews, ad hoc reviews and post procedural implementation reviews, staff competencies and adherence with national policies and standards and extensive clinical record review.

We will audit and log transactions for possible data omission or corruption, including error-tracking logs to back out any adverse events. Other critical systems, such as our secure member and provider portals, will use web services to exchange data in real time.

Reports

We will have a multifaceted approach comprising an oversight structure, policies, processes and data analysis tools to evaluate member and provider utilization patterns so we can improve our health plan operations. Our clinical leadership team will iteratively monitor and analyze key metrics identifying utilization trends and the effectiveness of provider practices, hospitals and clinical programs.

Monitoring Individual Outcomes

We will monitor and report individual member outcomes using the following tools:

- **Health plan suite of data analytic tools.** A suite of data analytics developed to make sure leadership will have tools readily available to outline key management indicators and metrics for members and providers. The suite will facilitate information sharing among members and their care management teams to integrate care and manage provider and member outcomes. For member information, it will track concerns provided through the call center along with claims information.

- **Our clinical management platform.** Our clinical management platform will allow the care manager and ITT to document and report the member's progress and implementation of their plan of care and make sure the plan of care continues to meet the member's needs. The member, PCP and other providers can view and update the member's clinical progress. Our clinical management will support the efforts of the care manager and the ITT to proactively monitor each member's health status and progress toward achieving their goals.
- **Member profiles.** Our clinical system will provide the care team with a complete member profile that integrates the member's diagnosis, utilization, inpatient admissions, ER visits, pharmacy data, allergies and evidence-based gaps in care with their acute care, preventive care, chronic disease management, medical, behavioral, specialty care visits, plan of care and social services.
- **HEDIS.** We will track and monitor compliance at the individual member level to identify gaps in care and barriers to care. When opportunities are identified, our field-based registered nurse consultants will meet with the provider and their office staff to review performance and the associated clinical practice guidelines and to identify opportunities to improve the practice's systems to improve compliance.

viii. Population Health

Social determinants, such as financial resources; employment status; living situation, caregiver support, risks related to housing and food security; community and personal safety; awareness of available community resources; transportation concerns; race; ethnicity; language; and health literacy, are a significant driver of an individual's health.

Collects

The breadth and type of data we will integrate into our data warehouse using various sources, such as claims data and enrollment data, includes member demographics, contact information and preferred method of communication, medical history, medication, allergies, immunization status, laboratory test results, radiology images, vital signs, personal statistics such as age and weight, social determinants of health (SDOH) data and billing information. Additional data sources will include 834 enrollment files; medical, behavioral and pharmacy claims; encounter data and lab results; SDOH screening and referral data; and admission, discharge and transfer (ADT) feeds from the Division's Health Information Exchange (HIE).

Identifying Members – Advanced Data Analytics Suite

We will continually integrate and analyze data using our suite of data analytics tools to understand members' social, behavioral and medical needs; circumstances; health risk; and appropriate intensity of care management services. These tools will help us:

- Stratify members into care management levels in alignment with their health risk
- Identify drivers common to members who require intensive clinical intervention
- Identify subpopulations within the larger population and provide interventions accordingly
- Identify each member's health risk

We will implement our identification and stratification process initially for new members (using available historical data) and monthly for established members. We will use our predictive modeling tool to analyze variables, such as gender, age, future inpatient risk, prior year total cost of care spending, acute inpatient admissions, ER visits, pharmacy, behavioral conditions and total chronic conditions. Its analysis will apply more than 300 clinical rules to identify members with gaps in care, condition-specific triggering events, high utilization, risk markers and substance use concerns. Our algorithms integrate and analyze a variety of data sources, including medical, behavioral and pharmacy claims; lab results; prior year total cost of care; utilization, such as acute inpatient admissions, ER visits and pharmacy; social determinants-related data; census data; and demographics. **Our predictive modeling algorithms have positive predictive validity of nearly 80%.**

Analyzes

Supported by a well-established information system, our teams have experience actively collecting, integrating and managing disparate data sets to support population assessment and inform our population health management strategy. We will integrate diverse types and sources of data, predictive modeling and advanced analytics tools to stratify and segment our population, identify disparities, understand drivers and determine appropriate clinical and population health interventions.

We will use our sophisticated predictive modeling tool to further segment populations for targeted population health intervention. Our tool uses advanced analytics to identify and stratify populations. The segmentation tool's diverse functionality will enable our teams to stratify, segment and sub-stratify our members by numerous characteristics to help identify member cohorts for heightened engagement. Specifically, we can look at clinical risk factors, filtering by member characteristics such as race and ethnicity.

We will incorporate social determinants into our care management approach as follows:

- **ICD-10 codes.** Implementing ICD-10 codes will help us identify the influence of social determinants on our members' ability to access care and track the delivery of services to address social determinants, while avoiding additional administrative work for providers.
- **Screenings.** Using data from member screenings to identify barriers that may negatively influence their ability to meet their goals. Our:
  - Initial health risk screening and comprehensive health assessment will include two questions related to social determinants
  - Adult and pediatric core assessments will each include 33 questions related to social determinants
  - Access to care assessment will help determine the member's barriers to accessing care
  - Data analytics tools will identify key drivers common to members who require intensive clinical intervention, such as special health care needs and unmanaged medical or behavioral conditions
  - Monthly predictive modeling analysis using our predictive modeling and care management analytic solution will review a variety of data sources to identify the influence of social determinants to each member's overall risk
  - Hotspotting tool will identify cohorts of members with specific needs, including social determinants, so we can connect those members to resources that address their social needs
  - Geospatial analysis will include mapping capabilities that overlay social determinant data with member addresses. The resulting output will allow us to observe population clusters with drilldown capabilities to the member location. This capability provides insight on how to overcome disparities that may be associated with environmental factors such as pollution, flood zones, natural disasters, etc.

Validates

We will rely on run and control charts, which track weekly progress over time, to understand outcomes. By tracking our progress, we can quickly identify where significant improvements have been made and link our interventions to shifts in the outcomes. We recognize the importance of understanding variation to draw the right conclusions on the effect of our intervention.

Reports

We will share data across internal staff and leaders from departments and routinely share analyses and workable data with providers, community, state, county and local partners to support provider-led and community-based population health management. These efforts will further create opportunities to develop member and population level interventions. Our data tools will allow us to meet Mississippi's population health reporting

needs. Our reporting will track the requested clinical, cost, utilization and member experience measures at the broader population level and by risk tier, subpopulation and demographics (e.g., race, ethnicity, age, gender).

[END OF RESPONSE]

4.2.2.9: Program Integrity (Unmarked)

A. Fraud, Waste, and Abuse

1. Describe the Fraud, Waste, and Abuse program that the Offeror will implement, including ...

A cornerstone of our compliance and ethics program, our anti-Fraud, Waste and Abuse (FWA) program will focus on prevention, detection and correction activities to minimize or prevent overpayments due to FWA. As vigilant stewards of state and federal health care dollars, we will be committed to identifying potential member and provider FWA.

Our program will incorporate the required elements as outlined in 42 C.F.R. Part 455, Section 1902 (a)(68) of the Social Security Act, 42 C.F.R. § 438.608 and Section 10 of the Draft Contract and will be based on seven core elements of an effective compliance program, as shown in the following figure.

Figure 1. Elements of an Effective Compliance Program. We follow the seven elements of an effective compliance program to establish a culture of effective compliance.

The intent of these seven core elements will be to make certain we honor our commitment to the highest standards of ethics and integrity. These elements will be essential to the implementation of a comprehensive and effective compliance and ethics and FWA program in Mississippi. We understand the MississippiCAN and CHIP model contract and other program elements necessary to support the Division in stewardship of these vital health services.

Our anti-FWA efforts will enhance federal and state oversight and, together with local partners, we will strive to be the leaders in program integrity, safeguarding the programs with advanced, upfront strategies that avoid recovery and save the Division substantially more dollars. We recognize the best time to address FWA is before a claim is paid.

FWA Savings
During the past three years, our FWA activities have saved Medicaid $357 million, including $109 million related to CHIP members nationally.

Our anti-FWA program, with oversight from our local compliance officer, who will report to the chief executive officer and board of directors, will be comprised of two principal functions: our special investigative unit (SIU) and our payment integrity department, both of which will be supported by our legal department. This staffing model — consisting of a local compliance officer, a program integrity manager who will focus on Mississippi FWA and one local investigator —will enable us to effectively prevent, detect, correct and report FWA and assist with prosecution of any FWA in an efficient manner.

Staff training will prioritize professional development of our local compliance officer and SIU staff along with our vast support staff network across our entire company. All employees, managers and directors, applicable company contractors and subcontractors or vendors and those employees of other company segments who perform work on our behalf will be required to complete compliance FWA training. General education will include examples of potential FWA issues and schemes, resources available for reporting suspected instances of FWA and pertinent laws and regulations review, including the Federal False Claims Act and Whistleblower

Protection. Subcontractors and vendors will be required to attest annually that all new staff have been trained and all existing staff have had annual training on FWA identification, reporting, standards of conduct and whistleblower protections. In addition to general new employee orientation training, we will provide mandatory annual and/or periodic employee compliance training, including, but not limited to, the topics of the Code of Conduct, Privacy and Security, Organizational Conflicts of Interest and Anti-Corruption.

Our SIU will set specialized annual training goals to make sure we have a team of highly qualified investigators. In addition to mandatory annual compliance training, our SIU investigators will complete at least nine hours of investigations training each year, and we will set annual training goals beyond the baseline requirement for every investigator. Our local SIU staff will draw from our enterprise-wide SIU staff who have a diverse set of backgrounds and extensive training and experience in identifying and resolving FWA activities. All our SIU staff will receive extensive training to monitor provider and member behavior for any aberrant or wasteful trends.

We will maintain a well-established set of written standards and documented policies and procedures for internal fraud controls, spanning entity level, financial, operational and general computer control activities. These controls can be either preventive and/or detective in nature.

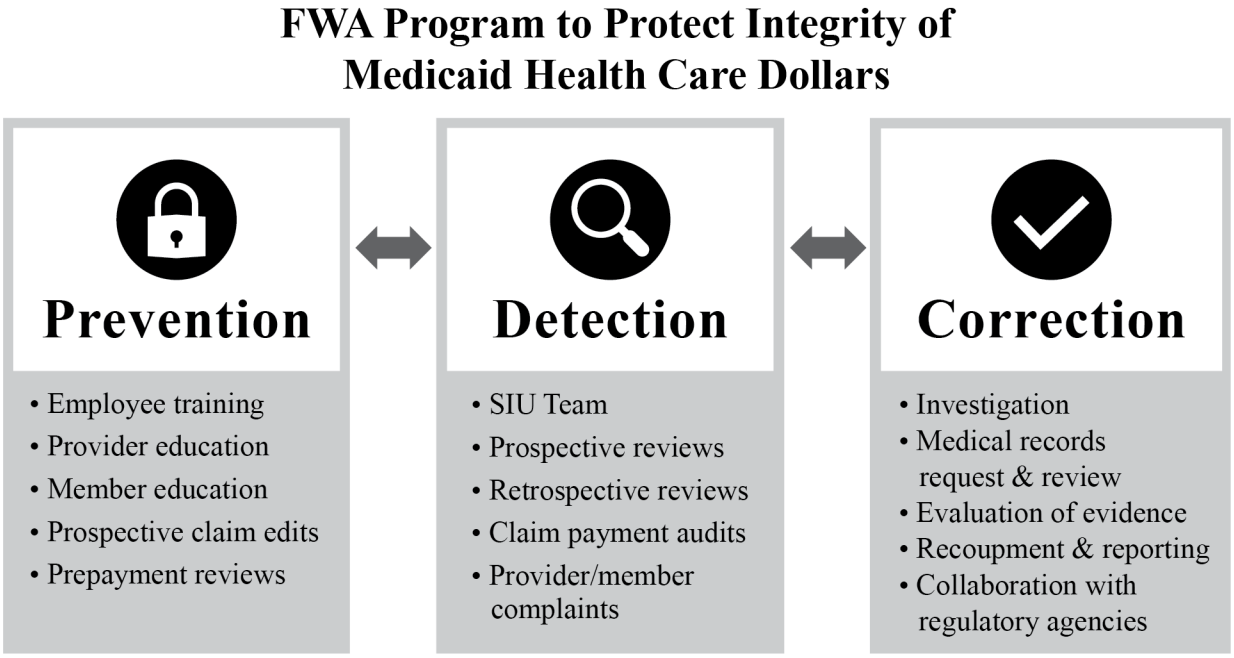


Figure 2. Fraud, Waste and Abuse Program. Ongoing feedback improves prevention, detection and correction efforts.

The following policies will be implemented to prevent and detect employee fraud:

- Anti-Kickback
- Avoiding Conflicts of Interest (and Outside Directorships)
- Delegation of Binding Authority
- Federal Government Contracting
- Insider Trading
- Non-Retaliation Policy
- Various Privacy and Security Policies
- Antitrust Policy
- Gifts and Entertainment (Business Courtesies)
- Anti-Corruption Policy
- Honoraria Paid to Employees
- False Claims Act Compliance Policy

- Interactions with Pharmaceutical, Medical Device or Biotech Manufacturers, Wholesalers or Distributors
- Compliance with the Federal Health Insurance Portability and Accountability Act of 1996
- Reporting Misconduct Policy

We will support effective lines of communication encouraging reporting through managers, senior management, compliance officer, the organization's compliance hotline and the Compliance and Ethics Help Center. In addition, the Help Center will allow for anonymous reporting of potential FWA concerns or issues through either a toll-free number or online reporting form. The company reporting resources will be available to all parties with mechanisms to receive complaints from Mississippi constituents to safeguard whistleblowers, including the anonymity of complainants to protect them from retaliation, and establish clear processes and structure for addressing compliance concerns quickly and effectively.

Compliance, business functional areas, health plan personnel or other organizational areas will conduct auditing and monitoring activities for FWA to identify, prevent and correct regulatory risk for the organization and our partners. Monitoring activities will verify that the compliance FWA program is effective and drives routine feedback on organizational performance and compliance.

a. Proactive and reactive fraud, waste and abuse detection methods that will be used, including dollar amount thresholds used for …

Achieving Operational Excellence

To comply with contractual and regulatory requirements, we will perform both prospective FWA activities (before claims are paid) and retrospective (after claims are paid) FWA activities. We will not have a dollar threshold for initiating a fraud review. Upon state pre-approval all prepayment reviews will be completed within 12 months of case initiation and all pre-approved retrospective reviews will have a look-back period of a minimum of 18 months and a maximum of 36 months based on the date of service of the claim.

Our preventive FWA program will focus on proactive provider-centric and claims-centric analytics to generate cost savings by helping to prevent overpayments and identify and educate on aberrant provider billing practices. For example, our preventive Provider Awareness campaigns will be targeted reviews aimed at engaging and collaborating with large groups of practitioners who are identified as needing education for billing issues. Our engagement with the provider will encourage billing behavior change in a more collaborative manner than a medical record review. We will customize our campaigns based on specific needs. By addressing opportunities for provider education or investigating inappropriate provider billing practices before paying a claim, preventive FWA activities may lead to cost avoidance and reduced administrative costs. In the past three years, we have delivered 154,031 provider awareness letters for our Medicaid programs, including 686 for a state program like Mississippi. In accordance with the model contract, we will complete at least three Division-acceptable provider site audits annually, as necessary.

To help facilitate analysis, our prospective FWA program will integrate all effective fraud detection strategies into one powerful solution. This software includes provider peer-to-peer profiling, claim-centric editing and predictive modeling tools that uncover previously undetected aberrant behaviors. We will apply these tools to the daily claim stream to identify fraud and abuse before the claim is paid. We will request medical records (once we identify the suspect claims) using a system-generated letter that identifies the specific claim being reviewed and explains the documentation needed to complete the review. We will manage each investigation to verify claims are returned to the customer for processing within the applicable state prompt-pay guidelines. Using vast data assets, we will offer a "living laboratory" for rule development and testing, minimizing false-positive fraud detection results.

In states similar to Mississippi, we have designed and deployed additional analytics (COVID-19, telehealth) based on anticipated and known aberrant behavior because of the pandemic.

Driving Innovation and Value

As the COVID-19 claim and billing history matures and evolves, we continue to edit and enhance these analytics, reflecting the traditional model focused on historical knowledge. In addition, we are coordinating with national and state agencies and regulators to address emerging COVID-19 fraud schemes and continue to plan accordingly to confirm appropriate people, process and technology are applied.

A few examples of potential schemes and patterns we are reviewing and monitoring:

- Procedures impossible to perform via a telehealth encounter
- Duplicative billing of COVID-19 related testing
- Incorrect billing of various COVID-19 testing procedures
- Specimen collection in the absence of an associated test
- Genetic testing related to billed SARS-CoV-2 specimen collection test encounter
- Durable medical equipment services that appear to originate as the result of a patient encounter for SARS-CoV-2 care
- Utilization and billing behavior disparity during the emergency period
- Billing for services not rendered in drive-through testing sites
- Double billing of vaccines (pharmacy and medical)
- Billing for multiple vaccines from multiple suppliers
- Billing for additional services along with the vaccines

Our retrospective FWA program will includes detection, audit, investigation and reactive recovery activities in cases where we have identified suspected fraudulent, wasteful or abusive business practices. Together with our vendors and contractors, we will perform retrospective activities in compliance with contractual and regulatory requirements for reimbursement accuracy. These retrospective activities will entail the same types of tasks undertaken regarding prospective detection, investigations and recovery and may occur in tandem. We will review these investigations within the regulatory Compliance Oversight Committee to determine next steps.

We will use advanced analytic techniques to discover patterns hidden in data. Our approach will produce insights that explain past performance and help predict future outcomes. The analytic models and rules we will embed into our business processes and applications will lead to operational efficiency and improved business outcomes. These analytic models will include:

Analysis	Description
Pre-Payment Data Analytics	Flags errors and irregularities to assist in identifying suspected FWA for follow-up prospective audit and retrospective investigation
Post-Payment Data Analytics	Analyzes paid claims to prevent future payments induced by FWA and to identify retrospective audit, investigation and recovery opportunities
Payment Error Analysis	Analyzes paid claims to identify various types of billing errors and irregularities that contribute to the identification of suspected instances of FWA for further analysis
Industry Trends (Sharing Awareness)	Reviews industry trends and information from professional associations to assess their potential impact on our benefit programs and to inform future FWA activities

Analysis	Description
Aberrant Billing Patterns	Identifies aberrant billing patterns that may indicate suspected FWA based on known or suspected schemes and practices (e.g., gender inappropriate services)
Provider/Member Verification	Verifies the existence of providers billing for services rendered to our members and the existence and eligibility of the affected members
Verification of Excluded Entities	Identifies providers, vendors and employees debarred or suspended from participation in federal and state health care programs

A detailed provider audit can detect FWA or other improper billing practices. We will perform selective audits on certain providers to look for potential FWA. As part of a provider monitoring program, providers may be selected for audit using various sampling criteria (e.g., random, statistical, on-site).

We will perform provider review audits and quarterly medical cost trend reviews as a component of retrospective FWA investigations. To comply with Section 10, of the Draft Contract, the fraud investigator will present these findings and evidence and request an on-site review with Division approval.

b. Process for acting upon suspected cases of fraud, waste and abuse;

To support the Division's efforts to mitigate incidents of FWA, our SIU will perform prospective and retrospective investigations of credible suspicions of fraud committed against our health plan and our programs. The SIU will be responsible for conducting investigative activities and has knowledge and experience in intelligence-led investigative practices and relevant legislation. The SIU will be comprised of highly qualified investigators experienced in health care and prescription drug FWA, industry business trends, practices and systems and infrastructure and understands federal and state law enforcement and litigation practices. The SIU investigators will conduct fact-based investigative activities and operations and present evidence in support of civil and criminal prosecutions. As part of our SIU team and to develop our partnership with the Division, **a Mississippi-dedicated SIU investigator will be available for day-to-day provider investigation-related inquiries from the Division's Office of Program Integrity.**

When reasonable cause to suspect subcontractor, member or provider FWA is detected from analytics (electronic mining of claims data) or internal and external tips, the allegation will be processed and reported immediately to meet the requirements as outlined in Section 10.3 of the Draft Contract and the Program Integrity Fraud and Abuse Standard Operating Procedure for referrals and reporting to the Division of Medicaid, Office of Program Integrity. Further investigation will continue in partnership and upon state approval from Office of Program Integrity.

Fighting Fraud During a Pandemic
In 2020, in a state of similar size and makeup to Mississippi, we identified a behavioral health provider double billing for telehealth services for the same member on the same date of service. After reviewing 1,051 claim lines, we recovered over $68,000 in Medicaid funds.

c. Process for complying with federal regulations related to disclosures and exclusion of debarred or ...

Ongoing monitoring of providers and subcontractors is an integral part of our anti-FWA program, and through policy and process we meet and exceed all state and federal regulations, in accordance with 42 C.F.R. § 438.610 and Section 1.9 of Mississippi Division of Medicaid Coordinated Care Contract, related to disclosures and exclusion of debarred or suspended providers. We will not knowingly have any affiliation with prohibited individuals or entities, as defined in state and federal regulations. Our program will include procedures for collecting ownership and financial disclosure statements from participating network providers to confirm disclosure forms are collected from all network providers in accordance with federal regulations, including 42 C.F.R. §455.104 and §455.106. This process will consist of mailing forms during initial contracting, upon

request from the Division for revalidation or when notified of a change in ownership; reviewing completed forms for accuracy and completeness; and checking the information against the Office of the Inspector General and Excluded Parties List Systems database; and, when applicable, reporting exclusions to the Division within a timely manner, according to Division and state regulations.

Each month, we will review state and federal reports to identify participating providers who have had Office of Inspector General sanctions on Medicare and Medicaid participation, General Services Administration debarments or other sanctions against their license or certification. If a provider does not have a valid license or has received a sanction or debarment, we will act in accordance with our provider participation agreements, the credentialing plan and regulatory and accreditation requirements. We will monitor providers for complaints, potential quality of care concerns or identified adverse events and identify, track and resolve concerns. We will take immediate action if the issue poses any potential risk to the member. Further, our contracts with third parties will contain language requiring them to screen their employees as required by applicable state and federal law. We will check exclusion status of all contracted providers against the following lists:

- Health and Human Services Office of Inspector General's List of Excluded Individuals/Entities
- General Services Administration Excluded Parties List Service
- GSA's System for Award Management
- CMS' Medicare Exclusion Databank
- State Board of Examiners
- National Practitioner Data Bank
- Health Integrity and Protection Databank
- Social Security Administration Death Master File
- National Plan and Provider Enumeration System
- U.S. Office of Foreign Assets Control
- Mississippi Sanctioned Provider List

If a provider is found to be debarred or suspended, we will put a payment suspension flag into place. This means all claims the provider submits will be held and not paid as appropriate. Payment suspensions can cover, among other items, one or more providers or only one provider in a facility or group, certain billing codes or the entire range of codes available for that provider to bill, certain time frames and geographic areas. Payment suspension requests will be implemented in a timely manner and as prescribed by the regulator. Regulator initiated payment suspensions will be completed within 24 hours of notification and released within 24 hours of notification of regulator lift.

d. Process for interacting with the Division, including the Office of Program Integrity; and,

Partnering with the Mississippi Division of Medicaid Office of Program Integrity (OPI) and local Medicaid Fraud Control Unit (MFCU) will be critical to our anti-FWA program to address suspected subcontractor, member and provider FWA. We will engage in areas of interest for past, present and future investigations to help improve the effectiveness of FWA oversight activities. We will notify the Division's OPI immediately, in writing, of discovery of subcontractor, member or provider-suspected FWA and within 30 calendar days of the discovery of any overpayments or underpayments of services provided to Medicaid members by providers.

Our local compliance officer, who will serve as the main point of contact, will enable coordination and oversight of any program integrity on-site reviews requested by the Division, including all requested documentation and records. As required, and at least monthly and quarterly, our local FWA staff and

compliance officer will attend any in-person meetings and via phone, teleconference or video conference, as needed.

We will provide timely notification and reporting to the Division including identified overpayments, changes in a member or provider's circumstances and prompt referral of any potential fraud, waste or abuse identified to the Division program integrity unit. In addition, within 90 calendar days of execution of this contract, annually thereafter and 60 days before implementation of any future revisions, our Fraud and Abuse Compliance Plan will be submitted to Division's OPI for approval and will encompass all requirements listed in Section 10.2 of the Draft Contract.

Catching Fraud, Waste and Abuse Affecting Our Most Vulnerable Population

In 2019, using a multi-organizational approach along with data analytics, we uncovered fraud involving a national dialysis provider. This provider, through a third party, purchased individual commercial exchange policies for Medicaid members with renal disease and received 10 times the reimbursement for each treatment. This exposed members to copayments and other out-of-pocket expenses they would not have with their Medicaid health plan. We moved these members back to their Medicaid plan and recovered millions of dollars in excessive payments while referring the case to the appropriate Medicaid agencies and the Medicare Drug Integrity Contractor (MEDIC).

e. Other components of the Offeror's fraud, waste, and abuse program.

In addition to our detection, investigation, payment prevention and recovery efforts, we will take prompt corrective action when FWA is discovered, including among subcontractors and vendors. All subcontractor and vendor performance management and reporting activities will be managed by our delegation and vendor oversight manager.

Corrective action may include, and is not limited to, the following:

- Referring a matter to law enforcement officials or prosecutors for criminal prosecution
- Referring a matter to outside counsel for civil litigation
- Reporting providers to state professional licensing authorities and medical boards
- Notifying and educating the offending provider or member
- Issuing a corrective action plan to the provider
- Referring a provider to our network management team for appropriate disciplinary action
- Advising our businesses, affiliates, subcontractors and local health plans regarding possible changes in contract or policy terms and procedures
- Creating and implementing new data mining queries and rules to identify the scheme at issue

If we issue a corrective action plan, our local compliance officer, along with the business leaders of the functional area(s) and the appropriate Joint Operating Committee, will monitor and evaluate the implementation of and progress made under the corrective action plan. They will be responsible for documenting whether the remediation activities are effective and addressing the concerns detailed in the corrective action plan.

B. Claim Denials

1. Describe the Offeror's proposed Denials Review and Reporting program, including:

We support the philosophy that all denials, irrespective of whether they are appropriate or inappropriate, are considered waste in the health care system. Our multifaceted approach will support our successful denials

review and reporting program, which is designed to reduce the denial rates and therefore reduce the administrative waste associated with those denials.

A key component of timely and accurate claims payment begins with the providers. We will proactively communicate with providers regarding claims submission through our provider services call center, our provider manual, provider educational materials, meetings, newsletters, eblasts, portals and websites. Through our provider services call center, utilization management and care coordination activities, we will offer a "no wrong door" approach to claim intake, making it easy for providers to receive prompt services, accurate information and to transact with our organization. Regardless of the provider's network status, our claims processing engine will deliver claims to the appropriate claims processing platform based on each member's demographic data and the corresponding eligibility information we have from the 834 enrollment file. This will allow claims data for various programs to flow through the same channel, verifying appropriate routing for all provider-submitted claims.

Our government operations claims processing teams operate with the philosophy that if a provider renders a service in good faith, we should do everything in our power to pay their claims.

When certain elements on the claim are missing or inaccurate, our claims processing team will operationalize a proactive provider outreach program, designed to outreach select providers while the claim is still pending an adjudication decision.

During this outreach, we will request the missing or needed information from the provider or designee, and if we receive it, we will try to further claim development and payment rather that deny it and require resubmission of a corrected claim.

a. A description of the Offeror's Denials Management program

Driving Innovation and Value

Our Denials Review and Reporting Management program will consist of a cross-functional local and national oversight team led by our local chief operating officer. Within our standard reporting, we use a powerful combination of tools to monitor claims both proactively and retrospectively.

Before adjudication, our edit solution will electronically identify "certain to deny" claims, alert providers and educate providers by delivering prompt and clear notifications on how to resolve claim errors. This pre-adjudicated claim editing capacity will allow us to auto-detect claims with potential errors. As part of our electronic data interchange (EDI) workflow, our proactive edit tool will deliver provider feedback within 24 hours of a claim submission via a standard 277CA report. Using our secure provider portal, providers can correct errors, reducing the complexity and provider concerns resulting from claims denials. By putting a transparent and proactive communication process in the EDI workflow, the solution will help reduce the

administrative expenses for both providers and our company. **Nationally, in 2021, those edits configured to hold the claim and electronically educate the provider saw a 4.72% repair rate**. **Edits configured to reject the claim and educate the provider reaped a 29.86% repair rate.** In 2022, we will develop additional edits and provider education.

Once claims are in our system for adjudication, we will use our claim analytics tool to systematically analyze and identify claims anomalies on a macro level before providers experience significant claims disruption. The claim analytics tool uses data collection and analysis to alert our analysts when there are statistical trends that require intervention and resolution before it becomes an issue —whether it is our system or provider submission error. This will allow our team to identify data patterns that can threaten seamless payment of clean claims in the future. The claim analytics tool allows us to look at potential causes for denials in real time and take a broader view of trends to facilitate provider education and process planning. The tool monitors all claims data daily, closely tracking points in the claims process where errors occur. It scans for unusual patterns in claims receipts, denials and rejections. Specifically, it checks for any claim anomaly that exceeds two standard deviations from the mean performance and triggers a manual review. This can result in provider outreach to correct a problem or our internal assessment of our own processes and systems.

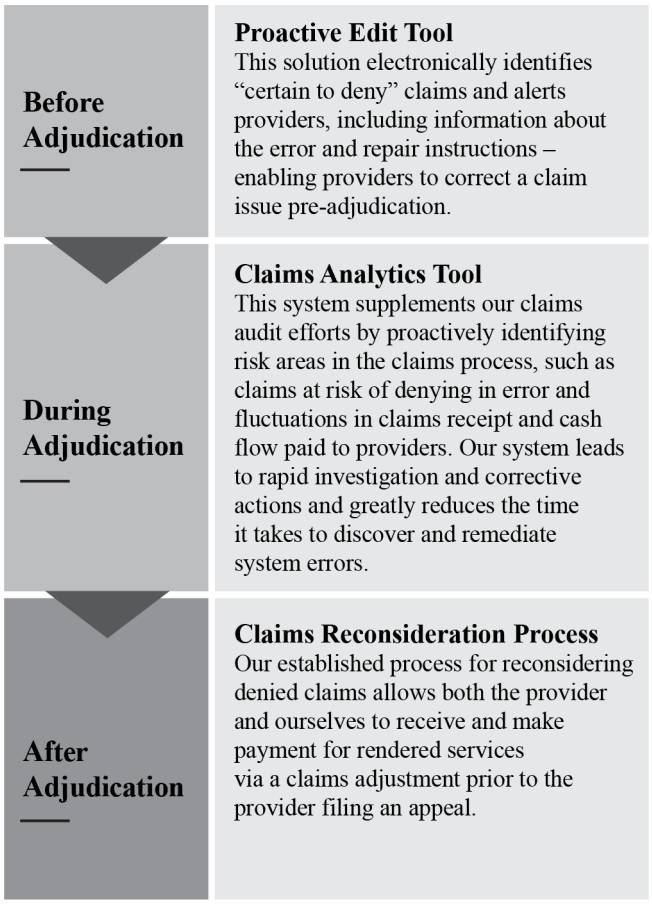


Figure 3. Our strategy to reduce administrative burden includes initiatives at every step in the claims process.

Identifying potential issues within the claims process daily will allow us to rapidly remediate issues. Complaints often indicate issues and a time lag, which means more claims might be affected by the same issue. These claims represent a high risk of appeal and ultimate overturn. By identifying these issues, we can reduce rework through reconsideration of claims denied in error and correct the error before a much larger collection of claims are affected.

As part of the overall claims process, we will review denial codes and their usage frequently to identify unusual trends and evaluate whether they are being used appropriately. This will allow an accurate representation of denial percentages and the opportunity to adjust codes as necessary to meet contract expectations. The team will have the flexibility to update invalid or misleading denial codes to help the provider through the remittance advice and further education. A recent example in a state similar to Mississippi is the identification of a denial code used in identifying claim lines, which are considered paid at zero due to inclusion in the overall payment made to the provider. This created an erroneous increase in denial percentages but was misleading to the provider community. The team created an informational code that allowed for a reduction of count of claim denials while meeting the expectation to providers in understanding that the claim line was payable at zero.

Proactive Monitoring Impact
In 2021, we had 1,535 alerts on our proactive edit tool requiring 342 actions. As a result, we avoided $67,956 in adjusted claims.

If our claim analytics tool identifies a provider experiencing a trend in claims denials based on billing process errors, we will engage their assigned provider advocate to provide guidance on how to resolve issues. Per a recent claims analysis in a state similar to Mississippi, our collective proactive efforts, including the tool's alerts and provider education and outreach, **reduced the denial rate by 4.75% in 2021**.

Proactive intervention and review. To enhance our focus on claims quality and support, we implemented an award-winning proactive claim monitoring system supporting our denial review program. This capability will provide enhanced insight to monitor claims changes, tailor provider outreach and education or implement necessary system changes. When key required claim elements are missing or inaccurate, our claims processing team will operationalize a proactive provider outreach program, designed to outreach select providers while the claim is still pending an adjudication decision.

During this outreach, the missing or needed information will be requested from the provider or designee, and if received, it potentially can further claim development and payment versus denial to the provider for resubmission of corrected claim. This increased transparency will provide a foundation for continuous improvement within the claims process.

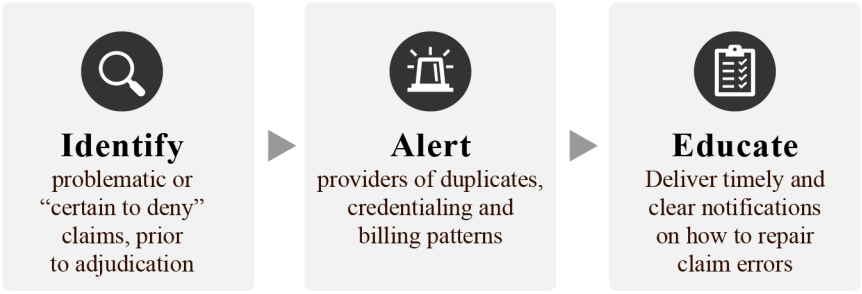


Figure 4. Our proactive edit tool is a pre-adjudication claim editing capability we use to auto-detect claims with potential errors. Part of the EDI workflow, the tool delivers provider feedback within 24 hours of a claim submission. Using our secure provider portal, providers can correct errors, reducing the complexity and provider concerns resulting from claims denials. By putting a transparent and proactive communication process in the EDI workflow, the solution will help reduce the administrative expense for both providers and ourselves.

Our analysts will use the daily data to perform same-day remediation, including internal outreach and updates, external outreach to the provider community and claim holds to prevent additional denials. The oversight team will receive regular updates from the analysts when high-spike patterns influence the market.

Another key program designed to reduce denials and support claim payment accuracy is our pre-disbursement auditing. Before claim payment, we will use our customer expanded audit program to initiate an audit to capture and correct claims containing known issues until a solution can be implemented. The purpose will be to reduce defects, eliminate rework and drive process improvement by correcting defective claims in a pre-payment status. These audits will focus on configuration, pricing or manual processing defects resulting in an incorrect claim payment. The audit findings will initiate system updates, revise processing guidelines and support data-driven results. **This program avoided more than 481,000 defects for an estimated $3 million cost avoidance nationally in 2021.**

If a claim undergoes all our proactive accuracy and built-in adjudication system checks and there is still an issue with the claim post-adjudication, we will react quickly to resolve escalated issues for providers, including aiding with reconsiderations and disputes. Our standard is to resolve these issues in 20 days or less. We will provide a single-point tracking and monitoring team for our provider services staff for claims issue escalations, which will allow them to rapidly

Actionable Results
Nationally, our system has generated more than 23,000 actionable alerts, resulting in rework avoidance greater than $4.5 million. In addition, there have been 1,718 collaborative outreaches to providers as the result of an alert being researched.

remediate complex provider issues by providing creating transparency. We will merge and streamline data from claims, enrollment, clinical episodes of care and utilization history, and provide an extensive review of provider concerns, root cause analysis and resolution.

Every week, a cross-functional team consisting of representatives from health plan leadership, operations, claim analysis and resolution and provider relations will convene to address aberrant trends and consider broader issues. Using data from various sources, the team will focus on claims denial reasons, and key drivers and trends. Understanding these patterns will allow us to make continual improvements such as enhanced communication, changes to our provider training materials, adjustments to our training schedules, revisions to our standard operating procedures and, if needed, systems changes.

The reporting aspect of our denial review and reporting program will include capturing accurate claims performance and trends using carefully defined algorithms, combined with a team of analysts who will continuously monitor the status of the claims process in real time. This comprehensive approach will enable our local reporting team to provide the Division with claims outcomes and detailed trend analysis at the overall claim level or line level. Our comprehensive reporting capabilities will enable us to contact the providers we identify with the highest denial percentages and provide direct education and assistance to mitigate the effect.

Monthly, we will submit a Claims Denial Report to the Division listing the denials processed during the previous month. This report will include a Division-defined breakdown of the denials by category, including, at a minimum:

- Prior authorization
- Claims completion errors
- Duplicate claims
- Services not covered or if a member is not eligible for services
- Timely filing
- Additional narrative explanations

We will submit this report by the 15th business day of the following month in the form and format required by the Division. We commit to working collaboratively to refine this report to align the Division’s expectations of reporting with our processes.

b. A summary/listing of the Offeror’s denials criteria/protocol

In addition to these standard denials, including, but not limited to, authorizations, duplicate claims, clinical editing, timely filing, benefits, non-contracted services and eligibility denials, we have established claim-processing criteria to deliver accurate claim outcomes and payment in response to claim submissions, which will correctly identify and describe services and procedures performed. We base processing rules and claim denial criteria on coding guidelines established by Current Procedural Terminology (CPT), diagnoses established by the Internal Classification of Diseases, standards established CMS, other industry regulations and standard coding guidelines. In addition, we perform claim edit procedures in alignment with National Correct Coding Initiative (NCCI) Medicaid standards developed by CMS. The NCCI claim editing standards include comprehensive and component code combination edits, and mutually exclusive edits that identify services that are unlikely or impossible to perform at the same time, on the same member, by the same care provider. We publish and maintain approved reimbursement policies based on CMS rules, state and federal regulations and other industry standards. We apply these reimbursement policies through claim edit protocols.

Our claim analytics tool takes real-time claims data (the batch of claims processed from the previous day) and applies automated control tests to the previous 30 days of processing to create alerts. Automated control tests are a method in process control of determining if some measured variable is out of control (unpredictable versus consistent). Alerts are based on state, subcategory (provider types and specialties and participation status), and denial grouping to determine real-time changes in claim behavior. The types of denials with alerts includes, but is not limited to, authorizations, duplicate claims, clinical editing, timely filing, benefits, non-contracted services and eligibility denials.

c. The Offeror's process for identifying claims and/or claims lines that meet the Offeror's denial criteria

Claim denials may occur due to the application of automated edits or standardized operating procedures (SOPs) applied through manual claim processing. Automated edits and claim SOPs are defined to support claim rules tied to coding standards, NCCI benchmarks, regulatory requirements and other approved reimbursement policy criteria. We will apply these standardized rules to each claim line to issue a final determination, which we will then report to the provider.

Our claim analytics tool supplements our claims audit efforts by identifying areas of risk in the claims process. The system not only alerts us to the risk of claims denied in error, but to fluctuations in claims receipts and cash flow paid to providers to provide us an end-to-end view of the claims process and expand our vision to additional areas that can improve provider satisfaction with claims payment. We designed this system to identify issues in a manner that leads to rapid investigation and corrective actions and greatly reduces the time it takes to discover system errors along with the volume of claims affected.

d. The Offeror's reconsideration process as it relates to claims denials

Our established process for reconsidering denied claims will allow both the provider and us to receive and make payment for rendered services via a claims adjustment before the provider files an appeal. If a claim undergoes all proactive accuracy and built-in adjudication system checks and there is still an issue with the claim post-adjudication, our investigation team will react quickly to resolve escalated issues for providers. This will include supporting reconsiderations and disputes with a standard to resolve these issues in 20 days or less. Our provider services staff will engage with this team for claims issue escalations, enabling rapid remediation. The team will merge and streamline data from claims, enrollment, clinical episodes of care and utilization history and provide an extensive review of provider concerns, root cause analysis and resolution.

Over the past several years, the investigation team staffing and engagement model in states similar to Mississippi has brought about significant improvements like faster turnaround times, modifications and enhancements to internal processes and policies based on direct provider feedback and resolution of issues. These improvements assist providers so they do not have to resubmit for the same instance and help new skilled resolution analysts to better understand and address providers' issues.

In addition, we will have a claims reconsideration form on our public provider website providers can complete and submit online, expediting the claims reconsideration process. For example, if the claim denial reason is lack of a Medicaid ID number, we will help providers find out how to obtain the ID number. Once they obtain the information and resubmit the claim, we will adjudicate the claim accordingly. We will work with out-of-network providers to correct claims submission errors that caused the denial. If we conclude the claim was appropriately denied, we will advise the provider of this finding and send the provider a written notice of their right to file an appeal that includes instructions on how to file.

We will maintain a comprehensive, transparent grievances and appeals process for providers post-payment, if the provider feels the claims payment is in error, that uses established processes, systems and time frames.

e. The Offeror's process for notifying and educating providers of claims denials.

Before the claim even enters our adjudication process, we will employ our proactive edit tool, which scans EDI claims, identifies certain claims to deny and returns the claims to providers pre-adjudication via a standard 277CA report. Proactive notifications will include clear instructions on how to repair errors and resubmit, along with access to supporting documentation regarding the triggered alert. This process will allow providers to update the claim within five days.

Notifying and educating providers of claim denials will begin with our provider remittance advice (PRA), which will comply with all applicable federal and state regulations. The PRA communicates detailed information to providers on the adjudication outcome of all claims. Providers can elect to receive PRA via electronic or paper means. In addition, our provider relations team will regularly work with individual providers to deliver notification, education and resolution support through email, fax, phone calls or face-to-face interaction. This team will use several resources to educate providers on successfully submitting claims and to keep them informed about denial trends.

We will use our claim analytics tool in our proactive outreach to providers experiencing high percentages of denials based on alerts the tool generates. Provider representatives will help providers correct the reason for denials and collaborate with providers to adjust claims if requested. We will use other tools to notify and educate providers of claim denials including:

- **Provider Manual:** All network providers will receive this guide upon initial contracting. It will be available on our provider website and serve as our CHIP provider training manual.
- **Provider Newsletters:** These will contain program updates, claims guidelines, information regarding policies and procedures, clinical practice guidelines and other timely information.
- **Provider Portal/Dashboard:** Our secure provider portal will give all providers access to critical and timely claims and claims denial information through a single source.
- **Telephonic Outreach:** Our claim monitoring system will trigger an alert if anomalous claims activity is detected. This will result in a provider services representative making direct outreach to a provider to discuss the observed activity. The provider will have the opportunity to correct the claim.
- **Field-Based Provider Training:** Field-based training is an important component of our continuous quality improvement efforts. The provider relations team will hold (at a minimum) monthly meetings with high-volume providers to present regular updates and refresher trainings. We will hold Joint Operating Committee meetings with key facilities to address operational issues, including training needs.
- **Webinars and Town Halls:** A facilitator will conduct real-time, monthly interactive webinars on topics such as denials. During town hall meetings, we will cover a variety of topics, including the top 10 denial drivers.
- **Provider Resolution and Dedicated Provider Escalation Team:** Provider advocates will use this model as another touchpoint for provider education by providing feedback about specific claim denials.
- **Proactive Claim Monitoring System:** Analysts will actively engage providers telephonically when significant issues are identified.

C. National Correct Coding Initiative (MississippiCAN)

1. Describe the Offeror's process to comply with Medicaid National Correct Coding Initiative (NCCI) for ...

We comply with the CMS National Correct Coding Initiative (NCCI) pertaining to Medicaid, which helps limit inappropriate reimbursement of claims. The Centers for Medicare & Medicaid Services develops and maintains

Medicaid NCCI edit files with quarterly updates posted to *Medicaid.gov* at the beginning of each calendar quarter. The CMS defines two types of NCCI edits:

- National Correct Coding Initiative procedure-to-procedure (PTP) edits define pairs of Healthcare Common Procedure Coding System (HCPCS)/Current Procedural Terminology (CPT) codes that are not to be reported together. Procedure-to-procedure edits flag incorrect code combinations and prevent improper payments.
- Medically unlikely edits (MUEs) define for each HCPCS/CPT code the maximum units of service a provider will report under most circumstances for a single member on a single date of service. Medically unlikely edits prevent reimbursement related to incorrect coding for excessive units.

Each quarter, we download both types of NCCI files from *Medicaid.gov*. We then translate the data into a file format compatible with our core processing and claim adjudication systems.

The claims system includes a wide variety of automated processing rules and edits to deliver extremely high processing accuracy. In addition to program benefits, benefit limits, duplication checks and other standardized coding methods, we implement NCCI claim edits within the processing platform to validate alignment with CMS definitions.

We completed comprehensive process testing and UAT review upon initial implementation of NCCI claim edits in 2015 to confirm NCCI editing accuracy. In addition, we routinely run quality and data validity audits, train claim processors, update claims operating instructions, review root cause items as needed and develop and implement solutions to permanently avoid claim inaccuracies.

National Correct Coding Initiative and MUE data is deployed into production on a biweekly/monthly average frequency. National Correct Coding Initiative and MUE files are submitted to the Application Management Services intake sites where those files are loaded in time based on a pre-published deployment schedule. The data deployment pre-production process validates the high-level file format accuracy only. Monthly claim editing system testing efforts will capture random testing samples of data for NCCI and MUE in the test claim regression suite. This testing confirms the editing accuracy.

We maintain NCCI Editing Reimbursement Policy to define how NCCI edits are applied to claim reimbursement practices. Policy content includes reimbursement guidelines, information on modifier use, state exceptions and a Q&A section. Our NCCI Editing Reimbursement Policy is publicly available through the provider website and is reviewed and updated annually, more frequently or as necessary.

We have a process in place to retrieve the updated NCCI files each quarter per an automated schedule. The files are then loaded into a test environment to go through testing as part of the established monthly releases. The updated files are then pushed into production after sign-off and approval of all testing each month.

[END OF RESPONSE]

4.2.2.10: Subrogation and Third-Party Liability (Unmarked)

A. Approach

1. Describe the Offeror's proposed approach to conducting subrogation and Third-Party Liability activities, ...

The escalating cost of health care programs and federal regulations dictate the need for flexible methods to verify the Division of Medicaid is the payer of last resort. Our processes and procedures will allow us to effectively carry out third-party liability (TPL) discovery, cost avoidance and recovery activities while complying with the requirements in Section 12 of Appendix A, Draft Model Contract; Section 1902(a)(25) of the Social Security Act and 42 C.F.R. § 433 Subpart D and 42 C.F.R. § 433.135.

a. Process for capturing Third Party Resource and payment information from the Offeror's claims system for ...

Our claims system procedures will confirm other responsible payers are identified, verified and recorded in our claim system pre-payment to achieve the Division's cost avoidance goals. Our processes and procedures will comply with Section 12.3.1 of Appendix A, Draft Model Contract. We will identify members' other coverage through member and provider notification, claim indicators, direct eligibility matching with other payers, the Division, initial new member assessment by a care manager and a suite of identification services from TPL vendors. **In 2021, in a state similar to Mississippi, we achieved more than $22 million in cost avoidance savings.**

Once we flag a member as having alternative coverage, subsequent claims edits will require a coordination of benefits (COB) review. We will not pay the claim until we receive the other carrier's explanation of benefits (EOB) or notification from the Division or another source that the other payer is not responsible for the service. Once we identify TPL and verify it directly with the other payer, we will coordinate activities to confirm we either avoid or recover the costs for services from the liable party. All data associated with TPL will be captured in our claims management system (whether from a provider claim, a member or other source), applied to the individual claim and available for reporting to meet contract requirements per Section 12.3.2 of Appendix A, Draft Model Contract.

b. Process for retrospective post payment recoveries of health-related insurance;

If we identify a potential third-party payer after we have paid a claim, we will generate a list of all impacted claims that we will use to recover payments from the primary carrier as of the effective date of coverage. The provider will receive a notification to refund the overpayment or appeal the overpayment notice. If the provider does not appeal or refund the overpayment within the designated period, we will adjust the affected claim and offset the overpayment from a future remittance to the provider. We will contact and request a check from providers who do not submit claims sufficient to offset the overpayment. During this process, we will contact a provider until we receive a check for the overpayment. Staff will record receipts from third parties as a claim reversal, and we will post a receipt to reflect the monies received. **In 2021, in a state similar to Mississippi, we recovered $5 million through our post-payment recovery process.**

On claims where we are required to pay as primary and pursue payment from the primary commercial carrier, we will submit claims directly to the commercial carrier. In addition, for any members where there is a match and only partial other carrier information is available, we will submit a claim to the invalidated carrier to determine whether the other coverage is valid and primary. The carrier will submit payments and EOBs, which we will use to post payments to the claims. Staff will review denied claims for potential resubmission.

We will report any payments recovered from third party or primary payers to the Division through monthly member encounter reports listing TPL amounts and cost avoidance and TPL recoveries reports. We will submit to the Division an annual report reconciling recovery amounts. We will recoup erroneous claims payments

according to contractually compliant protocols. We will void recouped claims encounters in full unless the recoupment is an adjusted claim value, in which case we will submit a replacement encounter.

c. Process for adjudicating claims involving third party coverage;

Our aggressive identification and validation of TPL is critical to our cost avoidance strategy of immediately rejecting claims covered by other available resources. Our claims system **(see figure)** includes built-in logic that will link a member's COB information to the claim being processed.

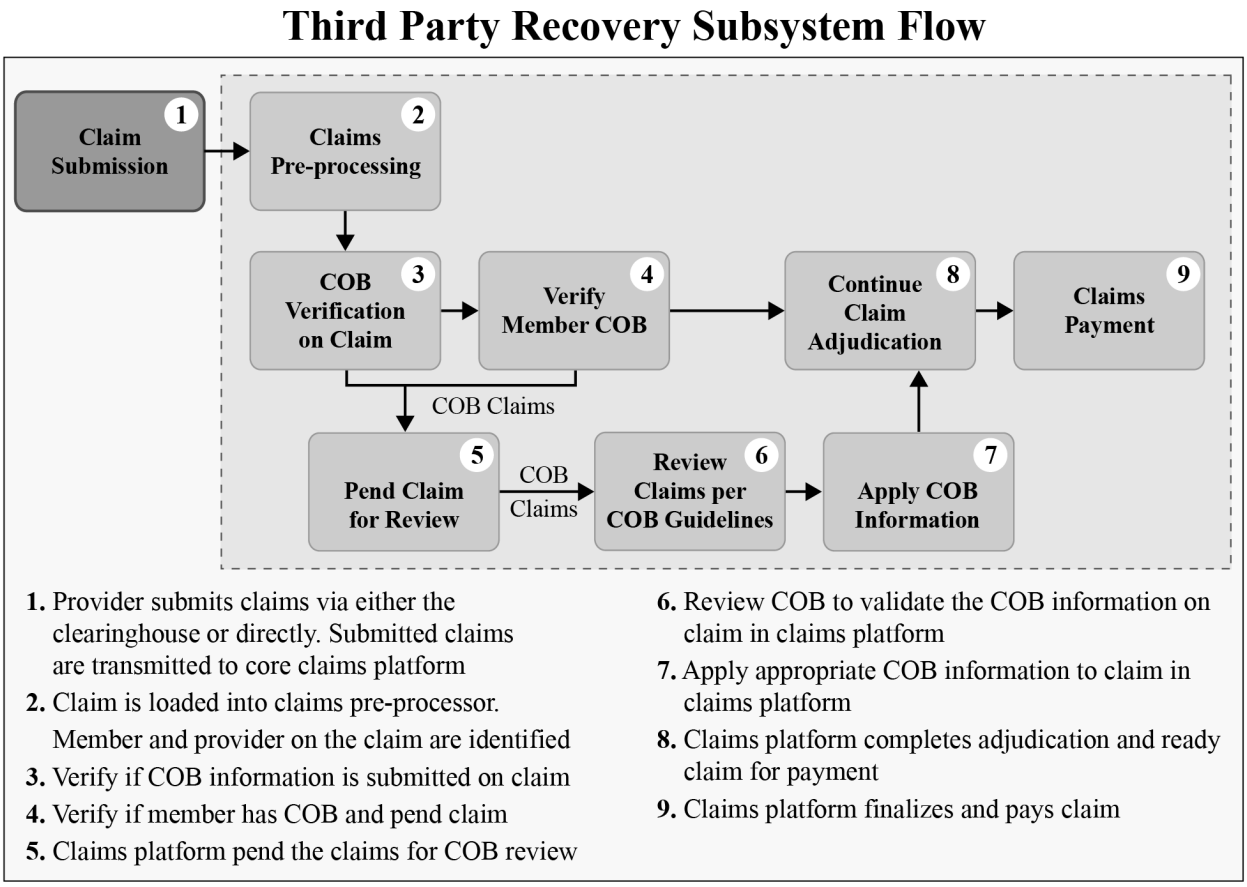


Figure 1. Our core claims engine uses built-in logic with links to a member's COB information to the claim being processed.

The most effective TPL approach is cost avoidance, which identifies claims covered by other available resources. We will have comprehensive edits in place to coordinate with a variety of payers, such as auto insurance and commercial health insurance carriers. When our system encounters a claim flagged for possible TPL, it will mark the claim as pending for manual adjudication. In the manual adjudication process, our claims examiners will coordinate benefits with the primary carrier's EOB.

We will pay any copayment, coinsurance or deductible the primary payer requires. We will pay, in full, up to the Division's allowed amount, regardless of whether the claim is from a network or out-of-network provider. If we receive a claim without the primary carrier's EOB, we will reject the claim and instruct the provider within 30 days of identification of valid TPL to pursue payment from the primary payer. If we cannot validate the subrogation and TPL information through online resources or a phone call to the alternative carrier, we will pay the claims as primary. If we discover a member has a primary payer after we have paid claims, we will adjust the claim and recover primary payments from the primary carrier effective date forward.

d. Process for identifying, recouping, and releasing claims;

Our process will comply with Section 12.3.2 of Appendix A, Draft Model Contract, and specifically with item 7, Third Party Resources regarding the 60-calendar day delayed payment rule. We will comply with state and federal mandates regarding claim types that are exempt from COB or TPL denials. We will pay these claims and turn them over to our audit recovery operations (ARO) team for COB recovery. We will not automatically reject these claims but will reimburse the provider and bill the correct third-party payer for the amount paid.

If a third-party insurer refuses to pay for or provide medically necessary services, we will not deny the service or require a written letter of denial. We will not leave it up to members to ascertain coverage for medically necessary services. In all medical emergencies, we will provide medically necessary services and coordinate payment retrospectively with the third-party entity.

Coordination of Benefits Recoveries

If we identify a primary payer after we have paid impacted claims, we will initiate an adjustment process to recover primary payments from the primary carrier effective date or other insurance effective date forward. The ARO team will have a comprehensive process in place to either recover these payments from the provider of medical service or recoup these payments from the member's other responsible carrier. At the direction of the health plan, ARO will execute for pay and chase claims.

e. Process for conducting education for the Offeror's attorneys and insurers about MississippiCAN and CHIP;

We will conduct education regarding program and contract requirements. The subrogation team will notify involved parties (i.e., insurance carriers and attorneys) of the subrogation interest and any applicable laws. We will educate attorneys, insurers and providers of our subrogation and TPL processes and their obligations in our provider agreements, provider manual, provider newsletters, through provider services representatives and our provider portal. We will target providers who are consistently noncompliant with subrogation and TPL claims and recovery activities for education. Our Medicaid contracts will require providers and subcontractors to cooperate with our TPL policies and procedures, including identifying services and individuals for whom there may be a financially responsible party other than the Division and assisting our efforts to coordinate payments with those parties. We will work closely with providers to educate them on claim submission requirements when they know a member has TPL coverage, which includes submission of the primary carrier's EOB.

f. Data analytics and informatics used to support the process; and,

We will use data analytics to augment the performance of the Division's subrogation and TPL program continuously. We will evaluate the diagnosis codes with the highest potential for subrogation recovery and perform specified queries and data matches with a property/casualty insurance company to identify the other insurers or other parties for an accident. We will use around 55,000 ICD-10 codes in our case creation process. The following range of codes are included in our identification of potential TPL: G4XXX, G5XXX, G8XXX, G9XXX, H2XXX, H4XXX, J6XXX, K08XXX, M1XXX, M2XXX, M4XXX – M7XXX, M9XXX, R2XXX, R4XXX, R5XXX, S, T, V, some U, W, X, Y and Z categories. Diagnosis codes will be continually monitored to determine success. The success of each code will determine the level of outreach, focusing on delivering the greatest recovery opportunity while minimizing abrasion.

Our analytics team will perform matches with a property/casualty insurance database vendor and a litigation database vendor to identify members who may have an open claim. The analytics team will add a score to a case within our tracking system, depending on the likelihood of recovery, which we will use for case assignment to verify the right analysts work the cases. Further, our claims system contains built-in logic, which will link a member's COB information to the processing claim. It will look for COB eligibility dates, the type of insurance coverage, whether an EOB is attached, primary COB and where it is a pay and pursue code or a non-

covered code and will process the claim accordingly. We will attempt to cost avoid all appropriate procedures unless we have been directed to pay and pursue. In the cases where retroactivity may have changed a member's eligibility, we will review these claims using complex algorithms and rework them upon identification.

We will employ data analytics and informatics to support identification and education of providers on issues of fraud and abuse. Proactive provider and stakeholder outreach are essential to the successful implementation of any fraud, waste and abuse program. Without appropriate outreach and education, provider pushback and appeals can occur. More concerning is providers may become disenfranchised from CHIP, affecting the Division's ability to provide services to the Medicaid population. In our experience, most providers support properly designed and implemented fraud, waste and abuse programs. Our claims analytics will provide in-depth information about each provider's billing patterns. This provides information on how billing may deviate from peer group norms. Providers identified as outliers may receive a letter detailing their abnormal billing trend and examples of the evaluated claims. If 12 months from the letter date there is no change in the billing pattern, we will consider an audit including review of medical documentation.

g. Process for providing supplemental third-party data and files to the Division.

We will continue to submit all required supplemental data and files to the Division in the frequency and format requested. Encounter data will include collections and claims information and retrospective findings via encounter adjustments. At the request of the Division, we can provide information not included in encounter data but may be necessary for the administration of TPL activity (e.g., casualty and estate recoveries).

We will report members — including, at a minimum, the member's name, Medicaid identification number, date of service, carrier name, carrier identification number, policy number and policy eligibility period — with third-party coverage per the Division's frequency and format. We will maintain information confidentiality as required by federal and state regulations. In addition, we will make requested data available to the Division (or its designated agent) during their annual TPL audit.

h. Process for reconciling third-party liability payments received on an annual basis for submission to the ...

When TPL payments are received, they will be applied back to the original claim. The TPL payments received will not be closed out until all dollars are accounted for and applied. We will provide a summary of these payments in the rate setting template annually.

2. Does the Offeror have an internal process in place to benchmark their TPL collections against "best ...

a. If yes, describe the Offeror's process.

Yes, we have an internal process in place to benchmark our TPL collections against "best practices" to make sure we are optimizing the TPL recoveries on behalf of the Division. The most effective TPL approach is cost avoidance, which rejects claims that should be covered by other available resources before payment when no evidence of EOB from the primary carrier is attached. We have a specialized team and formalized policies, procedures and systems dedicated to TPL identification, validation and recovery. This concerted effort — which includes requiring full participation from our subcontractors — verifies we are the payer of last resort for all covered services.

A team of dedicated and skilled COB operations staff validates each unverified TPL lead we receive from providers, members or the Division. If the Division provides validated leads, we will not revalidate unless the record cannot be auto loaded into the system. The team employs validation techniques, reports and regular open communication to monitor the process. Once we receive a vendor TPL file, the team evaluates third-party data for timeliness, accuracy and completeness through a stringent verification process eliminating all duplicates and verifying consistency with our cost avoidance and recovery policies. Validation methods include:

- Explanation of benefits received with claims
- Outbound calls to referenced carriers
- Web-based eligibility tools
- Online verification systems

B. Effectiveness

1. Describe any innovative approaches the Offeror will take to ensure that its Third-Party Liability program is ...

Our processes and procedures will allow us to carry out TPL discovery, cost avoidance and recovery activities effectively. Our experienced TPL staff will provide careful oversight and thoroughly researches and track any indication of other third-party coverage. **In 2021, across all our Medicaid businesses, we achieved more than $2.1 billion in cost avoidance savings.**

Our COB resolution process and dedicated team will make sure our Medicaid members are not held fiscally responsible, and the COB specialists will continue to follow any submitted issues until completion and resolution. We are committed to providing our members with effective cost avoidance and recovery services.

The subrogation program will consist of a combined prepayment and post payment process. The prepayment process will investigate potential accident claims before payment for coordination with available coverage under auto medical or work comp policies. This early detection and coordination will allow access to first party auto insurance benefits (PIP, Med Pay, No-fault) before they are exhausted and creates savings by redirecting claims to the primary payer.

We will use data analytics to continuously improve the performance of our subrogation and TPL programs. We will evaluate diagnosis codes to identify those with the highest potential for subrogation recovery and perform specified queries and data matches with a property and casualty insurance database to identify other insurers or parties to an accident. Our analytics team will perform matches with a litigation database vendor to identify members who may have an open personal injury lawsuit. We have multiple real time and other Application Programming Interface (API) processes to proactively identify new COB before claims payment. As part of the claims processing, these processes will use available real-time data and TPL sharing services to identify new COB, not already on file, to coordinate the claim in process. **Our real time and other API processes produced savings over $71.1 million in 2021 across all our Medicaid health plans.**

In addition, we will regularly analyze claims data for indicators that the member may qualify for Medicare benefits and use available TPL resources to identify the Medicare coverage information, when available. In a state similar to Mississippi, we are piloting a program for members who may qualify for Medicare but are not enrolled. Our pilot program works with the member to determine eligibility and then walks those qualifying members through every step of the Medicare enrollment process.

2. Describe any additional measurements the Offeror will use to measure the efficacy of its Third-Party ...

We have extensive experience coordinating benefits and thoroughly understand the coverage rules of other payers. The analytics team will use predictive analytics and a case scoring model to identify cases with the highest likelihood of recovery while reducing member abrasion. In addition, our internal database of property and casualty accident information will accelerate identification of cases with recovery potential.

Our comprehensive COB program is built upon organizational expertise, knowledgeable staff and an understanding of the financial and regulatory importance of COB/TPL activities, specifically for Medicaid plans. With extensive edits engineered to verify payments are not remitted on provider claims for non-covered services, our claims processing system is our primary cost avoidance mechanism. Additional edits will

automatically deduct the member's cost-sharing obligation from our provider payment. Additional cost avoidance techniques will include:

- **Third-Party Liability Data Collection and Validation:** Our COB team will validate each unverified TPL lead we receive from providers, members or the Division. Once we receive the Division's TPL file, we will use include the EOB received with claims, outbound calls to referenced carriers, the Council for Affordable Quality Healthcare COB Smart Utility, web-based eligibility tools and online verification systems and coordination with other payers to validate and confirm third-party resource and payment information.
- **Third-Party Liability Documentation:** Our COB team will enter pertinent member TPL information in our claims platform, with a COB indicator, policy number, group number and effective or term dates.
- **Coordination of Benefits with Third Parties:** Our claims platform filters and edits enable COB with a variety of payers, including Medicare, Special Needs Plans, Medicare Advantage Plans and Medicaid crossover claims through the Coordination of Benefits Agreement. We will coordinate benefits with auto insurance and commercial health insurance carriers.
- **Cost Sharing:** Any copayment, coinsurance or deductible required by the primary payer will be paid in full up to the allowed amount based on the contract requirements or the lesser of the other carrier's allowed amount or the Medicaid allowed amount. We will reject the claim and instruct the provider to pursue payment from the other payer unless a claim meets pay and chase criteria or if we receive a claim with the primary carrier's EOB.

[END OF RESPONSE]

4.2.2.11: Eligibility, Enrollment, and Disenrollment (Unmarked)

A. File Management

1. Describe how the Offeror will use the Division's eligibility and enrollment files to manage membership.

Using the Division's Eligibility/Enrollment Files to Manage Membership

Achieving Operational Excellence

A local and dedicated enrollment and eligibility team, working under the leadership of our chief operating officer, will collaborate with the Division to maintain accurate and timely eligibility and enrollment files. We will apply rigorous procedures for accepting and processing the eligibility and enrollment files successfully. Nationally, **we maintain an over 98% first-pass accuracy rate of inbound transactions** and apply a comprehensive enrollment process to confirm accurate member data loads, work first-pass fallout immediately and complete system updates in a timely manner. Automated updates will be completed on the same day the state file is received, and any needed manual reconciliation will be completed by the next business day. This thorough approach will make certain members and their families can access all available services from the first date of eligibility. We will use the files to manage membership as follows:

1. We accept the daily enrollment file from the enrollment broker via 834 Benefit Enrollment and Maintenance electronic transaction.
2. Upon acceptance, we load and process the file daily into our core transaction processing system, which stores member demographics, ethnicity, language preference, disabilities, special circumstances (asthma, pregnancy) and eligibility. The core platform facilitates member-tailored benefits administration, reporting, member services, claims payment and tracks eligibility.
3. We provide data to our enterprise data warehouse for reporting and data analytics.
4. We securely submit new member data for ID card and member information packet fulfillment.
5. We confirm membership information is available on the secure member and provider portals.
6. We provide membership information to applicable subcontractors and delegated vendors.
7. We provide member eligibility data to out-of-network providers so they can confirm member enrollment before treating the individual for non-emergent services.

Resolving Discrepancies

Our transaction platform will programmatically identify member enrollment file discrepancies. Standard operating procedures will be established to enable manual eligibility data entry and reconciliation using information provided in the Daily Recipient Extract File. Reconciliation will be performed daily to make sure all data discrepancies are resolved within 24 hours.

To guarantee data integrity, we will apply a five-step process to each file, as shown in the **following figure**.

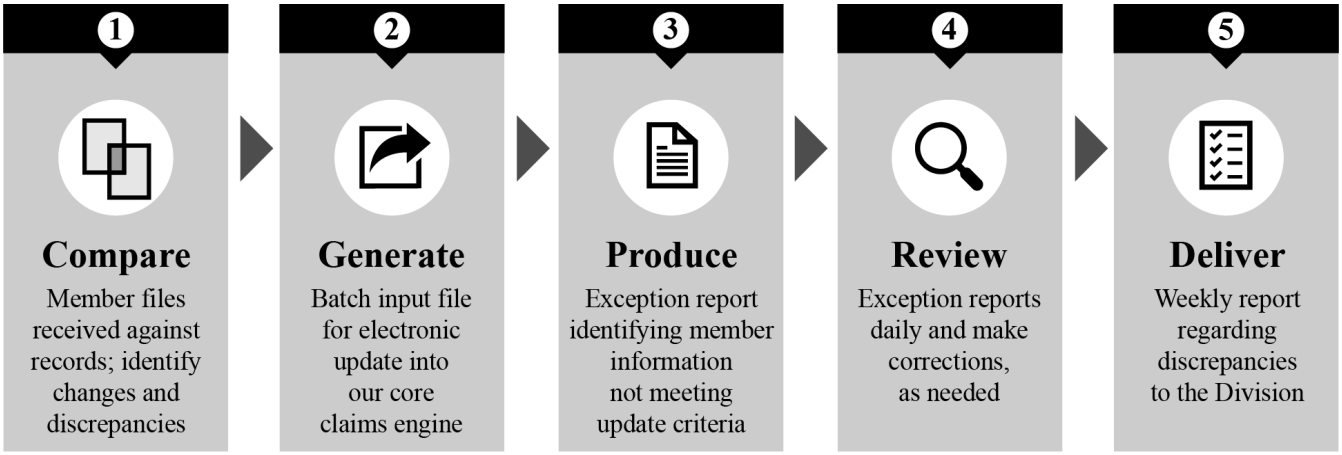


Figure 1. Robust and complete processes to maintain data integrity.

Accurate eligibility data is a high priority; we will compile a comprehensive database of member contact information to reach as many members as possible. We will complete an initial load to our database based on the address and contact information we receive from the Division in the eligibility file. The Division will ultimately determine eligibility for services and enrollment into MississippiCAN and CHIP, and the state will be considered the "source of truth" for member information. However, as we have seen in other states, it is not uncommon for members or their parents/guardians to report address and phone number updates to us directly. In these instances, member identity will be verified, and information updates made in our system temporarily to enable ID cards, member documents or other important information to reach the member as soon as possible. Because the state beneficiary database will be recognized as the source of truth for eligibility and enrollment data, the member will be advised to contact the Division directly to submit needed updates.

Driving Innovation and Value

We can further support member data accuracy through an address capture and reporting process. This approach will feature an automated, systematic method for capturing and reporting weekly member updates directly to the Division. We will use our core enrollment application system to identify new addresses and produce regular reports to the Division indicating member demographic changes received directly by our staff. In a state similar to Mississippi over the initial 10 months of functionality, this process identified over 100 unique changes captured at the health plan level, which we supplied to the state for correction. An enrollment innovation such as this will quickly deliver improvements in member contact information, achieve a higher level of core customer service and strengthen the ability to deliver member program enhancements.

2. Describe the Offeror's process for engaging Members who request to disenroll stay enrolled, including:

Engaging Members who Request Disenrollment

Relationship continuity, whether with a provider or with our health plan, is an important element in affirming members receive uninterrupted care. Throughout enrollment, we will take great care to engage MississippiCAN and CHIP members and their families in their health care and to fully understand the benefits of their plan. To support continuity of care, we will constantly assess factors influencing a member or a parent or guardian's request to disenroll from our health plan and will help them make the most optimal, informed decision regarding their health care.

a. Process for outreach and engagement of Members;

Based on our national experience, outside the annual open enrollment period, it is rare we receive notification from a member or a parent or guardian expressing intent to disenroll from the health plan; **in a state similar to**

Mississippi, we had only 370 requests to disenroll last year. However, we have accumulated strong experience in this area. If a member or a parent or guardian contacts us to request disenrollment, we will work to resolve the issue through appropriate and individualized interactions as described below:

Request Received via Member Services Center	▪ Service navigators "own" the issue from initial point of contact to resolution. They diligently work to identify any barriers to continual enrollment and resolve the issue. ▪ When assisting members, we will use Division-approved prepared questions to determine whether a specific issue is driving their desire to disenroll. When we have an option or remedy available, we ask if the available option will change the desire to disenroll. ▪ Using specialized assistance from a team of experts, including clinical and behavioral health staff, pharmacy and others, the service navigator can provide a thorough solution to the matter, regardless of complexity. ▪ Our efforts focus on educating a member or a parent/guardian on the plan benefits and continuity of care. Simultaneously, the service navigator can respond to the individual needs of the member or family, and we will encourage them to remain as a MississippiCAN or CHIP member.
Request Received via Care Manager	▪ For members assigned to a care manager, the care manager works to resolve issues that may be prompting them to contemplate disenrollment. We confirm continuity of care for all our members, in particular those members in our care management program, and work with the care team to overcome any barriers and resolve the issue.
Request Received via Community Health Worker	▪ Community health workers (CHWs) will intervene and provide successful resolutions to discourage disenrollment. Our CHWs personally connect with members and their parents/guardians, providing the education and resources they need to access timely and appropriate care. Through personal interactions, they will be able to understand issues members may be facing and identify solutions to overcome the problem. ▪ If needed, the CHW may engage additional care management resources to further assist with clinical needs.
Request Received via the Division	▪ If a member's family requests disenrollment for cause (such as not all related services are available within our network), a service navigator will contact them to identify any barriers and resolve the issue. ▪ If we are unable to address the member's needs satisfactorily and the family still wishes to disenroll, we will acknowledge the request and assist the member and their family with filing the request in writing to the Division.

b. Conducting Disenrollment surveys with Members to determine the reason for Disenrollment. Include how ...

Conducting Disenrollment Surveys

When the intervention to prevent disenrollment has concluded and a member or their family continues to seek to disenroll from the plan voluntarily, we will take immediate steps to understand why. Within five business days of the member's disenrollment, our member engagement specialists will conduct a state-approved disenrollment survey.

Disenrollment Survey Results
Less than 12% of disenrolling members reported dissatisfaction with our health care services in a state similar to Mississippi in 2021.

The survey asks the member or parent/guardian to share with us:

- Length of membership
- How often they accessed medical care
- How satisfied they were with the service they received
- The primary reason for disenrolling from the plan
- Their experience compared with similar services from other medical payers

We will collect, compile and deliver disenrollment survey results to the Division quarterly. Geographical trend charts identifying where disenrollments are occurring will be developed from the survey results. These results

will guide strategies identified by two strategic teams, a member retention team and a CAHPS task force team. These teams will use the results from the survey to improve the MississippiCAN and CHIP member experience.

Member Retention Team: The member retention team will comprise community outreach staff who use disenrollment survey results, among other data sources, to develop a strategic work plan about issues affecting member retention. They will use this information to improve member materials and enhance member engagement.

CAHPS Task Force: The CAHPS task force will review the disenrollment survey results and recommend specific interventions for implementation and program improvement as needed. Our task force will use trend data to provide targeted outreach and education efforts about the top disenrollment drivers, review survey results to identify and correct member issues and serve as a problem-solving entity for effective operations.

Retention Strategy
The CAHPS task force will examine areas for improvement in the membership experience. The retention team will collaborate with internal departments to strengthen MississippiCAN and CHIP, identify and correct member-related problems and serve as a problem-solving entity for effective operations.

Results Driven by Member Feedback Tools

Advancing Population Health Outcomes

As we continue to learn from our national Medicaid, Medicare and CHIP membership through tools such as the disenrollment survey, we will put these results into action. Examples of initiatives sparked by member feedback include:

- Increasing promotion of our nurse line — available 24 hours a day, seven days a week — so members are more aware of the availability of these services
- Expanding efforts through our "closed loop" initiative by deploying care managers to contact members who are having difficulty accessing services
- Identifying specific regions with elevated disenrollment requests and enhancing local community outreach about benefits and available services

c. The Offeror's draft disenrollment survey.

Our draft disenrollment survey is provided in **Att. 4.2.2.11-1 Disenrollment Survey**.

B. Assignment of Members to a Primary Care Physician

1. Describe the Offeror's proposed process to assign Members to a Primary Care Provider (PCP) within sixty ...

Assigning Members to a Primary Care Provider

For MississippiCAN and CHIP members and their families, assignment of the PCP will be the first step in establishing a medical home. The medical home is an important partnership between the member, the member's family and the member's other care providers.

Dedicated to a Healthier Mississippi

We will assign members to PCP within 60 calendar days of enrollment. Our preference is that members choose a PCP upon enrollment when we provide them with our provider directory. This active choice is highly correlated with overall health care engagement. However, when members do not make a choice, we will assign them to a high-quality PCP. The assignment algorithm takes many provider characteristics into account.

a. Assist Members when selecting a PCP and selection of a PCP for Members who do not make a selection;

Our member services call center will be equipped to assist members in selecting a PCP. However, if the member does not choose, or contacts us to assist, we will use an analytics tool with detailed algorithms for PCP auto-assignment using these criteria:

- A historical provider relationship recognized through claims history
- The current PCP/patient-centered medical home (PCMH) assignment of an enrolled immediate family member, if the member lacks a historical provider relationship
- Age, gender, language preference and geographic proximity, if the member does not meet the criteria for historical or family PCP/PCMH assignment
- Primary care provider quality analysis prioritizes network PCPs based on quality-of-care criteria and PCMH NCQA recognition

By maximizing this analytics tool, we will have the ability to review the member's location and important demographics such as preferred language, resulting in a logic-based auto-assignment to a PCP/PCMH able to meet the member's needs.

As shown in the figure, welcome calls to new members and their families are our opportunity to gather information and assist with member needs, discuss the features they desire in a PCP and help them change the auto-enrolled PCP if there is a more appropriate option. Primary care providers can be changed at any time a member requests the change and for any reason. Each welcome call will be individualized to meet the needs of the member but will include these essential topics:

Upon completion of the initial Health Risk Screening, if the member is determined to have a risk level assignment meeting our care management criteria, the member will be assigned a care manager. Care managers will complete a comprehensive health assessment and confirm members and their families have an assigned PCMH. If the member wishes to change, the care manager will help select the most appropriate PCP/PCMH. Each member is steered toward optimal use of their PCMH as the medical home for community-based health and preventive services.

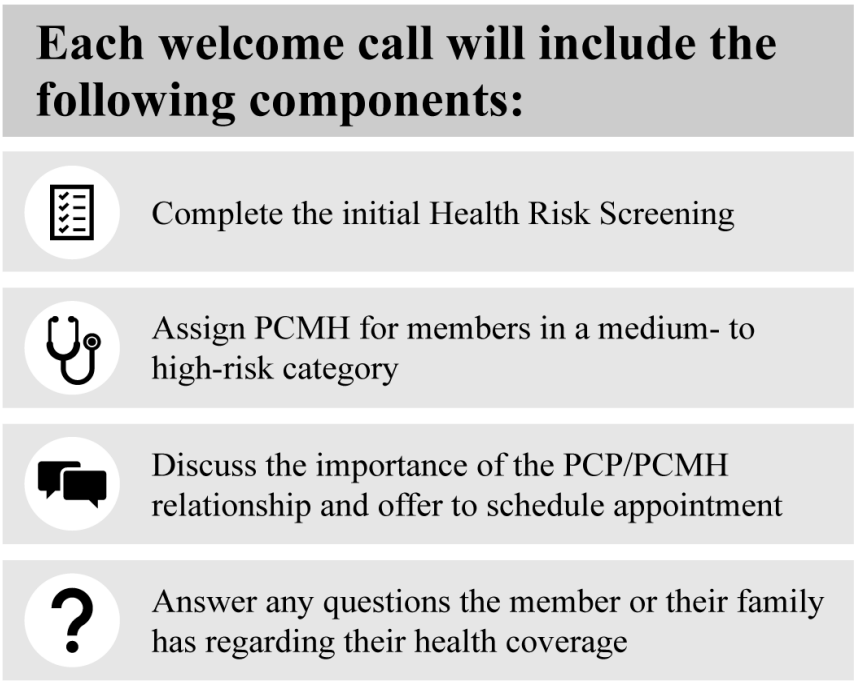


Figure 2. Welcome call components.

b. Track data to confirm that every Member is assigned;

Achieving Operational Excellence

To track data confirming PCP/PCMH assignment for all members, we will run a monthly report detailing a full list of current eligible members, their PCP/PCMH name and ID. Our eligibility team leader will review this report to confirm 100% of all members are assigned to a PCP/PCMH within 60 days of enrollment. For any member who cannot be loaded into the system or assigned to a PCP/PCMH automatically, our eligibility team will perform a manual load and assign the member to an appropriate PCP/PCMH, still complying with all contractual time frames. Over the past year, in a state similar to Mississippi, we successfully assigned 100% of all members to a

PCP/PCMH; our systems to assign members and our processes to track the data are well designed and function to verify compliance.

c. Inform PCP/PCMHs of new Members within the required time frames; and

We will work with our PCP/PCMHs in several ways to provide notification of newly assigned members within the specified five-day time frame. We update PCP/PCMH member assignments on the provider portal daily, email them about the change to their roster and encourage providers to access their roster using this medium. This offers a better overall experience by delivering up-to-date information, allows the provider to use our other website features and reduces the risk of inadvertent protected health information release. The roster on our provider portal will offer the following benefits:

- Delivers up-to-date access, 24 hours a day, seven days a week
- Displays in Excel format and is filterable and sortable
- Allows access at the taxpayer identification number or individual level
- Contains specific clinical data gaps to support person-centered care
- Identifies members added within last 30 days

We will notify providers of member roster updates with a notification postcard advising the PCP/PCMH to access the provider portal. We will perform annual audits via our provider verification and outreach team to make sure our contact information is current, complete and accurate. In addition, when we engage PCPs in VBP arrangements, our clinical support nurses will have face-to-face provider meetings to review their member panel and any care gaps. Finally, PCP/PCMHs can receive detailed member panel information and verify enrollment by calling our provider services call center.

d. Confirm that PCP/PCMHs received the list of assigned Members.

We will update member panel listings daily and make them available through on-demand access via our provider portal, and we automatically email providers when a member is assigned to their roster. Provider advocates will run monthly reports to verify our PCP/PCMHs are accessing their member rosters on a consistent basis. Primary care providers/patient-centered medical homes who have not accessed their rosters monthly will be flagged and contacted by a provider advocate who will help them access the report and onboard their new membership. Our provider advocates will verify the provider's email address and support them in gaining access to the provider portal and understanding how to use applications to view member panel details. Providers who experience member panel changes because of new member assignments, changes or program disenrollment will receive notification updates through monthly postcard mailings informing them of new assignments, as well as how to access the roster through the provider portal.

Our innovative member services module will address preventive care engagement in every interaction with a member.

Over a six-month period in a state similar to Mississippi, our service navigators engaged in over 1,400 conversations about gaps in care when members called for other reasons. This enhanced member engagement provides personalized and actionable health education and resulted in an additional 200 health care appointments scheduled during the member call.

2. Provide a sample of the report the entity will use to notify PCPs of their assigned Members.

A sample of reports that we will use to notify PCPs/PCMHs of their assigned members is provided in the following pages. These notifications deliver instructions to PCP/PCMHs on visiting our provider portal to access their updated roster.

Primary Care Physician Roster – [last name, first name]
Roster as of: yyyy-mm-dd

	A	B	C	D	E	F	G	H	I	J	K
1	LAST_ NAME	FIRST_ NAME	ID	PATIENT_DOB	RISK_CATEGORY_NAME	RISK_ SCORE	CLIENT NAME	NEXT_CONTACT_ DATE	ASSIGNED DATE/ATTRIBUTED DATE	ADDRESS	PHONE NUMBER
2	DOE	JANE	00001234567	1999-09-22	Higher Needs - Medical			07-29-2020 14:00	1/16/2020	305 FREEDOM LN,NORTHAMPTON COUNTY,EASTON,08045,PA	1234567891
3	SMITH	JOHN	00008910111	2005-10-07	Lower Needs - Medical				4/22/2020	821 RIVERSIDE DR,NORTHAMPTON COUNTY,EASTON,08045,PA	1234567892

	L	M	N	O	P	Q	R	S	T	U	V	W
1	INSURANCE ID	PROGRAM_ NAMES	LAST_ CLAIM	LAST_VISIT_DATE	NEXT_VISIT_DATE	PCP_NAME	ER_ VISITS	APP_ VISITS	ADTDAYS_ COUNT	DUE_ DAYS	FAMILY_ ID	PSU_ SCORE
2		High Risk Pregnancy	04-02-2020 04:00			AMI C LEE	1	0	0	0	123456789	N/A
3			04-12-2019 04:00			JEFF PETRIE	0	0	0	0	123456790	N/A

	X	Y	Z	AA	AB	AC	AD	AE	AF	AG	AH
1	CARE_ MANAGER	CARE_ MANAGER PHONE	MEDICAID_ID	RESIDENCE_STATUS	PCP_PHONE_ NUMBER	ROI_VALID_ FROM_DATE	ROI_VALID_TO_DATE	MBR_EFF_DT_ WITH_PCP	AA_ INDICATOR	MEDICAID_RECERT_ DATE	PROVIDER_ NPI
2	SUSY MAE	N/A	0009646268	N/A	1234567895	N/A	N/A	12/01/2018	AUTO	9/30/2019 12:00:00 AM	1962956410
3	DAVID OWNSLPC	N/A	0009646269	N/A	1234567896	N/A	N/A	10/01/2019	SELF	8/31/2020 12:00:00 AM	1962956411

- Providers may run reports on-demand
- Members automatically populate when assigned
- Identifies members added within last 30 days
- Flexibility to add and remove export fields for customization
- Flexibility to pull at individual provider level or TIN level to support large and small practices
- Contains clinical data to support whole person care
  - HEDIS, GAPS, IH Admits, ER Discharge
- Ability to enhance report based on business need
- Internal access has same view as provider

Notification of Roster Change

There has been a change to your roster of [redacted]
Plan members. The roster identifies our members who have selected you as their primary care provider (PCP).

Company Logo
Company Information

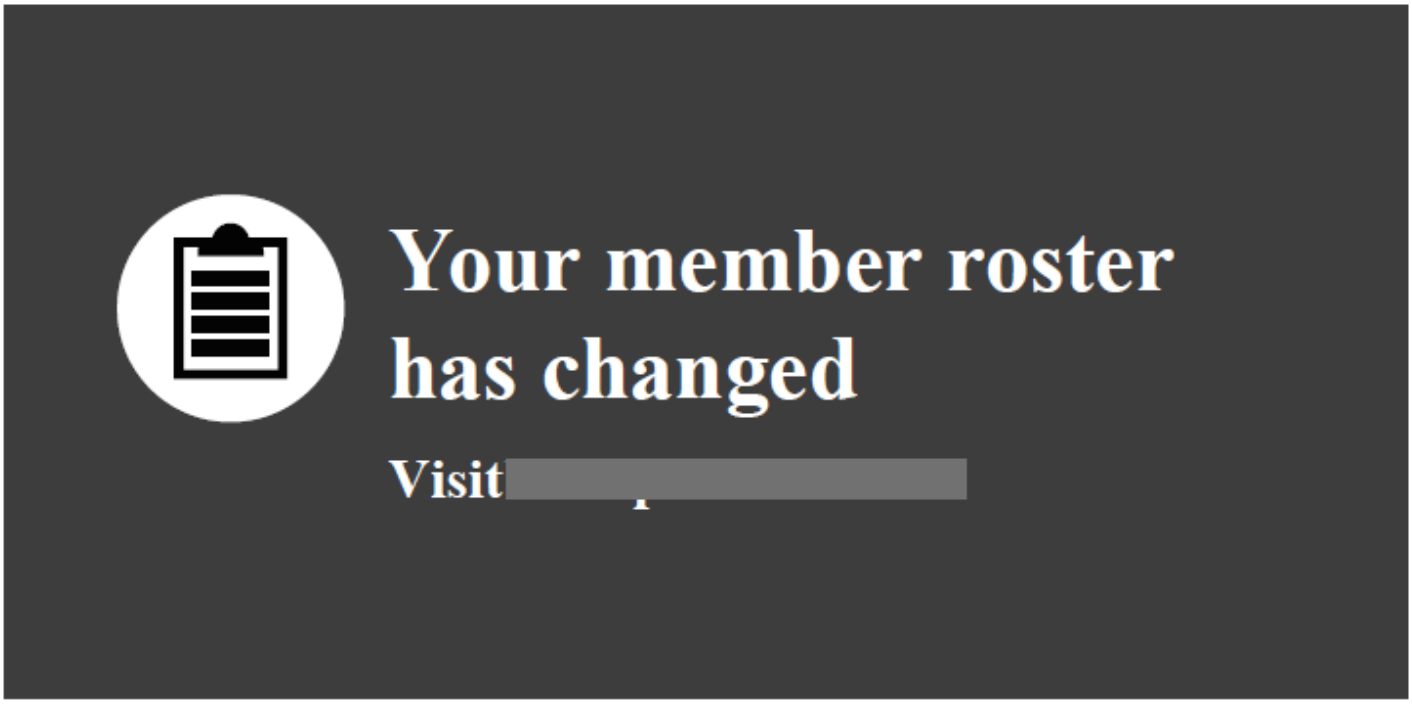
[redacted]

Please visit [redacted] >
[redacted] Provider Portal >
Clinical & Pharmacy > [redacted]
[redacted] >
Panel Roster for CAN or CHIP.

If you have questions,
please call [redacted]

Thank you.

[redacted]



Company Logo
Company Information

3. Describe the entity's proposed process to ensure that any new Member has an appointment scheduled with ...

Ensuring New Members Have Appointments Within 90 Days

We recognize maximizing the number of members who have a relationship with a PCP/PCMH goes beyond assignment. We will encourage members to develop a relationship with their PCP/PCMH and engage in their own health care. Scheduling an appointment is the first step toward developing the PCP/PCMH and member relationship. We will use multiple methods as part of our process to make sure new MississippiCAN and CHIP members schedule an appointment with their PCP/PCMH within 90 days of enrollment, including:

- Providing enhanced service navigator support during member calls to remind and assist members in making an appointment
- Providing care manager support to the best-fit selection of member PCP/PCMH and assist with appointments
- Tracking which members failed to schedule or keep an appointment with their PCP/PCMH and directed outreach to resolve the gap
- Outreaching to providers to collaborate
- Distributing member engagement and educational materials
- Monitoring data to confirm our efforts are effective

Staff Interaction with Members

As described in the following figure, we will educate our staff about overcoming barriers to help members make and keep their appointments. Our service navigators will interact with our MississippiCAN and CHIP members to provide the following personalized communications that encourage member PCP/PCMH connections:

- **Welcome Calls:** We will call new members to introduce them to the MississippiCAN program and CHIP. During the welcome call, we will provide program information, administer the initial Health Risk Screening and advise the member to visit their PCP/PCMH within 90 calendar days of enrollment. Service navigators will aid in scheduling appointments with the member's PCP/PCMH.
- **Member Services:** Members who contact our member services department will be encouraged to visit their PCP/PCMH; our service navigators will assist with scheduling appointments and transportation, if needed. Our innovative member services model provides service navigators with desktop information indicating when members have gaps in care so the service navigator can work with the member toward resolution.
- **Care Managers:** The care manager will collaborate with providers to verify the members enrolled in complex care management assigned to their panel are receiving services within 90 days of enrollment.
- **Community Health Workers:** Community health workers in Mississippi will use their knowledge of local communities to locate and engage members, establish relationships to connect members to their PCP/PCMH and coordinate appointments to remove barriers in care. The CHW will personally interact with the member to identify and resolve barriers preventing a member from scheduling an appointment with the selected PCP/PCMH within at least 90 days of enrollment.

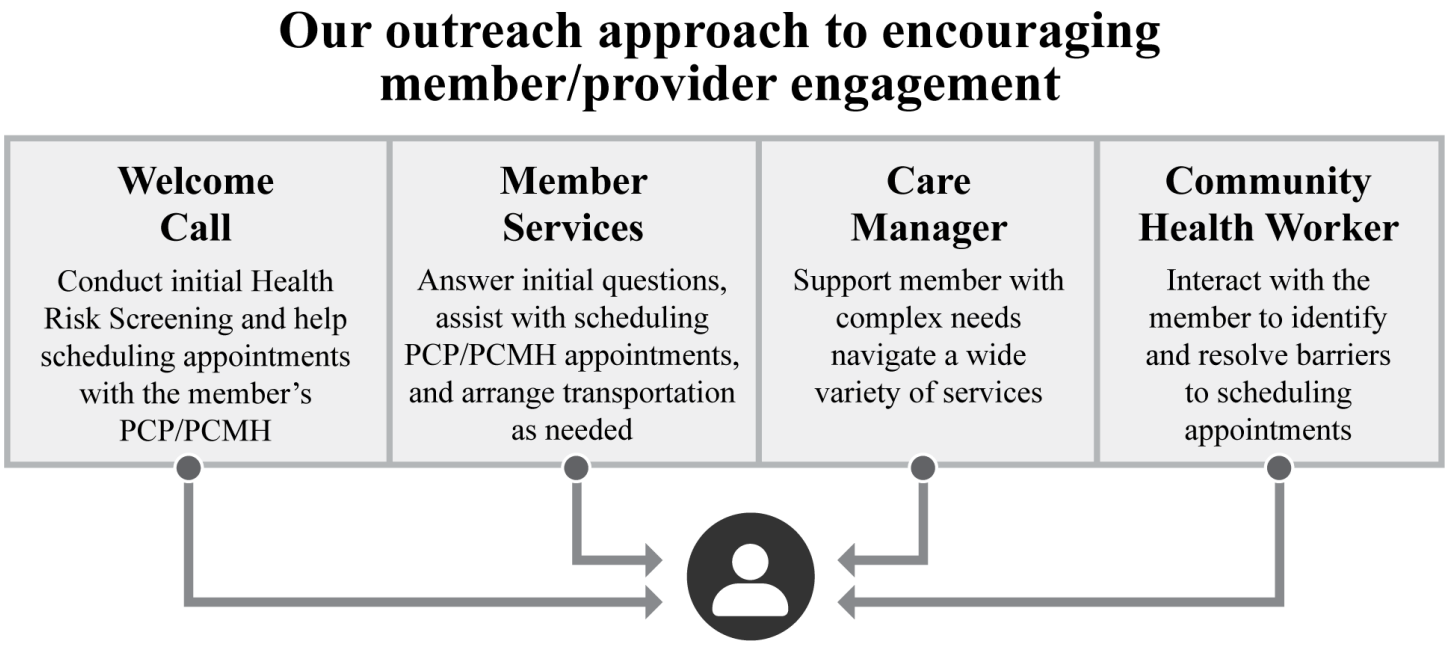


Figure 3. Staff interact with members in multiple functionalities, but all will focus on preventive care.

Provider Outreach

Nurturing Local Partnerships

We will provide PCP/PCMHs with information about their roles and responsibilities as a PCP/PCMH, including scheduling an initial appointment with each new member within 90 days of enrollment, and we will provide regular updated member rosters of the members assigned to their practice. If the PCP/PCMH office encounters any difficulty in reaching a new member, they can contact our member services department for assistance. We will poll PCP/PCMHs quarterly to assess compliance with appointment availability and provide follow-up education for those not meeting the established state standards.

Distribution of Member Engagement and Educational Materials

Our MississippiCAN and CHIP members will receive their ID card, printed with the PCP/PCMH's name and telephone number, with our welcome letter within 14 days after we receive notice of the member's enrollment. The welcome letter will provide easy-to-follow guidance, instructing members about the date their coverage begins, how to schedule an appointment, how to contact our member services department for assistance and how to obtain a copy of the provider directory. The welcome letter will encourage new members to register on our secure member website to find additional health plan and benefit information, including the ability to learn about their benefits. Once members are securely registered, they can download our mobile application for access to important information on the go, including access to the member ID card, provider searches and multiple ways to contact us. Members will receive our member welcome guide providing easy access to the important information they need right away. Our member welcome guide will be customized for the MississippiCAN program and CHIP and will provide basic information helping members learn how to get assistance, how to access care, how to make an appointment with their PCP/PCMH and the benefits and services covered under their health plan. The final piece of our welcome packet is our comprehensive member handbook, which will include a wealth of information and thorough and repeated messaging on the importance of scheduling a PCP/PCMH appointment.

4. Describe the entity's proposed policies and procedures for designating a PCP/PCMH as a specialist for Members with disabling …

Our Policies and Procedures for Designating a PCP/PCMH as a Specialist

Medically vulnerable individuals, including members with special health care needs, often have a level of need best met by a specialist who assumes the role of PCMH. Generally, members may choose a specialist as their PCP/PCMH when the specialist previously provided care to them or if the specialist has experience treating the relevant condition.

Examples of members who may be better served through a specialist designated as their PCP/PCMH include:

- A member who requires dialysis three days a week may be more comfortable with their nephrologist serving as their PCP/PCMH.
- A member with a specific diagnosis, such as cancer or sickle cell anemia, visits their oncologist or hematologist two to three times a week, but rarely visits a PCP/PCMH provider.
- A member within the intellectual/developmental disabilities program may prefer to name a provider with developmental and behavioral health expertise as the preferred PCP/PCMH.

Our experienced service navigators in Mississippi will receive training to assist members and families with appropriate PCP/PCMH selection, including how to assist members identified with disabilities, chronic conditions and complex conditions select a specialist as their PCP/PCMH. Our provider advocates will work with the member's selected specialty physician to obtain their consent to serve as a PCP/PCMH, including:

- Agreeing to provide or arrange for all primary care, including routine preventive care
- Providing those specialty medical services consistent with the member's disabling condition, chronic illness or special health care need per our care standards and within the scope of the specialty training and clinical expertise
- Confirming the specialist's admitting privileges at a network hospital

5. Describe the entity's proposed process for communicating with Members about their PCP/PCMH assignment and encouraging …

Communicating with Members about Primary Care Provider/Patient-Centered Medical Home Assignment

We will initially notify members of their PCP/PCMH assignment through our welcome packet mailing. The member's PCP/PCMH name will appear on the ID card. The enclosed welcome letter will highlight the member's benefits start date and encourage members to schedule an appointment with their PCP/PCMH. The letter will invite members to contact our member services team (contact information provided) for assistance with scheduling a PCP/PCMH appointment or changing their PCP/PCMH.

We will follow the welcome packet to MississippiCAN and CHIP members with a phone call to welcome members. Our service navigators will place these outbound calls to initiate member participation and provide personalized service, including information about the member's assigned PCP/PCMH, and assist with scheduling the initial appointment. We will make welcome calls using Division-approved tools and scripting to provide validated information and answer any immediate questions our members may have. Our service navigators will access free interpretation services to assist members who speak languages other than English. They will verify the member's address, confirm receipt of the ID card, discuss the importance of a PCP/PCMH, address PCP/PCMH access issues and change the PCP/PCMH, if needed.

In addition to our welcome call and welcome packet, we will inform members about their PCP/PCMH options through our secure member website, where members can access our intuitive provider search tool. Members will learn about their PCP/PCMH options through interactions with staff, including care managers and service

navigators, who assist with PCP/PCMH changes and help schedule appointments. Through each channel, we will clearly and consistently communicate to our MississippiCAN and CHIP members that they may change their PCP/PCMH at any time. This approach supports member empowerment, encouraging members to select PCP/PCMHs with whom they are comfortable, and results in the member being more likely to schedule and attend appointments.

Encouraging Members to Visit Their Primary Care Provider and Attend Scheduled Appointments

Our member-centric services model goes beyond typical customer service to combine member empowerment, enabling our service navigators to first assist the member with the reason for their call, and then apply member data and engagement techniques to benefit the member's health, emphasizing preventive health care. Service navigators will view desktop information allowing them to engage members who have gaps in care and work with the member toward resolution, whether that is scheduling an appointment or simply providing education about a benefit or needed screening.

Member Services Module Desktop Information	How the Service Navigator Uses the Information
Member has gaps in care (immunizations, wellness exams and so forth)	Our service navigator steers the conversation toward working with the member to resolve gaps and further helps by contacting the PCP/PCMH to schedule an appointment and arranging transportation if needed.
New MississippiCAN or CHIP member	Our service navigator makes sure the member understands the program and benefits, and that they received the new member materials. The member will have the opportunity to complete their Health Risk Screening and schedule a new PCP/PCMH appointment.

We will go even further to provide education and encourage completion of covered preventive service. Our innovative texting program will focus on members' preference for outreach. Members can be reached via text, automated phone call, live phone call or email. The goal is to improve the number of members we reach through outreach campaigns. The outreach education will focus on educating members about needed preventive care screenings or care required related to current medical conditions.

6. Describe the Offeror's proposed process for communicating with Members about PCP/PCMH assignments ...

Driving Innovation and Value

To make sure members are using their PCP/PCMH, we propose to use the following tools to monitor PCP/PCMH usage, identify gaps in care and resolve member barriers toward making and keeping their appointments:

- We will monitor member preventive care utilization by age and geographic location categories as a part of our health equity program. We will target quarterly outreach efforts to those geographic locations with the lowest rates of participation.
- Our provider portal will provide online tools and resources that will help providers streamline their work. When the PCP/PCMH checks their assigned member roster through the provider portal, we will automatically identify 90-day appointment, HEDIS®, EPSDT and immunization gaps for the member.
- We will use claims data and our predictive modeling tool to identify need, stratify member risk and coordinate services with members and PCP/PCMHs. We will track preventive services received through our sophisticated claims illustrator, which includes information on appointment attendance and a member's utilization of their PCP/PCMH. Our secure web-based care management system will automatically integrate claims and clinical data to identify the PCP/PCMH's members with gaps in care, or those who require follow-up care.

Member Outreach

We will send monthly notifications and reminder emails to our MississippiCAN and CHIP members who have gaps in care about the value of well-visit preventive services with their assigned PCP/PCMH and provide instruction on how to schedule an appointment. We outreach using evidence-based practices proven to be effective, including targeted emailers, reminder calls, direct person-to-person outreach calls and education by the care manager. We will identify and monitor members in the following ways:

- Our service navigators will perform welcome calls to all new members, providing information on all covered health and pharmacy services, including PCP/PCMH assignment, and assist in scheduling the initial appointment. We will conduct an initial Health Risk Screening with the member to identify potential health care and care management needs and determine the member's risk stratification level and the need for care management referral. If they can identify a barrier in PCP/PCMH utilization, such as transportation, the service navigator can help to resolve the issue directly with the member.
- We will send bilingual email reminders to notify members of the need for wellness and prevention visits with their PCP/PCMH. The notification will include due dates of screening or preventive services and concise directions on how to schedule an appointment. We will send a second notice if a screening visit has not taken place.
- We will make pre-programmed telephonic messages in English and Spanish to members identified as needing a specific preventive service, including initial 90-day appointments, immunizations and annual physical exams.
- Our outreach coordinators will make direct calls to members/families who have not scheduled the required services with their PCP/PCMH. Our care managers will engage enrolled members to assist with care needs. If a member communicates a barrier in PCP/PCMH utilization, the service navigator, outreach coordinator or care manager will resolve those issues directly with the member.
- After sign-up through our member portal, members will receive text messages reminding them to either take or refill their medication or reminding them about needed preventive care screenings or care related to their medical conditions.
- We will analyze the data we receive about PCP/PCMH utilization and create specific focus groups and surveys to target members who have not used their PCP/PCMH to identify reasoning behind the lack of utilization and what we can do to improve their experience using these services. We will then put those lessons into action to improve our services and proactively resolve the barriers members face in making full use of their PCP/PCMH.

C. Member Information

1. Describe the Offeror's proposed process for providing Members with information packets, including ...

Our Member Information Processes

We will create and deliver engaging and easy-to-understand information packets to our MississippiCAN and CHIP members within 14 calendar days of enrollment. **In a state similar to Mississippi, we have been 100% compliant with meeting the 14-day requirement for over 10 years**. Further, we will provide the Division with a copy of a member information packet annually — or at any point we make changes — for review and approval.

Evaluating the Effectiveness of our Communications

To evaluate the effectiveness of our communications, we use many methods, including:

- Community Partnership Advisory Council that includes members and community partners who provide us with feedback on effective ways to gain participation in outreach and education activities
- Key Member Indicator study
- Focus groups
- Member website survey
- Disenrollment survey
- CAHPS surveys

All of our new member materials will share a single theme: "Simple for you. That is our promise." We will develop our materials using an internal initiative to enhance health literacy by simplifying communications. We will write member materials at or below a third grade reading level and forward to the Division for approval. To confirm our member materials do not exceed third grade reading level, we use an internal readability tool that rates and confirms the materials we produce are easy to read, understand and act upon, and they present information most members can easily understand. The readability tool database, based on the Flesch-Kincaid reading level tool, provides us with word count and vocabulary grade level. We provide examples of the materials included in our information packet following our response to this section.

a. Language alternatives that will be available;

Increasing Access to High Quality Care

Using the 834 file delivered to us from the Division, we will collect information about our members so we can tailor our communications to Mississippi populations. An internal analytics tool will monitor the 834 files to determine our members' language preferences. In addition to the file from the Division, we will use information collected during member calls and member interactions with care managers and CHWs. We will capture language information from grievance and appeals, requests for translation services, requests for member information in alternate languages, requests for providers who speak specific languages or requests for special services for the hearing impaired. We can provide verbal and written member resources in any other languages needed by our members.

To support members who require alternative language options, our staff can access a language line solution that translates one language into another language. The language line provides accurate and complete first-person interpretation regardless of the speaker's country of origin or level of education. Interpreters are available 24 hours a day, seven days a week, to analyze the original message and select words that most accurately convey the true meaning of what is said. We will have access to translators who can accommodate all languages spoken by the member population and their families in Mississippi. It is important to note our plan provides free TTY and translation services to network providers when interacting with our members and their families.

When we identify a predominant language in more than 5% of members or potential enrollment base, we will translate core marketing and health information materials into that language using CMS and state requirements, special needs issues and best practice standards from professional organizations. Upon request, we will translate materials for a member on an individual basis as requested to make sure their needs are met.

b. How the entity will comply with information requirements listed in Section 3.2.6, Contractor Member ...

In compliance with the requirements, we will provide each member with an information packet indicating the member's first effective date of enrollment. We provide this information packet to the member within 14 calendar days after receiving notice of enrollment. We will use first-class or priority mail delivery services to provide the member information packet and provide a copy of the welcome packet to the Division on an annual basis for review and approval or at any point we make changes to the packet. For those members who re-enroll within 60 days of disenrollment, we will send a new identification card to the member and, upon request, resend the new member information packet.

Our new member information packet will include the member ID card and our welcome letter, which encourages members to make an appointment with their assigned PCP/PCMH. To help our members get started immediately, we will include each member's benefits start date in large bold print on the welcome letter. The welcome letter encourages new members to get connected by registering on our member website to review additional health plan and benefit information, including the ability to search for network providers. The welcome letter will include information on how to obtain a copy of the provider directory that is available in a user-friendly searchable format on the member website.

Another method to engage our MississippiCAN and CHIP members will be our member welcome guide. When new members first join a health plan, they often feel they do not have enough information, or they feel overwhelmed by too much information. Our member welcome guide will help new members access the important information they need easily in a simplified format. We created and tested the welcome guide in a blind study with a focus group of Medicaid members, both new and experienced with Medicaid, including multiple ages, genders and various family statuses. Our new member information packet will include the member handbook, an important resource and engagement tool for members and family members that contains essential information, including a summary of benefits, new member information, key contact information and health education. We designed it to be easy to read and simple to navigate.

c. The entity's proposed methods and creative approaches for obtaining correct Member addresses

As an experienced state partner in multiple states similar to Mississippi, we have developed best practices in obtaining correct member addresses to increase our chances for successful engagement. We will validate the member's address through every call we place or receive from a member. In addition, we will make available the Division-approved change of address forms at local community events for members to submit to the Division.

For our members in Mississippi who are difficult to locate due to non-reported address changes, limited phone access or minutes, homelessness, or inadequate housing, we will employ local CHWs in Mississippi who apply their knowledge of the community and follow up with community organizations, providers (including pharmacies) or community groups to get updated contact information. In addition, our Mississippi housing navigator will develop community partnerships with organizations, including the local Continuum of Care agency and local shelters that may allow individuals to use their address, along with other organizations that work with people who are homeless or who may have housing needs. Through these partnerships, we will explore the ability to contract with them to identify our members who are actively using their services, thus increasing our ability to locate members who are difficult to reach. An employment navigator will be available whose role will align with the housing navigator. They, through partnership and outreach, will help us locate members who are difficult to reach.

d. Process for following up with Members whose information packets or identification cards are returned.

When we receive returned information packets/ID cards, we will place these members at the top of our new member welcome call queue, providing our service navigators with a telephonic opportunity to speak with the

member and obtain a valid address. During all interactions with our members, we will verify their address and contact information and encourage them to keep their records updated. If our welcome call attempts to reach a member are unsuccessful, we will begin a "data mining" process to find the correct address, using the U.S. post office databases. If we are successful in the data mining phase, we will send a letter to the member requesting they contact our member services center. If we do not receive a response within 15 business days, we will engage our care management team, which includes care managers and behavior health advocates. If at any point we identify a valid address, we will update the validated information in our systems and encourage the member to contact the Division to update their contact information. We immediately resend the new member information packet, including the member's ID card. **In 2021, in a state similar to Mississippi, we had only four member information packets containing ID cards returned to us where we were unable to locate the member.**

e. Offeror may choose to include sample member materials in excess of the page limit.

A sample of our member materials is provided in **Att. 4.2.2.11-2 Member Welcome Guide**.

[END OF RESPONSE]

Att. 4.2.2.11-1 Disenrollment Survey

READABILITY
Flesch Reading Ease: 82.5
Flesch-Kincaid Grade Level: 2.9

Proposed MississippiCAN and CHIP Disenrollment Survey Sample

Introduction

In compliance with the MississippiCAN and CHIP reporting requirements, we are providing the following proposed Disenrollment Survey Report used to measure the reason for member disenrollment.

The information below reflects the proposed disenrollment survey questions and methodology for the Mississippi Division of Medicaid to review and evaluate.

A. Sampling Methodology

According to the proposed methodology, 100% of the members who disenrolled are targeted and surveyed by the Plan to determine the reason for their decision. The Plan is able to approach 100% of the members because the universe is very small currently and it is forecast to continue to be minor in numbers.

B. Survey Administration Methods

We will administer the following methodology in conducting the disenrollment survey:

- Three attempts will be made by the auto-dialer.
- If the auto-dialer reaches the member, they will be asked several questions to measure the reason for the disenrollment.
- If the auto-dialer is unable to reach the member, a message will be left.
- Members who respond to the message may return the call to the inbound call center.
- An inbound database will be created to include members receiving outbound calls from the call center.

C. Draft Member Disenrollment Survey

Below is a draft of the disenrollment survey for the Mississippi Division of Medicaid's review and evaluation.

MississippiCAN and CHIP Customer Disenrollment Survey

Survey Script

"We are very sorry that you decided to discontinue your membership with us. We are interested in improving our products and services to keep valuable customers. Would you please take a few moments to fill out this brief survey to help us understand how we can improve?"

This survey will take less than 5 minutes to complete**.**

1. How long were you a member with us?

- ☐ **Less than 6 months**
- ☐ **More than 6 months but less than 1 year**
- ☐ **1-3 years**
- ☐ **Over 3 years**

2. How often did you access medical care (doctor/pharmacy/case management) using our services?

- ☐ **Once per week or more**
- ☐ **2 to 3 times per month**
- ☐ **Once per month**
- ☐ **Less than once per month**

3. Overall, how satisfied were you with your service with us?

- ☐ **Very satisfied**
- ☐ **Somewhat satisfied**
- ☐ **Neither satisfied nor dissatisfied**
- ☐ **Somewhat dissatisfied**
- ☐ **Very dissatisfied**

4. Please tell us why you feel that way.

5. What was your primary reason for discontinuing your membership with us? *

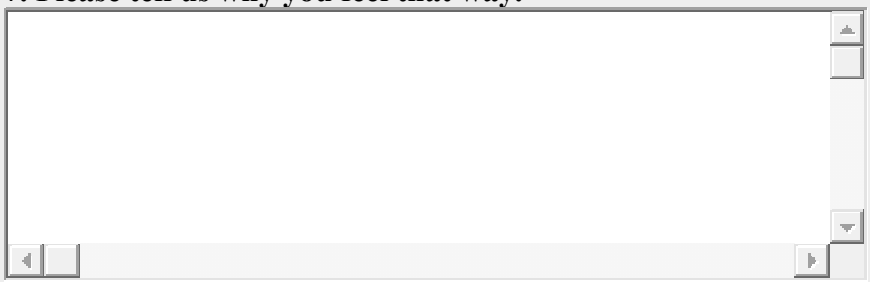
- ☐ **I wasn't aware that I was switched***
- ☐ **My doctor told me to leave**
- ☐ **Moving to another doctor**
- ☐ **Your services did not meet my expectations**
- ☐ **I no longer need services**

"If you have questions about the change of your enrollment, please contact the Division of Medicaid at 1-800-421-2408."

6. How did our service compare to similar services from other companies and other medical payers?

- ☐ **Much better**
- ☐ **Somewhat better**
- ☐ **About the same**
- ☐ **Somewhat worse**
- ☐ **Much worse**
- ☐ **Don't know**

7. Please tell us why you feel that way.



Thank you for your time and valuable input.

Att. 4.2.2.11-2 Member Welcome Guide

Readability
Flesch Reading Ease: 87.8
Flesch-Kincaid Grade Level: 3.0

Member Welcome Guide

Simple for you. That's our promise.

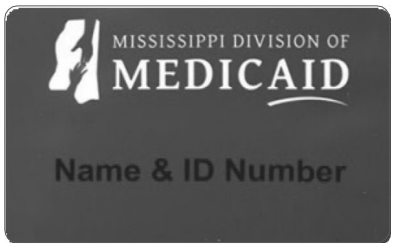
Thank you for joining. We want to be sure you have all the information you need to make this the best health care experience possible. This guide will walk you through the important steps for getting started.

Do you have your member ID cards?

You will need these 2 cards when you get health care services.

This is your member ID card. If you have not received this card, please call us at

TTY **711**.



This is your State of Mississippi Medicaid ID card. If you did not receive this card or if you need a replacement, contact toll-free at **1-800-123-4567**.

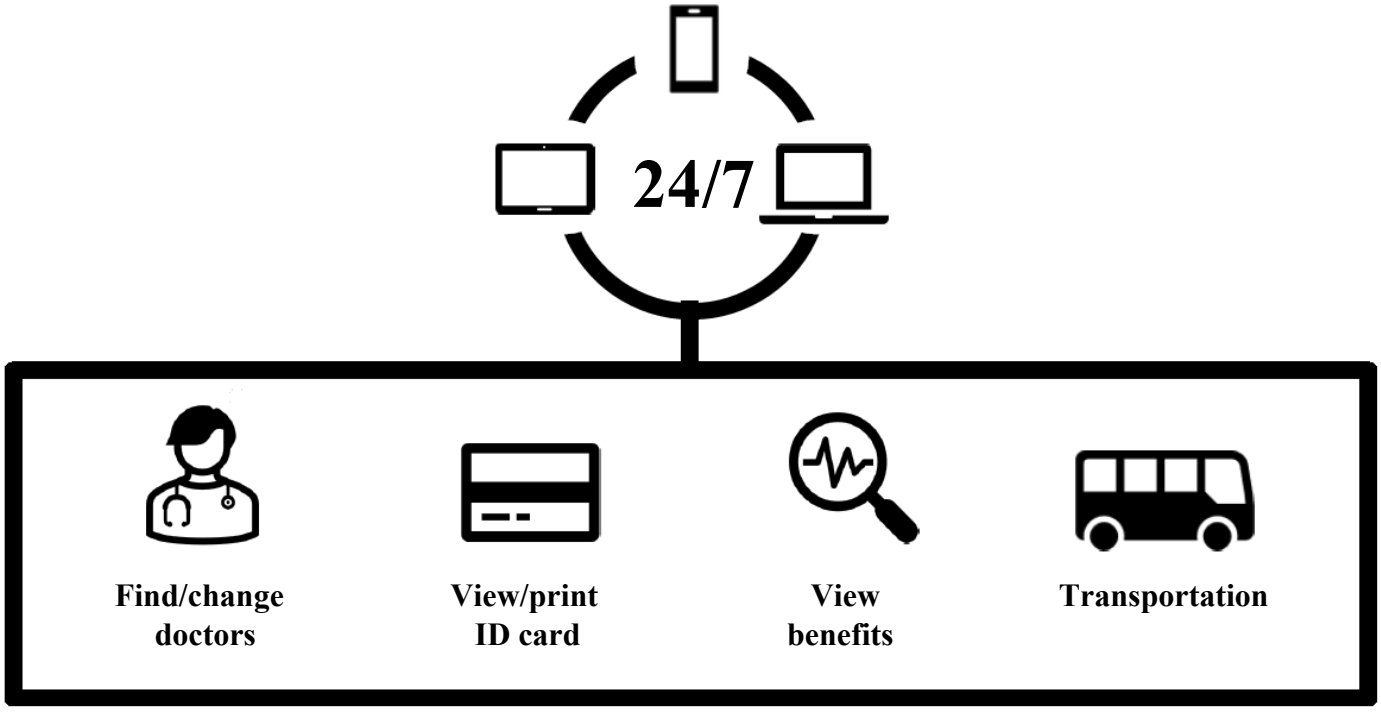
Get connected

Sign up for 24 hours a day, 7 days a week access to your health plan at **website**. It's fast, easy and secure. Use your computer, tablet or mobile phone. We make it easy to get the information you want and need.

- **Register at website address**. This is your secure member website. See your covered benefits. Search for providers. View your member handbook. Complete your health assessment. Search the Preferred Drug List and much more.
- **Download the health plan mobile app**. It's designed for people on the go. It includes many of the same features as the member website. Find it at the App Store or Google Play.
- **Follow us on Facebook**. Find fun, useful and interesting information for you and your family.

Watch our Getting Started videos.

They are less than 2 minutes long. They are full of helpful information. Go to **Website.com**



Need more help? Call Helpdesk Number, TTY 711, Monday through Friday from 7:30 a.m. - 8:00 p.m.

Helpdesk Number, TTY 711 **Website Address** **Mobile app**

Your benefits

There are no costs to you for most benefits and services. See your member handbook. Visit **website** for full details.

Medical benefit	Your in-network cost
Doctor visits Annual wellness visits Well-child visits (Health Check) Primary care provider (PCP) visits Specialists visits	**$0**
Common services Emergency and urgent care Hospital services Immunizations Pregnancy care	**$0**
Other covered services Mental health and substance use treatment Care management Diabetes supplies Vision services	**$0**

Network providers

You are covered for services provided by network providers. Find a list of these network doctors at **website**. You may also refer to your Provider and Clinic Look-up Guide or **call member help desk number**, TTY **711**.

Prescriptions

Your plan covers a long list of medicines. To see if you have any out-of- pocket costs, see your member handbook. Also see your member handbook for information about coverage for generic and brand-name drugs.

For certain prescriptions to fill, be sure to:

- Check that your prescribed drug is on the preferred drug list (PDL), posted on our website at **website**.
- This list will tell you which drugs are covered by your plan.
- Fill your prescriptions at one of the stores in our network. You can find a list of these stores on our website.
- Show your member ID card at the store when you get your medicine filled.
- This confirms who you are and helps the store to provide your medicine.

If you have questions about your medicines, ask your PCP. Or call the helpdesk at the number on the back of your member ID card.

Mental health and substance use treatment

You are covered for mental health and substance use treatment. This includes services for evaluations. It includes private and group therapy sessions. It includes substance use screenings and treatments. Talk with your doctor if you think you might need these services. They can help you decide the right options for you.

For more information, see the member handbook. Or call the **member help desk number**

Transportation

Your health plan coverage includes rides for medical visits. If you need a ride to your doctor, we can help. NEMT provides dependable rides. Members have great personal service to help go to and from doctor visits. NEMT will also work with you to meet your ride needs.

To schedule a ride:

Call **number**, 7 a.m.–8 p.m., Monday- Friday. Schedule your ride within 3 business days before your appointments.

- You will need to give the following information:
- Where you need to go
- What time you need to be at your doctor's office.
- If you walk with a cane or walker. If use a wheelchair or require a van with lift services.

Vision services

The plan covers: Routine eye exam once every 12 months for adults. Twice per year for children. We may preapprove additional services as medically necessary.

24 Hour Nurse

When you are sick or injured, it can be hard to know what to do. You may not know if you should go to the ER, visit an urgent care center, make a doctor appointment or use self-care. An experienced nurse can give you information to help.

You can call the toll-free number 24 hours a day, 7 days a week. There's no limit to the number of times you can **call number**, TTY **711**

See your member handbook

You will find more details about your covered benefits in your member handbook. You can always view it online at **website.**

Getting care

Your primary care provider

We call the main doctor you see a primary care provider, or PCP. When you see the same PCP over time, it's easier to grow a relationship with them. See your PCP for:

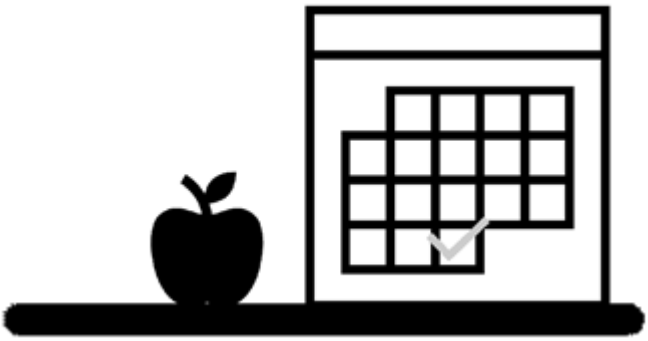
- Routine care, including yearly checkups
- Coordinating your care with a specialist
- Treatment for colds and flu
- Referrals for non-emergency services
- Other health concerns.

Change your PCP at any time

It is important to have a PCP you like and trust. You can change your PCP at any time online or simply by calling us. If you like, we can recommend someone for you.

Schedule a wellness exam soon.

Schedule an appointment with your doctor for your basic health assessment. Be sure to see your doctor for this visit within 90 days of joining our health plan. During this visit, your doctor will complete the Staying Healthy Assessment with you. This information also helps us to connect you with services to help you stay healthy, such as mental health or preventive care screenings.



Need help finding a PCP?

Call us at **helpdesk number**, TTY **711**,
or refer to the Provider and Clinic Look-up Guide.

4.2.3 Innovation and Commitment

4.2.3.1: Value-Based Purchasing (Unmarked)

The Division intends to develop a Value-Based Purchasing program to improve health outcomes during the ...

The Offeror must produce a Value-Based Purchasing proposal for the Division, taking into account the ...

We are committed to working with the Division and other coordinated care organizations (CCOs) to develop an Integrated Primary Care (IPC) value-based purchasing (VBP) program that meets the needs of MississippiCAN and CHIP members. Our VBP proposal will meet the objectives of the Mississippi Comprehensive Quality Strategy and requirements set forth in Appendix A, Draft Contract. In our experience, well-designed VBP programs improve clinical quality, member outcomes and health equity by aligning incentives for all stakeholders; containing costs; cutting waste and promoting delivery system transformation. Successful VBP programs need three essential components: the right financial incentives tied to quality measures promoting behavior and clinical transformation; support and technical assistance to enable provider success; and data analytic tools to measure and inform quality care and cost efficiency. Our proposal includes incentives for reducing identified health disparities, closing gaps in care and engaging difficult-to-reach populations; access to data analytic tools to measure and inform quality care; and support from field-based registered nurse consultants who collaborate with providers to review data, help identify opportunities to improve performance and develop strategies to integrate care coordination and care management.

We propose a continuum of VBP models the Division can use to create a uniform IPC VBP model and a Medicaid Value-Based Purchasing Work Plan that provides consistency and minimizes administrative burden for providers and members. Our proposal includes alternative payment models (APMs) such as quality-based pay for performance incentives, shared savings and risk-based capitated arrangements for a wide variety of provider types, **including PCPs, patient-centered medical homes (PCMHs), OB/GYNs, specialists, hospitals, behavioral health providers, dentists and pharmacists**. Our VBP programs will create partnerships with providers, state Medicaid agencies and other health plans, where jointly established goals and objectives are achievable and based on each provider's readiness. Having a suite of models across the continuum will allow us to meet providers at their current capabilities with the right payment structure to enhance quality, improve value of care and support them to take on more responsibility and risk in managing the population they serve. This provider-specific approach will support the ultimate goal of improving member health and health equity. As a provider matures in their practice transformation and gains experience with VBP, they will move up the APM risk continuum focusing on shared population health goals.

The following table summarizes how our proposed value-based APMs will align with the Division's objectives. Each of our proposed models are discussed in detail further in the response.

Division Objective	Our Proposal and Experience
Incentivize innovation by advancing value-based purchasing arrangements.	We are leaders in transforming how health care is delivered and reimbursed. Nationally, $80 billion of our network health care spend is tied to VBP contracts across our employer-sponsored, Medicare and Medicaid businesses. In the Medicaid programs we serve, we have implemented VBP contracts in more than 25 states, affecting more than 5 million members.
Minimize wasteful spending by reducing low-value care.	Our proposed VBP programs will help minimize wasteful spending by reducing low-value care through promoting care delivery at the right time, in the right place and in the right setting. Our **hospital performance-based incentive program** will reward hospitals for quality and efficient delivery of care. In another state, **participating hospitals showed a 12% reduction in readmissions, 3% improvement in length of stay and 6% reduction in radiology service utilization in the ER.** Our **physician-based shared savings programs** will incentivize PCPs and specialty care providers to minimize wasteful spending and reduce low-value care as they share in savings they achieve against total cost of care or clinical efficiency metrics.
Maintain compliance with state and federal regulatory requirements.	Our proposed APMs will comply with federal regulations 42 C.F.R. 422.208 Physician Incentive Plans and include all applicable language within the contracts.

Division Objective	Our Proposal and Experience
Partner with communities to improve population health and address health disparities.	To address disparities seen between populations, we propose a **Health Equity Incentive**. Using key HEDIS measures stratified by member characteristics (e.g., race/ethnicity) to identify disparities, providers will earn higher incentives for reducing an identified gap often experienced by historically marginalized groups.
Enable timely and proximate access to primary and specialty care.	Our proposed **Member Engagement Bonus** will reward PCPs for improving access to preventive care by engaging hard-to-reach members. Providers will be eligible to receive a quarterly bonus for completing an office visit for members who have not had an office visit in 12 months.
Improve chronic disease management and control.	Our proposed **Chronic Condition Retrospective Shared Savings APMs** will give providers the opportunity to be rewarded for quality and savings tied to benchmarks for the cost per episode. These programs will focus on critical, high-cost conditions and procedures such as asthma, diabetes, COPD and opioid use disorder (OUD).
Improve quality of mental health and substance use disorder care.	Our **Behavioral Health Community Based Provider Shared Savings APM** will reduce unnecessary hospital costs through high-quality outpatient care. Participating providers have shown **improvement in all metrics, including both 7- and 30-day follow-up after hospital discharge rates with a 5.2% improvement over baseline performance.** Our **Behavioral Health Facility Shared Savings APM** will lower behavioral health episode cost of care while driving improvements in quality outcomes such as follow-up after hospital discharge and readmission rates. Participating providers have shown **improvement in 7-day follow-up after hospital discharge by 13.9% and readmission rate by 5.7%.**
Prevent obesity and address physical activity and nutrition in children and adults.	Our **Quality Gap Closure Incentive APM** will close gaps in care and improve quality outcomes. This quality-based pay for performance incentive will reward providers who engage members in needed care. This program will be flexible and can be used to improve outcomes connected to the HEDIS measures most important to the Division, such as Well-Child Visits (WCV-30) and diabetes screening (CDC).
Enable maternal safety and appropriate care during childbirth and postpartum.	Our proposed **Maternity Retrospective Shared Savings APM** will give OB/GYNs an opportunity to be rewarded for quality and savings for meeting benchmarks based on the provider's historical cost per episode**.** Results in year one of implementation include providers demonstrating **5% savings accompanied by a 4% reduction in C-section rates.**
Reduce medication errors and improve adherence to medication regimen.	Our proposed **Independent Pharmacy Incentive** will focus on improving targeted quality measures and adherence to medication regimen.
Confirm appropriate follow-up after ER visits and hospitalizations through care coordination and case management.	Nationally, members whose PCPs participate in **our shared savings APMs show 9% lower admission rates and 2% fewer ER visits** compared to members whose PCPs are not in shared savings APMs.
Achieve an interoperable health information technology system that keeps health information secure and accessible to patients and other authorized parties.	We have developed a long-term strategy to support bidirectional, standards-based information exchange to enable bidirectional collaboration and real-time coordination of member treatment plans. We have helped payers and providers positively affect clinical, quality and cost of care outcomes with a focus on adoption of HL7 Fast Healthcare Interoperability Resources as a foundation for driving critical value-based care use cases.

Value-Based Purchasing Models and Reimbursement Methods

We propose a continuum of VBP models aligned with the Health Care Payment Learning and Action Network's (HCP-LAN) framework, which was created to drive alignment in payment reform approaches. Our VBP programs as shown in the figure will span the APM risk continuum from quality-based pay for performance incentives (APM 2), to shared savings (APM 3) up to global capitated arrangements (APM 4) and can be implemented with several different provider types. Most models will target PCPs, including federally qualified health centers (FQHCs), rural health clinics (RHCs) and PCMHs, while others will be specific incentive programs for behavioral health providers, dentists, pharmacists and specialty care providers. We will support providers by sharing new and useful data, technology and resources to help them succeed.

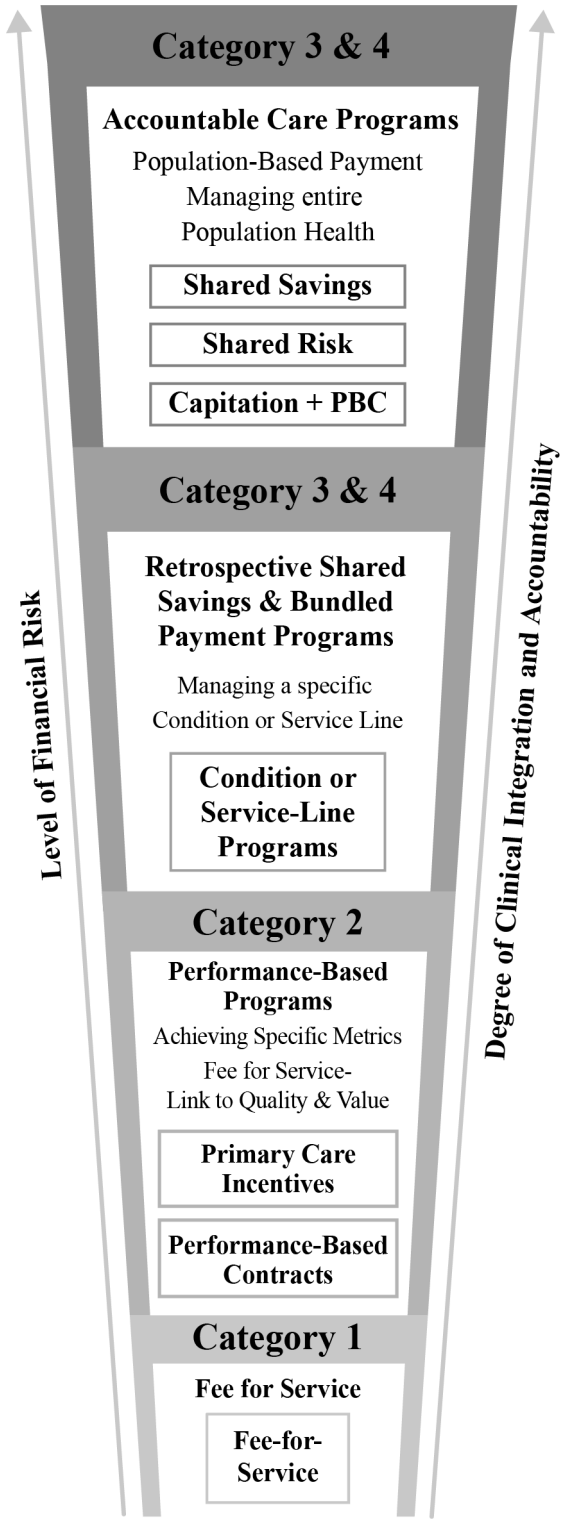


Figure 1: APM Hierarchy. Our APMs meet providers where they are in terms of clinical accountability and shared risk.

Incentives for Primary Care Providers and Patient-Centered Medical Homes

We support the Division's emphasis on quality-based improvements though innovative VBP models. Quality outcomes are the heart of all our proposed VBP models. We recommend the following models for consideration in the development of the Division's collaborative IPC model.

Our **Quality Gap Closure Incentive Program (APM 2c)** closes gaps in care and improves quality outcomes. This model includes key HEDIS and CMS Core Set metrics aligned with state quality objectives, such as asthma, diabetes care, cancer screening, well-child visits, prenatal and postpartum care. The metrics incentivized are flexible to meet the ongoing and changing priorities of the Division and its members. Participating providers receive fee-for-service reimbursement and opportunities to earn additional incentive payments for closing gaps in care. This program can be deployed widely to PCMHs and PCPs, including FQHCs, RHCs and pediatricians, and serves as an initial step into other APMs. **In 2020 in a state like Mississippi, providers in this program closed over 68,000 gaps in care and earned over $500,000 in incentives**.

We support the Division's vision of CCOs bringing innovation and knowledge of advancements in the Medicaid industry to improve health equity of MississippiCAN and CHIP populations. An innovation we propose implementing is our **Health Equity Incentive (APM 2c)**. While all our APMs will address health equity by identifying members with care opportunities, we know improving health equity and reducing disparities in outcomes requires focused intentional strategies. We will stratify key HEDIS measures important to MississippiCAN and CHIP members by member characteristics (e.g., race/ethnicity) to identify disparities within the provider's patient panel. Providers can earn higher incentives for improving care for all and for reducing an identified gap often experienced by historically marginalized groups.

Increasing Access to High Quality Care

We propose using a **Member Engagement Bonus (APM 2c)** for PCPs to further the Division's goal of decreasing barriers to access. This program will reward PCPs for improving access to preventive care by engaging hard-to-reach members. Providers will be eligible to receive a quarterly bonus for completing an office visit for members who have not had an office visit in 12 months. In addition, PCPs may be able to earn incentives tied to addressing care opportunities such as annual screenings or immunizations for these members.

To reinforce the Division's goal for all higher acuity members to use a PCMH as their PCP, **we propose providing higher incentives to NCQA PCMH recognized providers.** We recognize true practice transformation and high-quality care must be supported by appropriate payment structures to be sustainable.

Based on Mississippi Medicaid enrollment data, over 70% of total members enrolled in MississippiCAN and CHIP are children. We propose a Pediatric Accountable Care program exclusively for NCQA recognized PCMH providers. Our **Pediatric PCMH ACO (APM 3a)** will provide a total cost of care incentive for PCMH recognized physician groups with greater than 80% pediatric populations. This model will drive overall improvements in the quality and efficiency of care for our pediatric members, including appropriate, efficient utilization of high-cost, high-intensity clinical settings; reduced all-cause hospital readmissions; and reduced hospital admissions for chronic disease complications. Providers must have open panels, extended hours and manage at least 1,000 members. For PCMHs, at least two quality performance goals must be met to receive a per member per month (PMPM) bonus, paid annually. Providers in this program may be eligible for additional PMPM funding if additional quality performance and efficiency measures are met.

Aligned with the Division's goals of improving health outcomes and quality of life for members and improving cost outcomes, we propose our **Shared Savings (APM 3a) program**. This model will recognize most member care is directed by PCPs and PCMHs who have the greatest opportunity to affect the overall health and total cost of care for our MississippiCAN and CHIP members. In this program, participating provider groups will be eligible to share in savings they achieve against total cost of care or clinical efficiency metrics. PCPs and PCMHs in this program must maintain open panels and offer extended evening or weekend hours for expanded accessibility. We will provide clinical and analytical support to providers to enable their success and evaluate performance through a suite of quality measures aligned with state metrics to determine the distribution of shared savings each provider may earn.

Currently, reimbursement under MississippiCAN does not permit downside risk but the above shared savings model can be modified to include downside risk while increasing earning potential. Providers vary in their knowledge of and ability to succeed in risk-based contracts. Understanding the unique strengths and challenges of provider groups interested in risk-based contracting is important to make sure they are comfortable with the implications of these payment arrangements, have enough infrastructure to support care delivery in this model and are likely to succeed.

Similar to our shared savings program described above, our **Integrated Shared Savings (APM 3a)** program will support providers who have an integrated medical and behavioral clinical model within their practice. Providers will be eligible to share in savings they achieve against a blended total cost of care metric that includes both medical and behavioral health utilization. Practices must meet a quality gate of physical and behavioral health measures aligned with the Division's quality and performance measures to share in savings.

We expect the Division's Medicaid Value-Based Purchasing Work Plan to evolve as providers engage in practice transformation. If legislation changes and the Division desires to incorporate more advanced APMs for providers able and willing to take on value-based risk arrangements, we have models that can support such an environment. Our **Global Capitation Model (APM 4c)** will support a comprehensive population health approach by giving providers a monthly cash payment along with up-to-date clinical data to support proactive member engagement and to optimally manage high-risk patients. We will make capitation payments each month based on the number of members assigned to a practice. The practice will use the funds to provide or

arrange for the best possible care for each patient. Before entering into these agreements, we will conduct an assessment to gain a thorough understanding of providers' overall readiness, model of care, capacity and capabilities before implementing a delegated arrangement. The assessment will review criteria such as financial solvency and clinical operations, including data sharing and performance.

Providers participating in Maternity Retrospective Shared Savings have produced 5% savings accompanied by a 4% reduction in C-section rates in the first year of implementation in three states.

Partnering with States to Implement Capitated Arrangements

We worked with a state Medicaid agency to develop and implement a capitated agreement for a children's hospital. Under this global capitated arrangement, the health system provides care coordination for high-risk members and quality improvement (QI) activities. As part of the latter, they share in the health plan's attainment of the quality withhold and develop and implement other QI initiatives to support state goals. The current focus areas include well-child visits, immunizations and use of psychotropic and ADHD medications, for which we are collaboratively implementing interventions, including special events for members, member incentives and provider practice transformation.

Incentives for Specialists and Behavioral Health Providers

Driving Innovation and Value

The Mississippi Comprehensive Quality Strategy report identified three priority focus areas: 1) maternal and infant health, 2) chronic disease and 3) behavioral health. We recognize enhanced requirements for care management and PCMHs are at the center of the new draft contract (as provided in Appendix A, Draft Contract) and understand other provider types play critical roles in improving the health and outcomes in the focus areas identified. Our VBP proposal brings innovative models designed to incentive specialty providers.

We recognize the Division has long been concerned about the rate of preterm births in Mississippi. Studies show the Black infant mortality rate is 66.8% higher than the white infant mortality rate; the prematurity rate is over 35% higher for Black women than white women; and in Mississippi the pregnancy-related mortality ratio for Black women was nearly three times the ratio for white women. To address the increasing rates of poor maternal health outcomes for Black women and babies, **we propose two APMs targeted at improving maternal and infant care**.

Our **OB Quality Gap Closure Incentive (APM 2c)** will reward qualifying OB practices through annual bonus payments for achieving or exceeding target scores related to certain HEDIS prenatal and postpartum measures and improving birth outcomes. **Using this incentive in a similar state, targeted providers' prenatal and postpartum visit rates increased 39% year over year.** In addition, we propose layering on our health equity incentive program to help address the disparities seen between Black and white women as it relates to HEDIS prenatal and postpartum care measures.

Our **Maternity Retrospective Shared Savings (APM 3a)** will offer OB/GYNs, or principal accountable providers (PAPs), an opportunity to be rewarded for quality of care and savings for meeting benchmarks based on the providers' historical cost per episode. This program will focus on the full spectrum of perinatal care, including prenatal and postpartum visits, laboratory and imaging services and prescriptions and the professional and facility costs of delivery. We will align this maternity retrospective shared savings program with our perinatal rewards program, which will emphasize members' ongoing engagement with their OB/GYN provider and provide incentives to the member for meeting milestones. We will provide additional resources geared toward education, nutrition and virtual peer group support. This retrospective shared savings payment model has influenced the use of elective interventions (e.g., planned cesarean births) and the use of appropriate support during labor and delivery, thereby reducing the likelihood of avoidable complications and readmissions — ultimately improving the total cost of perinatal care. Recently, we updated this program by including health equity data and health outcome metrics such as severe maternal morbidity and preterm birth rate. Linking payment to outcomes is critical in holding providers accountable for providing appropriate care before, during and after pregnancy.

We will regularly update and improve our models based on feedback from subject matter experts, providers, members and other stakeholders. Our new **Dual Quarterback Retrospective Shared Savings** will include two PAPs. The PAPs may be two providers, a provider and a facility or a provider and a coordinating entity such as a birthing center or doula agency. Both PAPs will share in the savings opportunity. Recognizing Mississippi FQHCs provided prenatal care to over 5,000 patients, delivered over 2,500 babies in 2020 and serve a significant number of Medicaid members, we propose piloting a dual quarterback maternity retrospective shared savings model with an appropriate FQHC and their coordinating hospital.

We will continue to evolve our suite of maternity programs to include the dual quarterback model, NICU and newborn models and the **Next Generation Retrospective Shared Savings**. Our next generation models can be either one or multiple PAPs and will provide additional value-add, wraparound services or nontraditional SDOH-related services in conjunction with the episode of care to create a holistic experience for the member. In our retrospective models, all providers will retain their underlying participation and payment arrangements and be eligible for a shared savings payment and payment of any value-add or wrap service they provide.

Chronic diseases are among the most common health problems in Mississippi. Mississippi's cardiovascular disease death rate is the highest in the nation, and medical costs associated with chronic health conditions are expected to continue to rise. We propose a VBP model focused on specific chronic diseases and the provider who treats them. Our **Condition Specific Retrospective Shared Savings (APM 3a)** program will build on fee-for-service reimbursement and offers shared savings opportunities based on cost of care across a defined set of services related to conditions or procedures critical to Mississippi. This approach will provide the PAP for a given condition or procedure the opportunity to be rewarded for quality and savings tied to benchmarks for the cost per episode. These programs will focus on critical, high-cost conditions and procedures such as asthma, congestive heart failure, diabetes and OUD. These models will support the use of dual quarterback or next generation episodes of care as described above.

In state fiscal year 2020, nearly 20% of potentially preventable hospital readmissions among Medicaid members in Mississippi were attributed to adult mental health. To improve outcomes for members with mental health conditions, our **Behavioral Health Community Based Provider Shared Savings (APM 3a)** will reduce unnecessary hospital costs through high-quality outpatient care. Since members cannot be assigned to an outpatient behavioral health provider, we developed an attribution model whereby members who have two or more outpatient visits with the same provider are attributed to them during the measurement period. Providers will earn a shared savings lump sum bonus (based on reduction in the inpatient PMPM and if the meet at least one quality measure). Our **Behavioral Health Facility Shared Savings (APM 3a)** will lower behavioral health episode cost of care while driving improvements in quality outcomes such as follow-up after hospital discharge and readmission rates. Providers can earn up to 40% of the shared savings pool by meeting quality metrics and reducing the 30- and 90-day episode cost. Our **Behavioral Health Integrated Health Home (APM 3a**) program will offer eligible providers committed to integrated care the opportunity to earn a lump sum incentive payment for lowering the total cost of care (i.e., medical, behavioral and pharmacy) and meeting behavioral and physical health quality metrics.

Condition Specific Retrospective Shared Savings Results in Other States

- Asthma –A 2.5% improvement in the appropriate use of medication from 2016 to 2020
- Diabetes –A 2.5% improvement in the management of diabetes from 2017 to 2020

Incentives for Dental Providers

As VBP models evolve within the dental industry, we will use our broad experience and infrastructure to engage dental providers in VBP and new incentives for performance. Our proposed model will provide flexibility and scalability for providers while shifting the focus of the dental delivery system toward preventive care, improved care coordination and reduction of adverse health outcomes and disparities. Selecting the right

performance metrics for a VBP arrangement is critical to drive innovation, action and alignment of provider performance with state public health priorities on improving annual dental visit rates.

Our proposed APM for dental providers will allow providers to be eligible for incentive compensation based on their performance related to periodic oral evaluation, annual dental visits, sealants for children with elevated caries risk, prophylaxis and topical fluoride varnish application for children at elevated caries risk. We will target high volume dental providers, including FQHCs and other large dental practices, for the VBP compensation model and, as appropriate, evolve the quality metrics to achieve alignment, streamline administration and maximize outcomes among providers.

Pharmacy Incentives

Our approach to improving patient care includes engagement of the member's most frequently seen health care provider, the pharmacist. We plan to partner with a health care quality improvement company to implement an outcome-based performance program in collaboration with Mississippi pharmacy providers, incentivizing pharmacists who provide enhanced pharmacy services, including adherence counseling for members having trouble with their medication regimen. Pharmacists may be incentivized for management of hypertension, which includes measuring blood pressure values. This program will represent one of the first programs in the country to establish a value-based arrangement with community pharmacies on controlling blood pressure.

Our **Independent Pharmacy Incentive (APM 2c)** will improve targeted quality measures such as statin use in diabetes and HbA1c testing. This unique and customizable program will include a performance-based incentive to complement the overall strategy to transition health care to value-based medicine.

Hospital Incentives

Our **hospital performance-based contracting program (APM 2c)** will support national health care initiatives such as reducing readmission and early elective deliveries. Our program will reward hospitals for improving the quality of care provided to our members and improving efficiency. Our network management teams will collaborate with our medical director and the hospital to identify performance measures to include in the performance-based compensation provision, which will align with the Division's performance metrics. Hospitals can earn all or a pro-rated portion of an incentive based on their performance. In one state where we have deployed this model, participating hospitals showed a 12% improvement in readmissions, 3% improvement in length of stay and 6% reduction in radiology service utilization in the ER.

Implementation Strategy and Provider Recruitment

Our experience establishing and deploying Medicaid VBP strategies in more than 25 states shows we are most successful with a well-defined, disciplined implementation and support model. We will take an intentional approach to implementing APMs where we match providers with models to fit their capabilities, organizational culture and populations served and provide them with the support needed to be successful. To introduce, successfully execute and support VBP strategies, as shown in the figure, we will use the following three-phase process:

Figure 2. Provider Approach. We work collaboratively with providers to implement VBP innovations.

Identify, Define and Assess

We will conduct internal data analysis to identify potential provider partners. To propose the best APM, we will assess providers' ability and readiness in the context of the HCP-LAN framework, considering critical factors for each practice's success, including member panel size and stability, historical quality performance, utilization

data, cost-based claims data and geographic location in Mississippi. We will stratify the network to identify providers ready for VBP. Key elements include:

- **Member Panel Size and Stability:** We will evaluate a provider's panel size to align an APM with the provider. Stability is important so we can capture statistically significant performance data for APM incentives.
- **Recent Claims Data:** We will collect at least 12 months of recent claims data to conduct additional analyses, comparing costs against the enrollment mix of the practice. This total cost of care analysis will set the stage for reviewing the outcomes data internally and determining which providers to approach. We will share this data with providers as we talk with them about participating in our APM programs.
- **Quality Performance:** We will review the provider's current quality and cost performance and use this information to set realistic performance improvement thresholds.

Engage and Design

The first essential element to a successful VBP program is to align the model to meet providers at their current capabilities with the right payment structure to enhance quality and improve value of care. Foundational to our VBP proposal is developing true partnerships with providers. We will work with identified providers to determine the most appropriate APM, taking into consideration membership, degree of clinical and financial integration and commitment to and investment in population health management. During these meetings, we will discuss our APMs and participation opportunities, share baseline data, discuss current performance and mutually agree upon focus areas during the APM contract to improve quality, while lowering costs.

For quality-based pay for performance APMs, we will share the specifics of the program and begin implementation, as there is no risk to the provider. If a provider is willing to move into advanced programs, we will conduct an assessment to gain a thorough understanding of the practice's overall readiness, model of care, capacity and capabilities. This will include a review of their IT infrastructure to confirm they are compliant with data transfer processes and can report and submit encounter data accurately and timely in compliance with state requirements. For risk bearing arrangements, we will take additional steps: review the provider's interim and most recent audited financial statements; determine best method for risk mitigation specific to the provider and the situation, including security deposit, security reserve or letter of credit; evaluate experience with APMs in other lines of business or payers; and verify appropriate safeguards, including establishing stop loss reinsurance and financial reserve requirements based on the level of financial risk and the volume of services.

Deploy, Evaluate and Evolve

Support and technical assistance are the second essential elements to a successful VBP program. Once VBP contracts are executed, we will provide support and technical assistance to enable provider success. Providers will be assigned a **field-based registered nurse consultant** who offers tools, education and support in meeting the practice's goals. Our consultants will support providers by sharing timely and actionable data such as inpatient utilization and hospital discharges, collaborating on performance improvement and helping the provider build capacity so they can progress along the risk continuum. Our consultants will work with providers to develop a joint work plan targeting specific quality metrics and efficiency goals. Our strong analytical capabilities, data and reporting tools will help our partner practices identify areas of improvement.

Our thorough process for evaluating the effectiveness of APMs will include tracking cost, quality and performance. In addition to using quality and cost data, we will consider feedback based on Joint Operating Committee (JOC) meetings, provider engagement in the program and consultant recommendations. We will consider all of this as we evaluate the provider for movement up the APM risk continuum.

Supporting Providers in Value-Based Purchasing

The third essential element to a successful VBP program is access to data, analytic tools and technical assistance to measure and inform quality care. These tools include reference guides and other educational

materials that provide an overview of quality measures, including how they are calculated, coding guidance and documentation standards. We will provide additional education or reference material specific to the needs of the providers serving members in MississippiCAN and CHIP. We will encourage providers to further explore the resources on our provider education platform, which provides CMEs and CEUs and includes motivational interviewing training and shared treatment planning training. Providers can access evidence-based clinical guidelines from nationally recognized sources to guide their practice transformation at our provider website.

We will provide local clinical resources, supported by our medical directors who, in conjunction with our health care economics team, design reports to reflect provider progress toward quality goals and financial measures and who meet regularly with practices to empower them to provide better care by reviewing results, identifying opportunities for improvement and developing collaborative plans for members. To help providers participating in our APMs, we will provide reports and tools to help improve their quality performance. These will include:

- **Member Health Records:** An integrated dashboard of members' health records, with a detailed view of claims, prescriptions, health conditions, opportunities and care gaps, which enables coordination of care
- **Provider Scorecard:** A monthly report that includes practice- and provider-level HEDIS care opportunities and provider incentive program performance with associated available earning potential
- **Care Assistant:** A web-based clinical management system offering providers panel rosters, clinical updates such as ER and discharge notifications and member-level HEDIS care opportunities
- **Integrated Electronic Medical Record (EMR) Tools:** Available to providers using Epic, Cerner, Athena, eClinicalWorks, Practice Fusion, Allscripts and NextGen, this tool will provide access to real-time data directly in the provider's EMR, including eligibility, quality care opportunities (refreshed biweekly), patient health history (13 months), specialty referral and real-time prescription benefit information.
- **Raw Data Feeds:** For mature providers who can ingest, stratify and use population health data

For our quality gap closure incentive programs, we will share **monthly provider scorecard reports.** These reports will help identify care opportunities to improve quality at a member level by harnessing diagnosis and procedure code data from past health care claims and help participating providers understand the care gaps of members. Providers can use this data to help direct members to the most appropriate source for necessary care. By offering these programs to participating providers, we and our provider network will become clinically, strategically and financially aligned in driving better care for our members.

For our more advanced APMs, we will use health information technology to build capacity for providers to improve quality through investments in technology. These investments will enable real-time access to data at the point of service and improve member outcomes, provider performance and capacity and support delivery system transformation toward population health management. Our first innovative tool will integrate into a provider's EMR and add real-time patient information, including clinical, pharmacy, labs, prior authorizations and care opportunities. Our second innovative tool will bridge the relationship between patients and providers with meaningful and actionable information and knowledge where it is most needed, at the point of care. This tool will take data from across multiple systems and transform it into a single digital record. These tools will be available to providers upon contract execution, and providers will have access via our secure provider portal.

Experience Collaborating with Other Coordinated Care Organizations

We are confident that any of our VBP models could be implemented by all selected CCOs through a program-wide aligned approach and we recommend the Division allow each CCO flexibility to deploy their unique and innovative VBP models. We recognize the importance of creating administrative simplification and ease for providers working across multiple vendors and welcome the opportunity to work with the Division and the other CCOs to implement the strongest possible program. Using lessons learned and experience working with other states, we see the following areas where there is opportunity for consistency across all CCOs:

- **Use Consistent and Meaningful Measures**. Alignment of metrics is critical to amplify the effect of the VBP programs and make certain providers have resources to invest in building systems to manage member care differently. The measures for a multi-health plan VBP model need to be consistent across all CCOs. The consistency will limit provider administration and reduce complexity. All our current VBP programs (for example, our quality gap closure APM, which focuses on PCPs closing HEDIS gaps in care) are flexible in design and can align with the Division's Value-Based Purchasing Work Plan. Our programs offer the flexibility to modify the measures during the measurement period to align to the Division if measures are changed during the contract term.
- **Focus on the Right Measures**. In addition to the need for consistency, the measures selected for the multi-health plan VBP program must focus on the specific needs of our Mississippi members. They should align with Division priorities and be meaningful measures providers can achieve. For example, the size of their membership panel, member demographics and dedicated support staff should all be considered when selecting measures for participating providers.
- **Develop Consistent Data Tools**. Having scorecards with a consistent content and format across all vendors makes it easier for providers to understand and improve their performance. Integrated data is key in helping providers manage their entire population and is critical to their success in multi-health plan VBP programs and more advanced VBP models. We will collaborate with the other health plans and the Division to reduce administrative duplication for providers and align data reporting.

[END OF RESPONSE]

4.2.3.2: Patient-Centered Medical Home (PCMH) (Unmarked)

The Division has placed an emphasis on Patient-Centered Medical Homes for its next contracting cycle.

The Offeror must produce a PCMH proposal for the Division, including how it will have PCMHs interact ...

A strong, high-quality primary health care system is the key to improving the health of all communities and reducing health disparities. The NCQA's patient-centered medical home (PCMH) framework offers a systematic way to enhance the quality of primary care, especially the care of people with complex health care needs. Recognizing many medium- and high-risk members have an established relationship with a PCP, our key strategy is to work with the Division and the other coordinated care organizations (CCOs) to support PCPs who are caring for medium- and high-risk members to become NCQA recognized PCMHs. Focusing on these providers and encouraging their clinical transformation maintains continuity of care for members who are receiving good care while at the same time improving the primary health care delivery system. As shown in the following figure, we support providers through well-defined approaches to recruitment and engagement; partnership and collaboration; empowerment and incentives; and data and analytics throughout the lifecycle of practice transformation. These are designed to assist with measurement, continuous improvement and monitoring for success.

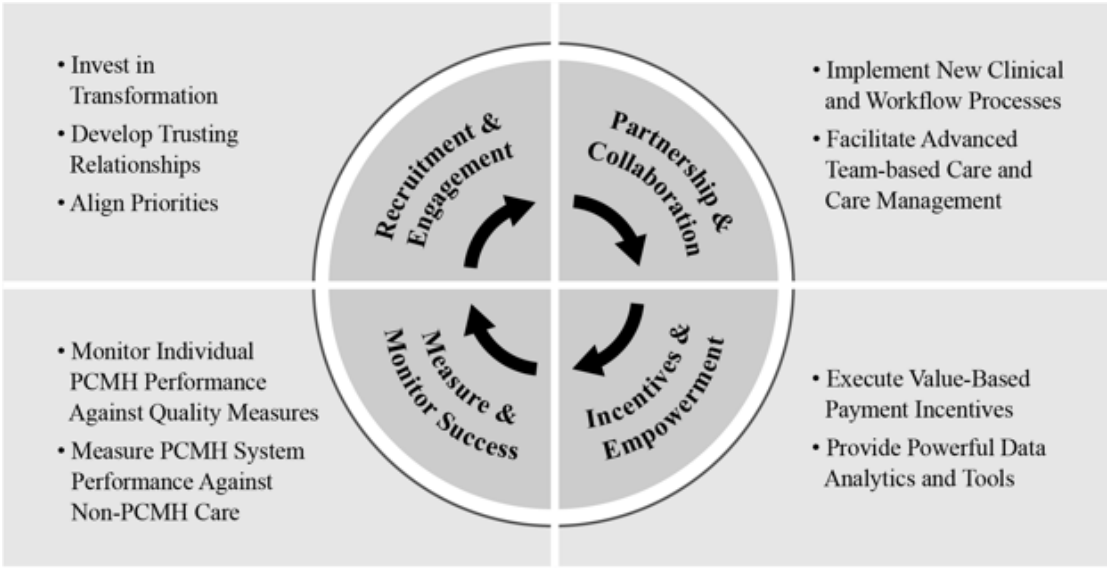


Figure 1. We take an intentional approach to supporting PCMH providers throughout the lifecycle of practice transformation.

We have extensive experience with several states in implementing PCMH programs. In one state, we started with 26 PCMH provider organizations serving 121,000 members in 2017 and successfully grew the program to 56 PCMH provider organizations serving over 214,000 members (42% of total membership) over four years by building trusting, collaborative relationships and empowering providers with data and analytics. Over the past five years, we have worked closely with another state partner to launch and grow a PCMH program modeled after the Centers for Medicare & Medicaid (CMS) Comprehensive Primary Care (CPC) , providing input and support through every phase of practice transformation. In Mississippi, we have identified eight provider groups consisting of 53 practice locations that are NCQA PCMH recognized as shown on the NCQA Health Care Practices report card. We have identified an additional 35 provider groups with multiple practice locations in Mississippi that we believe are good candidates to become PCMHs with NCQA recognition and are looking forward to partnering with additional practices to empower them to achieve this goal.

Recruitment and Engagement

We will partner with providers to meet them where they are in their practice transformation toward more accountable care and population management. To begin the transformation, we will establish a trusting

relationship to recruit and engage each provider. We will work with them to determine the initial and ongoing level of support needed based on their performance, infrastructure, capabilities and preferences in addressing social determinants of health (SDOH) or health disparities, data sharing, training and other interventions.

How we will recruit providers to become patient-centered medical homes

We recognize providers sometimes need upfront investments to be prepared to drive improvements in member health outcomes, decrease inappropriate utilization of services and engage members in needed care to decrease health risk. Therefore, to assist providers, we will make a **financial investment of up to $250,000** to help providers become NCQA recognized. This investment will support the cost of the NCQA survey tool and review fees for initial recognition of approximately 40 provider locations. Partnering with the other CCOs making similar commitments, we can maximize our reach and combine our efforts to create a collective improvement and accelerate the rate at which providers become PCMH recognized.

For some providers, financial cost is not the biggest barrier to becoming NCQA recognized. In 2020, 65% of community health centers or federally qualified health centers (FQHCs) in Mississippi were NCQA PCMH recognized according to the Health Resources and Services Administration (HRSA). When we review the current NCQA Health Care Practices report card, however, many community health centers that were recognized in 2020 are no longer recognized. Even though HRSA provides funding to cover the NCQA survey tool and review fees for initial, renewal and add-on recognition surveys of health centers and provide technical assistance, providers struggled to maintain recognition. In conversation with the Community Health Center Association of Mississippi, we realized having a "champion" within the provider practice to make sure processes and criteria are established, documented, then maintained is essential to the ongoing labor-intensive process of recognition.

To assist not only community health centers but all providers in developing "champions" within their practice, we will **commit to having four field-based registered nurse consultants** who are NCQA PCMH Certified Content Experts (CCEs). These nurse consultants will provide face-to-face technical assistance and training as providers prepare for, complete and maintain the NCQA PCMH recognition. Our consultants will be based throughout Mississippi so each region of the state has a dedicated nurse consultant to provide face-to-face support. The NCQA PCMH Content Expert Certification program certifies individuals who demonstrate comprehensive knowledge of the PCMH model of care and the NCQA PCMH Recognition Program, including a mastery of the NCQA concepts, criteria and the PCMH recognition process. Today, the NCQA website lists only three PCMH CCEs in Mississippi. Adding four will more than double the number of experts resulting in expansion of the PCMH model. In addition to the support our PCMH CCEs will provide directly to the practices, these consultants will convene regional learning collaboratives to bring together providers going through the recognition process and providers who may be interested in becoming recognized. The learning collaboratives, using the "all teach, all learn" approach, will be an opportunity to work together to solve problems, complete tasks and learn new concepts.

How we engage with providers and patient-centered medical homes

Nurturing Local Partnerships

A fundamental ingredient for successful transformation is developing relationships with PCMH providers, building trust and aligning priorities to achieve better health outcomes for MississippiCAN and CHIP members. Our experience shows assigning each provider a

dedicated core team **(as shown in the figure)** focused on practice transformation develops a clinically oriented provider relationship better positioned to achieve results.

The support team will be centered around the nurse consultant who will coordinate with a multidisciplinary team, including chief medical officer, our health care economics data experts, care managers, population health leads, quality experts and others involved in the patient care. This core team will partner with the provider to facilitate the implementation of the mutually agreed-upon Clinical Action Plan goals based on data and analytics. The consultant will be the relationship owner and work with other members of the team to develop and maintain relationships and engagement with providers.

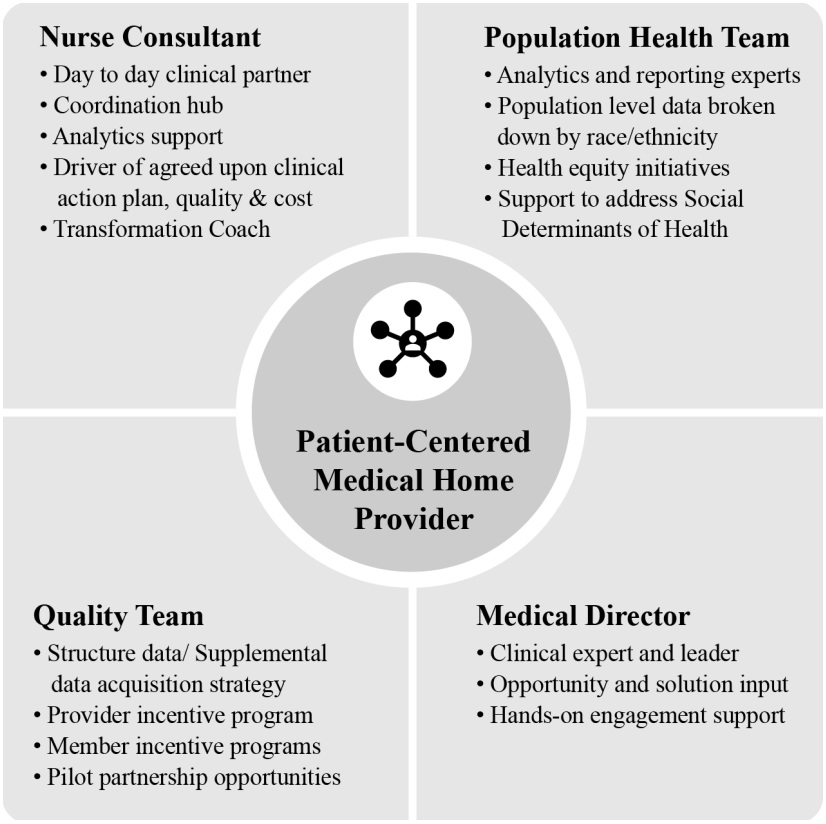


Figure 2. Multiple teams within our CCO support our PCMHs.

The goal of this team will be to make sure PCMH providers have the practice-based population health management data, analytic tools, clinical support, account support and contracts in place to identify and achieve their goals. We will begin building a relationship by holding an orientation meeting where relevant operational and performance-related topics are discussed. We will learn about the practice transformation efforts underway, roles of the staff, analytic capabilities and existing clinical and utilization goals in place. At this initial meeting, we will introduce the features and benefits of our clinical processes, suite of reports and our population management analytical tools.

The core team will work with the provider to develop a Clinical Action Plan, which will evaluate performance across six pillars **(as shown in the following figure)**. The core team and provider will use the Clinical Action Plan to set goals and identify specific action steps to achieve these goals. Our model, developed in concert with providers and our experience in other states, is centered on identifying medium- and high-risk patients, drivers of health care utilization and outcomes and helping providers act in a timely and patient-centered manner to manage their attributed population.

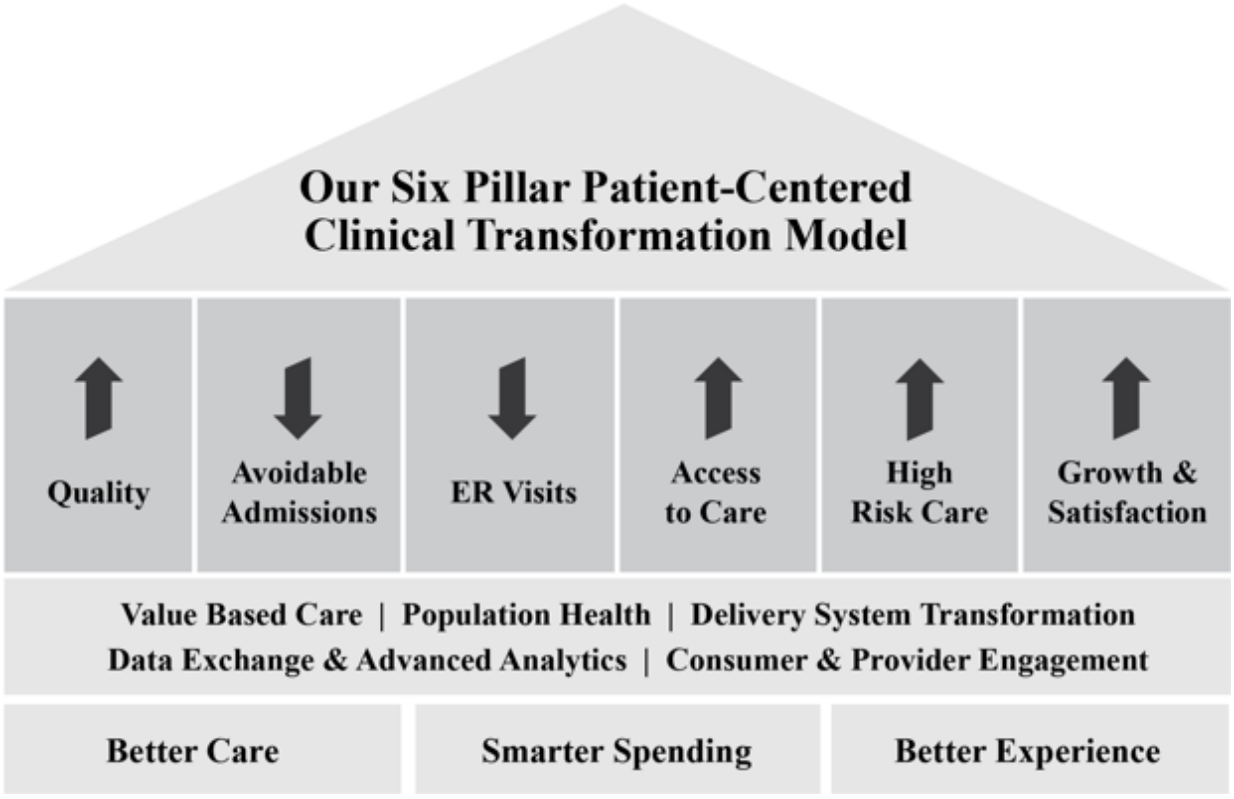


Figure 3. Our nurse consultants work with providers to develop a Clinical Action Plan to evaluate performance across the six pillars.

Providers will receive consultative services to effectively focus on:

- Increasing convenient same-day and after-hours access to primary care
- Implementing the Institute for Healthcare Improvement (IHI) Model for improving quality of care
- Improving comprehensive care transitions, using the Coleman model, to coordinate appropriate follow-up and improve care coordination following discharge from an inpatient unit or the ER
- Identifying high-risk members using our identification and risk stratification software
- Promoting and strengthening person-centered initiatives within PCMH by encouraging and supporting team-based processes of care and engaging with members, families and communities

Partnership and Collaboration

Foundational to our PCMH proposal is developing true partnerships with providers. In collaboration with providers, our PCMH model focuses on achieving the IHI Triple Aim of higher quality, better experience of care at a lower cost by focusing on quality, integrated care, establishing valued partnerships and delivering technology tools that support population health management strategies for our PCMH providers. We intend to create close relationships through our partnerships, with easy and frequent communication with our care managers and the rest of the extended care team at both the population and individual member level.

How we partner with patient-centered medical homes

Our ongoing commitment to the PCMH model includes distinct supports for providers to help develop and continually improve their capacity for **advanced team-based care and care management**. Our engagement model is performance based, flexible, collaborative and tailored to the provider's needs and priorities. We will tailor our support to better meet the needs of the providers because we know small rural health centers have different needs and resources than FQHCs or independent providers. We will tailor the intensity of our interventions to the unique capabilities, resources, level of readiness and culture of provider practices, which is assessed based on size, performance and level of engagement. Nurse consultants will provide a higher level of

support to practices struggling to meet the quality and efficiency performance thresholds, and to providers who are new to the PCMH program. As providers mature in their transformation and become more self-sufficient, we will provide a less intensive level of support based on providers' needs and desires. The baseline level of support for a mature, high-performing practice will include a quarterly Joint Operating Committee (JOC) meeting, access to data technology tools and monthly quality and utilization reporting.

To facilitate practice transformation, our high-touch nurse consultants in collaboration with providers will develop Clinical Action Plans that identify drivers of PCMH success, barriers to this success, and outline specific steps to achieve clinical and financial goals. Using provider-specific data, up-to-date hospital data, authorization data and claims-based data, our nurse consultants will guide provider staff to measure, monitor and manage member care and to present results and outcomes to the provider's executive leadership.

We will provide technology tools (at no cost) and share data with PCMHs to achieve shared goals. We will provide training to provider staff to use our suite of population health management data and analytics. The nurse consultants will evaluate the use of any outside data sources, such as hospital admission, discharge and transfer (ADT) feeds and integrate them into the provided tools to make sure the provider has the most comprehensive data available for their patient population.

Our experienced nurse consultants will help providers interpret and use the data we provide in the following ways, including, and not limited to:

- **Monthly (or more frequent) clinical work sessions**: To review standard data reports, provider-specific ad hoc reports, member-specific analyses, the formal Clinical Action Plan, and progress toward attaining or maintaining PCMH certification. These work sessions will provide the opportunity for our nurse consultants to answer questions about the data, share best practices and gather local practice-specific insights. These sessions will result in directed recommendations and actions to help providers improve outcomes described within their Clinical Action Plan.
- **Quarterly Joint Operating Committees (JOCs)**: To review of clinical metrics (inpatient admits/1,000, ER encounters/1,000), quality, and financial reports, progress toward goals set in the Clinical Action Plan and opportunities for further improvement. Typically, our medical director, pharmacist, provider services manager, plan senior leadership and others may be engaged, depending on JOC topics.
- **Topical web-based meetings**: Via web-based meetings, to share ad hoc analysis, provide training and align on respective responsibilities for agreed-upon performance improvement initiatives, including PCMH certification or re-certification. In states similar to Mississippi, outcomes of these web-based meetings have included decreases in ER utilization and readmission rates.

Our goal will be to help providers access and act on the data in ways that improve outcomes for our members. The support we will provide extends beyond data sharing and interpretation. The job of a nurse consultant will be to help each assigned practice understand and apply the data we share to inform clinical transformation, which reduces cost and improves quality. Nurse consultants will complete clinical and workflow assessments of each provider to facilitate optimal population health management processes. The data and assessments will inform the Clinical Action Plan. Our nurse consultants will assist providers in their clinical transformation by:

- Helping practices define and implement post-discharge follow-up processes to reduce readmissions
- Helping the providers act on the data by working to define and implement a screening reminder flag in the electronic medical record to improve diabetes screening for members who live with schizophrenia
- Reviewing risk stratification results of the population and identifying specific evidence-based care opportunities for each member in their medical home

Post-discharge care management coordination with a PCMH
A 61-year-old male diagnosed with amputation and diabetes was discharged from the hospital with no diabetic supplies. Our care manager connected with a nurse consultant who had a case coordination call with the member's PCMH resulting in all diabetic supplies being ordered by the provider and delivered to the member.

Our nurse consultants will hold collaborative regular meetings with providers to review performance and identify opportunities for improvement. Providers will be presented goals for specific measures, results of claims and utilization metrics related to all members, including those who are being monitored for various conditions such as diabetes, asthma and hypertension. We will share monthly provider scorecard reports, which will depict each assigned member's unique care opportunities. The scorecard data will be shown in a trend format so a provider can analyze their practice's performance over time related to quality benchmarks and goals. This reporting format will allow them to see how far they are from the goal they want to achieve and what their past performance has been. The report will provide a list of members to conduct outreach and schedule appointments for needed care. These reports can be adjusted to focus on specific measures that are part of a VBP contract or expanded out to all HEDIS preventive measures. The scorecard will offer insight into providers' clinical and coding practices, which can help them to adjust or remediate issues shown in the reports.

Using Provider Reports to Drive Transformation

Nurse consultants use reports to assist practices in discovering coding issues regarding gaps of care measures such as HbA1c and EPSDTs. For example, a nurse consultant worked with a provider's director of quality to audit charts in comparison to the provider's electronic medical record (EMR) of members that showed care gaps on reports. The review identified weaknesses in the provider's processes and inaccurate coding. Through their relationship with the provider, the nurse consultant was able to provide educational resources and assist with developing new processes to embed codes and templates in the provider's EMR to improve documentation and efficiency for the provider.

How we coordinate with patient-centered medical homes on care management

Patient-centered medical homes are critical partners in guaranteeing the success of our care management program, which aims to create and promote timely access and delivery of health care and services, continuity of care and coordination and integration of care. Coordination among providers is a key aspect of effective team-based, well-coordinated person-centered care, and we will work closely with PCMHs to share accurate, timely and actionable information. As required by the contract, we will use a PCMH as the PCP for higher acuity members. We will inform providers of referrals made and when the acuity level of members changes for any reason so the provider can document the referrals and acuity in their records. Within at least 72 hours of a member's discharge from a hospital, our care manager will contact the member's PCMH to work collaboratively to assist with follow-up care, accessing prescriptions and providing referrals.

On an individual member basis, our care managers, quality staff and medical directors will communicate directly with our PCMHs and their teams. We will create close relationships with providers, have frequent enough contact to easily share information at both a population and individual member level and ensure providers are in the routine of communicating with our care managers and the rest of the extended care team (including the member). Timely and complete coordination of services will be critical to addressing gaps in care and changing treatment plans as members' conditions change.

Our approach to coordination with providers will incorporate written policies, contractual requirements, training, oversight and follow-up so collaboration occurs between our care managers and the member's providers. Our provider manual, which is part of our provider contract, will outline the processes and expectations for providers to coordinate and collaborate regarding member care. As the most important partner in a member's health, we will expect our PCMH providers to:

- Take the lead in managing the health care needs of our members as we support them through access to comprehensive data and analytic tools, which offer insights at both the individual and practice level
- Review information shared regarding the member's treatment plan, goals and concerns

- Engage in information sharing noting new barriers in access to care or new condition diagnoses
- React and respond to the member's needs and listen to their concerns
- Participate in case conferences when invited
- Maintain a collaborative relationship with care managers, which fosters the ongoing engagement and care of our members

Incentives and Empowerment

We will use incentives to drive improvements in quality, health equity and access, which lead to improved member outcomes. We will take an intentional approach to implementing incentive programs where we match providers with models to fit their capabilities, organizational culture and populations served, and provide them with the support and tools to help them succeed. We will empower providers by offering technology platforms to support clinical activities. These platforms will provide insights into patients and services and outcomes that will drive the approach and care for populations.

Incentives we use to retain patient-centered medical homes

We propose using two pay for performance programs, which will incentivize providers to provide care for members who have care opportunities. Our **Quality Gap Closure Incentive Program** will focus on closing gaps in care and improves quality outcomes. This model will include key HEDIS and CMS Core Set metrics aligned with state quality objectives, such as asthma, diabetes care, cancer screening, well-child visits, prenatal and postpartum care. The HEDIS and CMS Core Set metrics incentivized will be flexible and can be designed to meet the ongoing and changing priorities of the Division and MississippiCAN and CHIP members. We will support the Division's vision of CCOs bringing innovation and knowledge of advancements in the Medicaid industry to prioritize improved health equity of MississippiCAN and CHIP populations. An innovation we propose implementing is our **Health Equity Incentive**. Improving health equity and reducing disparities in outcomes requires focused strategies. We will stratify key HEDIS measures important to MississippiCAN and CHIP members by member characteristics (e.g., race/ethnicity) to identify disparities within the provider's patient panel. Providers can earn higher incentives for improving care for all and for reducing an identified gap often experienced by historically marginalized groups.

We will expect PCMHs to align with the Division's person-centered care approach, to consistently have higher quality ratings and to have appropriate utilization when providing comprehensive care to our members. We recognize true practice transformation and high-quality care must be supported by appropriate payment structures to be sustainable; therefore, providers who are PCMH recognized will be eligible for higher incentive payments in our pay for performance programs. **For our NCQA recognized PCMHs, we will pay them twice as much per gap closure than non-PCMHs in the above Quality Gap Closure programs. For example, closing a needed gap for diabetes (HbA1c), PCMH providers may be eligible to earn $40.00 per gap closure, while non-PCMH providers would earn $20.00.**

Since over 70% of people enrolled in MississippiCAN and CHIP are children, a model designed to improve quality of care for children is vital to the success of the program. Pediatric practices are typically not targeted for shared savings agreements because of low morbidity and thus less utilization and total cost of care to earn shared savings. We propose to implement a **Pediatric Accountable Care Model** in which providers will be eligible for an annual per member per month (PMPM) bonus by meeting certain quality measures. Our **Pediatric PCMH ACO** model will only be available to providers who are PCMH recognized physician groups with greater than 80% pediatric populations. This model will drive improvements in the quality and efficiency of care for our pediatric members, including, but not limited to, appropriate, efficient utilization of high-cost, high-intensity clinical settings; reduced all-cause hospital readmissions; and reduced hospital admissions for chronic disease complications. Practices must have open panels, extended hours and manage at least 1,000 members. For PCMHs to earn incentives in this program, at least two quality performance goals must be met to

receive a PMPM bonus, paid annually. The PCMHs in this program may be eligible for additional PMPM funding if additional quality performance and efficiency measures are met.

Our **PCMH Shared Savings** model recognizes PCMHs have the greatest opportunity for favorably affecting the overall health and total cost of care for our MississippiCAN and CHIP members. In this model, participating PCMHs will be eligible to share in savings they achieve against total cost of care or clinical efficiency metrics. The PCMHs must maintain open panels for new patients and offer extended evening or weekend hours for expanded accessibility. Providers who are PCMH recognized will be eligible for a higher percentage of the shared savings than providers who are not PCMH recognized.

Empowering patient-centered medical homes with technology and tools

From national experience, we know health information technology and clinical engagement are foundational to support providers in clinical activities in their PCMH practice. We will empower providers by offering technology platforms that provide insights into patients and services, which will drive the overall performance of the population. Our tools are web-based and can be accessed at a provider's convenience through our provider portal. Our clinical tools are actionable and allow providers and their support teams to improve on each of the six pillars of practice-based population health transformation outlined earlier. These tools will include:

- **Member Health Records**: An integrated dashboard of individual members' health records with a detailed view of claims, prescriptions, health conditions, opportunities and care gaps, which will enable coordination of care
- **Provider Scorecard**: A monthly report that will include practice- and provider-level HEDIS care opportunities and provider incentive program performance with associated available earning potential
- **Care Assistant**: A reporting platform that will support the needs across the care continuum through access to care, expansion of high-risk patient care, reduction of avoidable admissions and non-emergent ER visits and enhancement of quality care. The tool will provide:
  - Automated access and improved efficiency for retrieving and viewing data to support population analysis
  - Timely clinical insights to health data to support identification of members who may need clinical care management and services
  - Download capabilities to a provider's data analytics warehouse or EMR system

Our health information technology has been developed to support providers to improve quality. Our investments in technology will allow real-time access to data at the point of service, improve member outcomes, provider performance and capacity, and support delivery system transformation toward population health management. We have developed two innovative tools to support data sharing. The first tool will integrate into a provider's EMR and add real-time patient information, including clinical, pharmacy, labs, prior authorizations and care opportunities. The second tool will help bridge the relationship between patients and providers with meaningful and actionable information and knowledge where it is most needed — at the point of care. This tool will take data from across multiple systems and transform it into a single digital record. We will make these tools available upon contract execution, and providers will have access via our secure provider portal. Our providers will have access to scorecard reports that generate opportunities to improve quality at a member-specific level by harnessing diagnosis and procedure code data from past health care claims.

Helping Providers Identify and Prioritize Opportunities

During a meeting with a provider group with multiple practice locations, we recognized their difficulty identifying HEDIS measures to prioritize. Our consultant analyzed the provider's data to find trends and patterns and shared the findings with the provider group. We thus helped the provider identify practice site variations. The provider then used these insights toward translating best practices from their higher performing sites and incorporating them into the other sites. This collaborative effort gave us a clear plan to help progress toward shared targets.

Using Data to Measure and Monitor Patient-Centered Medical Home Success

One of the NCQA specific standards and guidelines is structured around performance measurement and quality improvement. An unrelenting focus on measurement and continuous quality improvement is essential to the development of high-reliability health care delivery. We will help providers develop ways to measure performance, set goals and develop activities to improve performance. We will provide the data, tools and technical assistance to measure performance, set goals and monitor success.

Method for measuring success of patient-centered medical homes individually

We will track individual PCMH performance against quality measures throughout the year based on administrative data obtained from claims. For PCMHs who participate in our proposed **PCMH Shared Savings**, performance metrics will include year-over-year medical expense trend and utilization rate trends, such as inpatient and ER. Based on the degree of progress toward targeted improvement metrics, we will collaborate with them to modify and adapt our support to identify solutions to address challenges and build upon success. We will modify model metrics and standards based on changes in HEDIS specifications, and metrics or standards the Division uses to assess performance of Medicaid health plans.

Through our regular collaborative JOC meetings, we will monitor provider adherence to NCQA PCMH standards and guidelines around team-based care, patient-centered access, care management and care coordination. Part of our ongoing monitoring will include verifying each PCMH:

- Provides patient-centered care and practices evidence-based medicine and clinical decision supports
- Participates in continuous quality improvement and performance measurement and coordinates care between all health care providers used by the member
- Engages all members or family members to actively participate in decision making
- Uses health information technology to support care delivery and efficiency improvement
- Provides for enhanced access, including extended office hours, open scheduling and alternative communication models such as web-based or telephone options

Method for measuring success of patient-centered medical homes as a system

To measure success of the system, we will compare performance both among PCMH providers and against non-PCMH providers. The same tools and reports we use to track individual PCMH performance against quality measures throughout the year can be aggregated to review system performance. This will allow us to identify trends among all PCMHs and identify PCMHs that may be outliers. Our nurse consultants will use this information when they meet with individual PCMH providers and at regional learning collaboratives.

We will review the performance of providers who participate in our ACOs or shared savings through a propensity match analysis. This statistical matching technique estimates the effect of ACOs by accounting for covariates. This analysis is completed using a greedy match algorithm to produce one-to-one matched pairs with balanced covariates and characteristics across the treatment group (ACOs) and control group (non-ACOs).

We have the clinical experience and technical capabilities to help the Division develop a PCMH provider community. We have worked collaboratively with other state Medicaid agencies and CCOs to successfully increase the number of PCMH providers. We look forward to working with the Division to develop its IPC VBP model centered around PCMHs and care management. [END OF RESPONSE]

4.2.3.3: Social Determinants of Health (SDOH) (Unmarked)

The Division requires Contractors to devote at least 0.5% of its Capitation Payment to efforts to improve ...

Dedicated to a Healthier Mississippi

Understanding social determinants of health (SDOH) disproportionately contribute to poor health outcomes and are the basis for health disparities, it is essential we address these barriers by identifying each member's needs, connecting individuals and families to supports and services, developing local partnerships and investing in community organizations and initiatives to create sustainable access to services. The landscape of social service supports is complex and made up of numerous agencies each with unique goals, distinct financing and regulatory requirements and various degrees of data infrastructure and capabilities. With these complexities in mind, we developed our SDOH model drawing on our experience addressing SDOH both nationally and in states similar in size and composition to Mississippi. Nationally, among the 4 million individuals we screened for SDOH needs in 2021, we referred 74% to a local resource or service, and **in eight out of 10 cases, we reconnected with the member to determine their needs were met with our closed-loop referral system.** We continue to expand this capability to include more individuals, and with the help of recent data investments, we will ensure an approach that dually addresses both individual and community needs at scale.

In addition to deploying our proposed SDOH model for MississippiCAN and CHIP populations**, we commit to using at least 0.5% of the capitation payment to invest in initiatives that address the social needs facing members, their families and communities.** We will partner with local stakeholders to understand their unique needs and invest in partnerships that support their communities. In addition to the domains listed in our investment table, we will make sure we have funds to address other emerging community needs that arise during the year.

Domain	Anticipated Annual Capitation Payment Investments
Education and Employment	$655,000
Food Insecurity	$1,000,000
Health Equity	$1,645,000
Housing Instability	$800,000
Emerging Community Needs	$400,000

1. Describe the Offeror's approach to and experience with collecting data on non-medical risk factors for ...

Our Medicaid and SDOH experience in states similar to Mississippi shows identifying social needs early can potentially resolve an individual or family's need before reaching a crisis point. Through this experience, we developed a model that attempts to identify and address SDOH needs proactively during regular member interactions. In states of similar size and composition, we collect SDOH data that identifies member housing, food, transportation, employment, educational attainment and financial stability-related needs. We analyze trends in SDOH data, in conjunction with geographical indicators, through an SDOH repository to determine where we deploy resources and which community resources we support to improve SDOH, particularly to combat disparities.

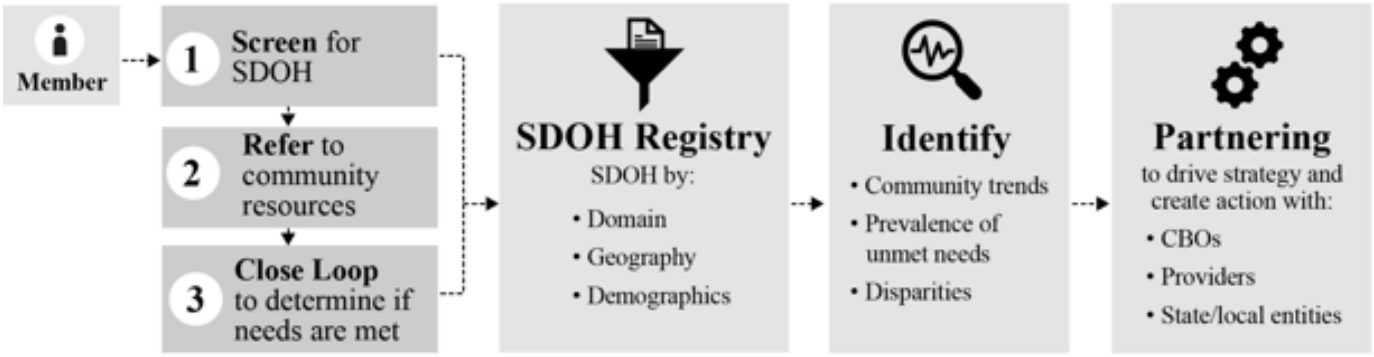


Figure 1. Our SDOH screening, data collection, analysis and action process.

Data Collection

We will use internal data collection and external research, along with standard, evidence-based screening tools to identify each member's unique needs. Our national SDOH repository aggregates SDOH data from multiple sources to track identified SDOH needs and referrals to community resources, including ICD-10 Z codes, SDOH-specific screens and information from referral platforms. We will continue to build this repository to track end-to-end referrals to confirm our members' identified needs have been met.

Data collection will begin with outreach to MississippiCAN and CHIP members to assess social, physical and behavioral health needs. We will evaluate members' SDOH needs during enrollment and no less than annually. Our service navigators will engage with members during an initial Health Risk Screening (HRS) and use these opportunities to screen for SDOH needs. In addition, our service navigators will be trained to screen for SDOH needs during any routine member interaction and connect the member in real time to community resources. High-risk members referred for care management will be further screened for SDOH needs with a Comprehensive Health Assessment (CHA) tool. Our internal screening data will be complemented by ICD-10 Z codes collected by our provider partners. Where possible, we will use survey results collected by providers using the Protocol for Responding to and Assessing Patients' Assets, Risks and Experiences (PRAPARE®) tool. We will further supplement our internal member-level SDOH data with external data sources, such as County Health Rankings, Census data, CDC Social Vulnerability Index data and community health needs assessments. This will allow us to better understand health within the communities where our members live and further contextualize member-level data on SDOH needs.

The following table identifies the SDOH domains and metrics to be collected, screening tools to be used and member populations to be included in the data collection. Data from these screening tools will be incorporated into our SDOH repository and feed into our care management platform to inform clinical decision making.

Screening Tools	Domains Included	Metrics Collected	Member Population Focus
Adult and Pediatric Health Risk Screening (HRS)	▪ Access to basic necessities, including food, clothing, medicine, transportation ▪ Housing instability and safety	▪ Members screened ▪ SDOH needs identified ▪ Members referred ▪ Referral outcome	▪ All MississippiCAN members ▪ All Mississippi CHIP members
Comprehensive Health Assessment (CHA)	▪ Access to basic necessities, including food, clothing, medicine, transportation ▪ Ethnicity and cultural orientation, gender identity, sexual orientation ▪ Care giving, familial and other social support ▪ Housing stability ▪ Neighborhood safety, other social stressors such as exposure to violence or other adverse factors in the home environment ▪ Education and military service ▪ Preferred language and communication capabilities	▪ Members screened ▪ SDOH needs identified ▪ Members referred ▪ Referral outcome	▪ High-risk MississippiCAN and CHIP members

Data Analysis

Our SDOH data analysis will be supported by several tools that analyze the internal and external SDOH data collected through our HRS and CHA screenings and information gathered by health plan staff and providers.

Screening Tools	Domains Included
Risk Stratification	Data collected from the member will be stored in our national SDOH database, allowing us to use information from claims, SDOH data and regional or geographic data to identify people who are considered high risk for both overutilization and underutilization of clinical care or whose social barriers, such as lack of stable housing or transportation, affect their ability to access care.
Social Determinants of Health Dashboard	Our SDOH dashboard will analyze and visualize our internal SDOH data. The analysis will inform our staff about member and community needs, show geographic and domain trends and help identify disparities.
Hotspotting	Our Hotspotting tool will allow us to quickly identify members with high needs or high costs to better address their complex care and SDOH needs in our ongoing efforts to reduce the total cost of care. The tool will analyze data at the ZIP code level, providing us with the ability to deploy targeted outreach and clinical interventions to underserved geographic areas. Race and ethnicity data can be incorporated into the tool, allowing us to identify whether there are racial or ethnic disparities in complex care and SDOH needs for further tailoring of interventions.
Geographic Analytic System	Our geographic analytic system platform will enable our local teams to create, interact and share maps and location data within a secure environment. We will use this technology to create heat maps and overlay various data points to get a full picture of what affects our members most. We can use this technology for emergency preparedness by understanding which members will be affected the most by natural disasters and diverting resources to accommodate their needs.
Ad Hoc SDOH Analysis	Our health care economics staff will provide ad hoc data analysis that is flexible and customizable to help our teams understand SDOH needs for our members and their communities and support our ongoing SDOH strategy efforts.

Action

Our comprehensive data analysis will drive action at the member, community and system level. By integrating various sources of SDOH data with clinical, demographic and geographic data, our teams can assess member macro-level social needs, potential social service capacity issues and provider barriers to SDOH screening and referrals to better address SDOH needs for Mississippians. This will allow us to tailor care management engagement or enrollment in focused clinical or SDOH initiatives. For example, in a similar state, we implemented SDOH screening for key domains, including employment, and found 37% of our members were experiencing unemployment or underemployment. We learned that a significant number of individuals facing unemployment and underemployment were Black men. Based on this data, we developed a targeted Employment Pilot focused on Black men in an urban area and hired an employment navigator to support members with employment and education needs. Early results from the program show approximately 40 members were referred to local employment training programs.

Our SDOH action portfolio will include:

- **SDOH Resource Directory and Social Care Tools:** Real-time data on SDOH needs will enable us to connect members to accountable networks of community-based organizations (CBOs) providing services and supports for underserved communities. As our staff engage with a member and identify a social need, we will use our closed-loop SDOH resource directory and care tool. With this tool, we will provide MississippiCAN and CHIP members with local resources to address their immediate needs and know when social services have been delivered. This tool will be available in 130 different languages, allows the ability to text and email referral information directly from the tool, includes a member-facing website available for self-referral and has end-user reporting capabilities. This tool's data will be aggregated into our SDOH database and integrated into our care management platform.
- **Targeted Member Interventions:** Informed by SDOH screenings and member engagement, we will identify members whose social and clinical needs require higher intensity engagement and could be supported by specific health plan programs. For example, a member interested in advancing educational attainment may be identified and referred to enroll in our GED benefit.

- **Provider Support:** To support all providers in screening their patients for SDOH, we will share our SDOH billing protocol online through our provider portal. In addition to educating providers about collecting SDOH data, we will integrate identified SDOH needs into our provider data integration tool, giving providers greater visibility to their patient's social needs outside clinical care.
- **Community Engagement and Investment Alignment:** Our comprehensive SDOH approach will provide data and experience to influence and align investments in the community. Member-level data aggregated in our SDOH registry will be combined with member feedback, health plan staff knowledge and community and provider partner experience to provide a blueprint about where SDOH service gaps exist. This analysis will drive our Community Investment Strategy, which will seek to convene cross-sector partners and use data to identify gaps, develop partnerships and implement community-level interventions.

Our data collection, analysis and action will provide a roadmap for us to partner with community organizations, coordinated care organizations (CCOs) and state agencies to mitigate social barriers and improve member and community health.

SDOH Needs Identified During Routine Call Resulted in Housing and Employment Supports

During a routine member call, our service navigator identified an adult member with asthma who was homeless and living in her car with two children. Our staff referred the member to the local health plan housing navigator for assistance. While the member was approved for a housing voucher, she was unaware that landlords would accept it. The housing navigator worked closely with the local housing authority to develop a list of landlords and available properties in the area. The member secured permanent housing for her family, and other community resource agencies assisted with basic needs. The referral resulted in the member not only securing stable housing but also finding employment.

2. In the Offeror's view, what are the greatest SDOH challenges facing the MississippiCAN and CHIP ...

While there are several common themes among SDOH challenges across the country, we understand each state, county and local community has unique needs and barriers. In preparing for this response, we conducted data analysis and met with members, providers and CBOs. Through these discussions and analyses, we identified four key SDOH domains of concern affecting MississippiCAN and CHIP members: food insecurity, homelessness and housing instability, educational attainment and employment opportunities, and broadband access. Within each domain are additional individual, family and community effects to consider across geography, race and age.

Food Insecurity: For many Mississippi families, the inability to access healthy foods makes it difficult to prepare nutritious meals. Food insecurity and lack of access to healthy foods often results in health disparities, increasing the risk for conditions such as obesity, type 2 diabetes and heart disease in both children and adults.

The 2021 Mississippi County Health Rankings and Roadmaps report found 15.9% of Mississippians are food insecure, higher than the national average of 11.7%. *In Kemper, Tallahatchie, Leflore and Holmes counties, 30% or more of the residents reported limited access to healthy foods.* In addition, the 2016 Mississippi State Health Assessment and Improvement Plan identified many Mississippians have limited access to healthy foods. This can be compounded by cultural barriers to health, including unhealthy traditional cuisine and traditions centered around food consumption.

Homelessness and Housing Instability: Numerous studies across the country have demonstrated the positive affects affordable and supportive housing have on housing stability, increased employment, improved mental and physical health and reduced active substance use. Access to safe, affordable housing reduces utilization of ER and inpatient hospitalizations among members with high utilization and reduces criminal justice and child welfare involvement for individuals and families in those systems.

The lack of affordable and safe housing in Mississippi is consistently identified as a significant concern. The 2021 Mississippi County Health Rankings and Roadmaps report states 15.4% of people in Mississippi experience a severe housing problem, which can include lack of complete kitchen facilities, lack of plumbing

facilities, overcrowding or severely cost-burdened occupants. This issue disproportionately affects minority households, affecting 29.9% American Indian, 22.5% Black and 22.5% Hispanic. In addition, the National Low Income Housing Coalition ranked Mississippi 50th in the country for the gap between wage and rental housing costs, further evidence of the affordable housing crisis faced by Mississippians. *A minimum wage worker in Mississippi needs to work 68 hours per week to afford a one-bedroom rental home.*

Educational Attainment and Employment Opportunities: Education is a key SDOH, and it is strongly tied to employment. Better education leads to more stable employment which, in turn, may mean access to quality health care, a living wage and housing in a safe, non-polluted environment. As noted in the 2016 Mississippi's State Health Assessment and Improvement Plan, *one in five Mississippians aged 25 or older have not completed high school;* this challenge disproportionately affects Black individuals and those living in rural communities, as they have lower high school completion rates than white individuals and those living in urban areas.

In addition to the gaps in educational attainment, the statewide unemployment rate in Mississippi stands at 5.5%. When looking at this information by geography, race and other demographic factors, the unemployment rate is even more pronounced for minority and rural communities. For example, the unemployment rate for Black workers in Mississippi is 7.1%.

Broadband Access: According to the Census Bureau, most Mississippi counties are defined as rural with a population of less than 2,500 people. In addition to Mississippi's rural nature, Mississippi has fewer physicians per capita than any other state, leading to physician shortages, particularly with specialists. These physician shortages lead to poor health outcomes, particularly in rural areas, where access to care is exacerbated by provider shortages.

As the COVID-19 crisis has illuminated, broadband access is vital for families so they can maintain their connections to school, employment, community resources and health care providers. Without this access, families often struggle to meet basic, daily needs, which can have long-term effects on health outcomes. As of 2018, 80.6% of Mississippi households have access to high-speed internet, which is defined as the percentage of households with a broadband internet subscription and a computer, smartphone or tablet. Mississippi falls below the national average of 88.3%, and *Black households in Mississippi are even more disadvantaged, with only 73.9% reporting high-speed internal access*.

3. What approaches will the Offeror take to address these challenges?

Our SDOH Action Framework for Mississippi will be guided not only by research and data, but by the needs articulated by members, community partners, providers and other stakeholders. We will support members in real time with resource navigation, care management supports and targeted programs while partnering and investing in community- and system-level initiatives that seek to address the systemic and racial inequities that perpetuate the barriers members face each day.

Member Supports and Programs

Our SDOH approaches for MississippiCAN and CHIP members will be integrated throughout our operations. The table below describes member programs and benefits designed to support a member's SDOH needs.

Program	Description	Target Population	Related SDOH Domains
SDOH Resource Directory and Social Care Tools	Our staff will use our SDOH resource directory and social care tools to connect our members with social needs to local resources for support. Through this closed-loop referral tool, our staff will monitor referrals and verify the member's need has been addressed.	All MississippiCAN and CHIP members with an identified SDOH need	All
In-Home Health and	Our in-home health and wellness service assessments program will provide annual assessments to adult members in the	MississippiCAN members with chronic conditions	All

Program	Description	Target Population	Related SDOH Domains
Wellness Service	comfort of their homes, including in rural areas with limited access to health care. An advanced practice clinician (APC) will conduct a health and social needs assessment and evaluate the environment for potential risks and other social and behavioral health needs. The APCs will help close gaps if our members need support, like transportation or food services.	who live in rural areas or lack reliable transportation	
Community Care Package and Meal Service Program	This program will provide our members access to healthy food options while managing their chronic conditions. Meals provided are high-quality, nutritionally tailored meals designed by dietitians and professional chefs, tailored to health conditions.	Perinatal and postpartum members; members with high-risk chronic conditions; members in need of post-discharge care	Food Insecurity
Empowerment Manager (SDOH Navigator)	Our empowerment manager (SDOH navigator) will contact our members to assess their housing and employment needs and connect them to our related health plan benefits and state or local community resources that provide housing, job training or education supports.	MississippiCAN and CHIP members with identified housing and employment needs	Housing Stability, Employment, Educational Attainment
Housing and Health Supports	This targeted program for members with complex health and social needs will link individuals to housing with wraparound support services and assign an integrated treatment team who will develop a customized and holistic care management plan.	MississippiCAN members with complex health and social needs	Housing Stability
Mississippi Home Corporation Partnership	We will partner with the Mississippi Home Corporation to improve housing for our members, including advocating for the member housing rights, connecting members to needed legal sources and educating the member on their rights.	All MississippiCAN and CHIP members with an identified housing need	Housing Stability, Legal Aid
Pest Control and Bed Bug Treatment	We will offer pest control and bed bug treatment to members as needed and assessed by our population health team. Infested homes have a variety of negative effects on physical health and mental health and have economic consequences.	All MississippiCAN and CHIP members	Housing Stability
Green & Healthy Homes Initiative	We will partner with the Jackson affiliate for GHHI to create safer homes by removing environmental and physical challenges that negatively impact health.	All MississippiCAN and CHIP members	Housing Stability
Educational Supports	We will offer educational supports for members with less than a high school degree who are interested in obtaining their GED. Our empowerment manager (SDOH navigator) will connect the member to GED resources and provide navigational support and coaching throughout the process. We will cover the cost of the practice and GED tests and follow up with the member to share additional resources to support their long-term goals.	All interested MississippiCAN and CHIP members	Educational Attainment, Employment
Independent Living Transitions Program	Our independent living transitions program will use an interactive website to help teens learn skills in areas that have historically prevented them from achieving stable, independent lives. The platform is an interactive program that will teach the practical skills of managing bank accounts, securing housing, creating a resume, finding job training and applying for college.	All adolescent MississippiCAN and CHIP members	Employment, Educational Attainment
Non-Emergency Transportation (NET)	We will offer additional NET services as part of our comprehensive approach to maternal and child health. We will offer 10 one-way or 20 round-trip rides to social services, which may include food banks, WIC office, SNAP-ed education programs or other health, behavioral health and substance use providers.	Pregnant MississippiCAN members; CHIP members	Transportation Access

Program	Description	Target Population	Related SDOH Domains
Cellphone Program	We will assist our members in gaining access to our cellphone program, which offers a free phone, free monthly data, unlimited texting and free monthly minutes to eligible low-income customers.	MississippiCAN members with complex needs, as determined by health plan staff	Social Isolation
Tablets for Virtual Care Management and Social Support	Through a partnership with T-Mobile, we will purchase tablets and unlimited data plans for virtual care management and social supports for our members who have access to care barriers and do not have broadband access at their home. We will pre-load the tablets with key health care applications.	MississippiCAN members with complex needs, as determined by health plan staff	Broadband Access, Educational Attainment

For our members in Mississippi who are difficult to locate due to non-reported address changes, limited phone access or minutes, homelessness or inadequate housing, we will employ local community health workers (CHWs) in Mississippi who apply their knowledge of the community and follow up with community organizations, providers (including pharmacies) or community groups to get updated contact information. In addition, our Mississippi empowerment manager (SDOH navigator) will develop community partnerships with organizations, including the local Continuum of Care agency and local shelters that may allow individuals to use their address, along with other organizations that work with people who are homeless or who have housing needs. Through these partnerships, we will explore the ability to contract with them to identify our members who are actively using their services, thus increasing our ability to locate members who are difficult to reach.

Community Investments and Partnerships

Nurturing Local Partnerships

With decades of experience working with state, county and local partners across the country, our organization has transformed our entire community investment approach. It is rooted in fully benefiting from our local and community partners' capability and capacities, who best understand their community challenges and determining where we can add value. By listening to and understanding "on the ground" health challenges and blending this with clinical data and insights, we will develop community-based strategies that close gaps in care and reduce racial and health disparities.

Program	Description
Community-based initiatives that close gaps in care and reduce health disparities	Over the last two years, our community-based initiatives to close gaps in care and reduce health disparities have committed more than $8 million in 20 communities on cross-sector collaborative projects, such as partnering with an urban public housing agency and local providers to address childhood asthma in public assisted housing. We executed data sharing agreements with public housing agencies, cross matched our membership, analyzed data to identify pressing community health issues and jointly worked to design interventions. This initiative is the evolution of efforts we have executed in other states with community, family and individual needs similar to those faced by Mississippians. **We will serve the Jackson metropolitan area with our community-based model in Mississippi, and we will partner with Jackson Hinds FQHC and several community and faith-based partner organizations to address SDOH that create barriers and perpetuate health disparities**. By aligning and partnering with these organizations, we aim to develop collaborative approaches to address community health needs that use each organization's capacities and resources in a coordinated way to expand our collective influence.
Community College Sponsorship Program	We will invest in a local community college to support educational opportunities for 100 Black students annually. This initiative will ease the burden of student loan debt, which disproportionately impacts low-income Black families.
Catholic Charities Partnership	We will provide support for the Born Free/New Beginnings program for chemically dependent pregnant and parenting individuals. The program includes housing, daycare, financial assistance, clothing, household assistance, infant items and comprehensive case management.
Jackson Public School District	We will invest in a school nutrition program with the Jackson Public School District to provide students and their families with regular access to nutritious food at five school-based food pantries in the Jackson Public School District.

Provider and Health Care System

We will work with our health system partners to support members beyond their clinical needs and develop programs that integrate SDOH data collection, analysis and actions into core practices and operations. In states of similar size and composition, we launched **Provider SDOH Screening Incentive Programs to** motivate providers to screen members for SDOH needs, submit relevant ICD-10 Z codes, refer members to trusted CBO partners to address those needs and confirm member receipt of the referred services. Rather than only paying for coding, our payment models put greater emphasis on closing the loop, making certain our members receive the services they need. In our SDOH closed-loop referral programs, providers submit Z codes for screened members so outstanding needs are included in claims information submitted to us and subsequently included in our national SDOH registry, which will provide SDOH information to our care management platform. **We will launch this innovative provider incentive model with MississippiCAN and CHIP providers.**

4. How will the Offeror address Health Equity through its SDOH programs?

Foundational to our company's operating philosophy are our policies on equal opportunity, equity, diversity and inclusion, which we apply both internally and externally. Our three-tiered approach as shown in the figure encompasses breaking down barriers to care and **building health equity** for members we serve, the health systems in which we operate and the communities in which our members live. We know that roughly half of Mississippians live in rural or poor areas, where there are higher levels of unemployment, poverty, health disparities and lower levels of educational attainment and access to care. We acknowledge such disparities are rooted in historic and present-day realities of systemic discrimination that have differentially distributed resources such as health care access, housing, education, employment and income — making it particularly challenging for some populations to attain their full health potential. We are continually learning and evolving personally and organizationally to gain a deeper understanding of these disparities and the diverse needs of the population we serve, and we continue to develop culturally competent staff and services that address these disparities and promote health equity.

Figure 2. Our Health Equity Approach.

While we commit to instill health equity in our internal and external strategies, we will incorporate opportunities to improve health equity in our day-to-day operations. To confirm we fully understand the SDOH needs for our Black, Indigenous and People of Color (BIPOC) communities, **we will conduct two additional outreaches to these members and families when attempting to complete the HRS and use nontraditional data sources, such as pharmacy contact information, to reach these members.** In addition to the individual engagement with our BIPOC members, our SDOH repository will enable us to review SDOH needs, including unmet needs, by race and ethnicity to identify SDOH disparities. Equipped with this data, we will be better positioned to engage in data-driven initiatives to reduce inequities in our communities. In addition, we will seek the new **NCQA Health Equity Accreditation,** which focuses on reducing disparities, aligning the work culture with diversity, equity and inclusion principles and creating distinction with this commitment.

Health equity will be infused throughout all aspects of our SDOH programming, and all staff will be committed to focusing a health equity lens on our work. Our local health plan leadership team will include **population**

health director and health equity director positions, senior health plan-level leadership positions with accountability for building and deploying initiatives that advance health equity, reduce disparities and reduce implicit, explicit and institutional bias experienced by people of color. These leaders will identify health disparities experienced by MississippiCAN and CHIP members and work with internal and external partners to build solutions, inclusive of addressing SDOH needs, to reduce those disparities. The population health director and health equity director will report directly to the health plan medical director. These positions are included in Appendix E 4.2.3.3 Social Determinants of Health (SDOH).

5. How will the Offeror integrate SDOH evaluation into other programs (i.e., Care Management, Quality ...

Understanding and addressing SDOH are critical components of our overall person-centered clinical strategy. We will integrate SDOH evaluations and interventions throughout our care management, quality and population health processes. These will include initial and ongoing SDOH screenings, community assessments and home visits with environmental evaluations. Our risk stratification process will include SDOH measures, and our closed-loop referral processes will incorporate SDOH impactable interventions. Finally, our quality improvement processes will include SDOH factors that influence Index of Disparity, which will allow us to better address member care gaps in ways that are more person-centered.

The SDOH focus will include routine SDOH screenings for members and their communities and population-level identification of SDOH trends. These teams, along with our behavioral health clinicians, CHWs and care managers, will proactively hold recurring meetings to discuss member and community SDOH concerns, share new SDOH-related resources and job aids, reinforce SDOH resource and referral tool use and training, discuss the SDOH screening process and potential improvements and share successes and challenges with member HRS completion. These teams will collaborate during weekly rounds meeting, during which staff will hold in-depth discussions about members of heightened concern and HEDIS measures. The unified work across these teams illustrates our proactive, collaborative approach that will lead to improved SDOH issue identification and support before reaching a point of crisis.

Our care management and quality management teams will be critical to our population health management program, as these teams will be instrumental in creating personal and trusted connections with our members and providing member-level data. Our team will undergo specific SDOH-related trainings to make sure they are equipped to support member needs by using screening data and our referral tool to connect them directly to local resources. We will invest in a comprehensive social health education curriculum focused on advancing health equity and developing deep expertise in our member-facing staff and strategic leaders for social drivers of health. Trainings will include:

- Interactive, virtual, self-paced series of eight modules for teams or individuals, designed to cover the core empathy curriculum and continued education on health equity, health disparities, how to apply motivational interviewing, active listening, addressing burnout and secondary trauma, advocating for psychological safety and encouraging reflection that commits to action. This series will address implicit bias, empathy versus sympathy, equity versus equality, mindfulness, responding versus reacting and using intentional response communication techniques.
- Partnership with the nationally recognized organization, Pathways Community Hub Institute (PCHI), to develop a self-paced culture, identity and race training that illustrates how American culture has affected SDOH. This three-module series will focus on developing self-awareness, understanding your own identity, practicing cultural humility, member-focused care, mindful communication and empathy. The training is built upon culturally and linguistically appropriate services standards and how they should influence our response to members' social needs.

Collaboration across our staff who assess member-level data and engage with members, coupled with these intensive trainings, will allow us to infuse our SDOH approach, including evaluation, need identification and member supports throughout our health plan operations.

Additionally, use the Social Determinants of Health: Staffing table in Appendix E, Innovation and ...

We provide the social determinants of health staffing tables on the following pages.

[END OF RESPONSE]

Social Determinants of Health: Staffing	
Title of Position: Health Equity Director	
SDOH Component to which Position will be Linked: Strategies to improve health equity, population health outcomes, health literacy and health promotion.	
Description of Position: The health equity director will collaborate with internal and external stakeholders to reduce structural barriers to health services stemming from unjust social, economic and structural circumstances that disproportionately impact racially, ethnically and linguistically diverse communities, people with disabilities and people of all gender identities and sexual orientations. This senior-level, Mississippi-based health plan position will use evidence-based principles to develop and deploy initiatives that continuously improve health equity for MississippiCAN and CHIP members.	
Number of Staff Expected to Fill this Position/Staffing Need: 1	
Employee(s) filling this position would be: **[ ] Hourly [X] Salaried**	**Employee(s) filling this position would be:** **[X] Full-Time [ ] Part-Time**
Expected Wage of Position (Hourly rate or salary): [redacted]	**Expected Location of Employee:** **[X] Mississippi [ ] Out-of-State**
Title of Position: Empowerment Manager (SDOH Navigator)	
SDOH Component to which Position will be Linked: All SDOH components noted in response, with a particular focus on housing.	
Description of Position: The empowerment manager (SDOH navigator) will be accountable for developing and implementing a community-based housing navigation and SDOH program designed to connect MississippiCAN and CHIP members with appropriate, affordable housing units, resources and support services to successfully maintain residency. This position will assist with housing assessments, crisis intervention and continuity of care coordination.	
Number of Staff Expected to Fill this Position/Staffing Need: 1	
Employee(s) filling this position would be: **[ ] Hourly [X] Salaried**	**Employee(s) filling this position would be:** **[X] Full-Time [ ] Part-Time**
Expected Wage of Position (Hourly rate or salary): [redacted]	**Expected Location of Employee:** **[X] Mississippi [ ] Out-of-State**
Title of Position: Community Health Worker	
SDOH Component to which Position will be Linked: All SDOH components noted in response, with a particular focus on SDOH screenings and referrals.	
Description of Position: Community health workers (CHWs) are the liaisons to Medicaid members, confirming appropriate care is accessed and providing home and social assessments and member education. Our CHWs will work in a team-based structure and will spend most of their time in the community engaging directly with members. Our CHWs will conduct SDOH screenings and connect members to community resources. In addition, CHWs will share escalated and emergency cases with the empowerment manager (SDOH navigator) for further support.	
Number of Staff Expected to Fill this Position/Staffing Need: 3	

Employee(s) filling this position would be: **[X] Hourly [ ] Salaried**	**Employee(s) filling this position would be:** **[X] Full-Time [ ] Part-Time**
Expected Wage of Position (Hourly rate or salary): [redacted]	**Expected Location of Employee:** **[X] Mississippi [ ] Out-of-State**
Title of Position: Spiritual Care Support	
SDOH Component to which Position will be Linked: All SDOH components noted in response, with a particular focus on SDOH screenings and referrals.	
Description of Position: The spiritual care support position will offer spiritual support to members in need by providing existential, spiritual and emotional support across no/all faith traditions, with a focus on the member's values, ethics, sources of meaning and purpose. The spiritual care support position will partner with the care manager, who will acknowledge the family's deep faith and inform them about our Spiritual Care program, including clinical and spiritual care/chaplaincy services.	
Number of Staff Expected to Fill this Position/Staffing Need: 1	
Employee(s) filling this position would be: **[X] Hourly [ ] Salaried**	**Employee(s) filling this position would be:** **[X] Full-Time [ ] Part-Time**
Expected Wage of Position (Hourly rate or salary): [redacted]	**Expected Location of Employee:** **[X] Mississippi [ ] Out-of-State**

[END OF RESPONSE]

4.2.3.4: Value Added Benefits (Value-Adds) (Unmarked)

The Division will assess any proposed Value-Adds as part of the Innovation and Commitment score. A list of ...

If offering any Value-Add in its response, the Offeror should make summary proposals of any and all ...

We provide detailed charts of our value-added benefits and related staffing on the following pages.

[END OF RESPONSE]

Proposed Value-Added Benefit: Summary Chart	
Benefit Name: Enhanced Dental Benefits – Dental Care Management (DCM) Program	
Target Beneficiary Population(s): • Perinatal and postpartum members • At-risk children based on social determinants of health (SDOH) qualifiers. Qualifiers include cancer, diabetes, asthma, HIV/AIDS, other chronic or autoimmune disease and physical, intellectual or other disability.	
Benefit description, including any limitations and prior authorization requirements: Our DCM program will connect members with unmanaged health conditions to targeted, condition-specific tools and services. The DCM program will include enhanced dental coverage for individuals during pregnancy (perinatal and postpartum) and children who qualify based on SDOH at-risk conditions, including cancer, diabetes, asthma, HIV/AIDS, autoimmune diseases and/or have physical, intellectual or other disabilities. This program is designed to improve overall health outcomes and reduce total cost of care by proactively focusing on preventive and person-centered care. High-risk members will be identified through a dental health risk assessment (HRA) and other data and are assigned to a dental care manager and enrolled in care management. The care manager will then assist with removing barriers to care, including allocating transportation and determining cultural and language preferences, scheduling appointments, following a member through an individualized treatment plan, coordinating with the member's dental provider, identifying external resources to aid overall health improvements, including connecting the member with their PCP, medical care manager, and community resources, and educating members on how oral health impacts their overall health.	
Projected utilization in year one (total units): 5,756 dental procedures	**Price per unit:** $84.67
Gross value: $487,361 annually	**Offsetting costs (provide amount and basis for estimate):** $48,736 based on experience in other states and literature research
Net Value (gross value minus offsetting costs): $438,624	**Will a staffing investment be made for this Value-Add? [X] Yes [ ] No** **If yes, use the Proposed Value-Added Benefit: Staffing Chart to provide details.**

Proposed Value-Added Benefit: Staffing	
Title of Position: Dental Care Manager	
Value-Add to which Position will be Linked: Dental Care Management (DCM) program	
Description of Position: The dental care manager, a licensed dental hygienist, will be responsible for facilitating a collaborative process of telephonic dental care management services for our members that promotes cost-effective, quality oral health care. They will conduct outreach, engagement and deliver oral health education to members by completing a member-specific dental assessment and coordinating dental appointments with their dental home provider who will develop a treatment plan for members' oral health needs.	
Number of Staff Expected to Fill this Position/Staffing Need: 1 Dental Care Manager	
Employee(s) filling this position would be: **[ ] Hourly [X] Salaried**	**Employee(s) filling this position would be:** **[X] Full-Time [ ] Part-Time**
Expected Wage of Position (Hourly rate or salary): [redacted]	**Expected Location of Employee:** **[X] Mississippi [ ] Out-of-State**

Proposed Value-Added Benefit: Staffing	
Title of Positions: Dental Care Coordinator	
Value-Add to which Position will be Linked: Dental Care Management (DCM) program	
Description of Position: The dental care coordinator will be responsible for supporting dental care managers with organizing and coordinating a member's dental care activities in support of oral health and wellness. The dental care coordinator will help administratively support the DCM program and facilitate timely communications with all stakeholders to confirm quality coordinated care and services are provided in a safe, appropriate and effective manner to the member.	
Number of Staff Expected to Fill this Position/Staffing Need: 1 Dental Care Coordinator	
Employee(s) filling this position would be: **[X] Hourly [ ] Salaried**	**Employee(s) filling this position would be:** **[X] Full-Time [ ] Part-Time**
Expected Wage of Position (Hourly rate or salary): [redacted]	**Expected Location of Employee:** **[ ] Mississippi [X] Out-of-State**

Proposed Value-Added Benefit: Summary Chart	
Benefit Name: Enhanced Vision Benefits	
Target Beneficiary Population(s): MississippiCAN adult members, age 21 and over	
Benefit description, including any limitations and prior authorization requirements: Complete pair of eyeglasses once every calendar year, at no cost to the member. No prior authorization required; members can self-refer to a contracted provider. *Enhancing Overall Health through Vision Care* Our enhanced annual eyeglass benefit for adult members will have the added benefit of driving greater utilization of comprehensive routine eye exams. In addition to improving vision health for our members, routine eye exams can help uncover many medical issues, including high blood pressure, high cholesterol and diabetes. We expect an increase in the number of diabetic retinal exams, which are an important part of comprehensive routine eye exams for adults with diabetes. All diagnoses resulting from routine eye exams and diabetic retinal exams (DREs) will be relayed to our member's PCP via notification from our vision benefits administration subcontractor. This notification will alert the PCP that the member has seen an eye care provider, outline the services rendered and diagnoses found during the eye examination and give the eye care provider's contact information. This information will allow the PCP to determine if member education and counseling are necessary or if specialty referrals and/or medication changes might be needed.	
Projected utilization in year one (total units): 3,717	**Price per unit:** $26.85
Gross value: $99,801 annually	**Offsetting costs (provide amount and basis for estimate):** $49,091 based on experience in other states and literature research
Net Value (gross value minus offsetting costs): **$**49,901	**Will a staffing investment be made for this Value-Add? [ ] Yes [X] No** **If yes, use the Proposed Value-Added Benefit: Staffing Chart to provide details.**

Proposed Value-Added Benefit: Summary Chart	
Benefit Name: Virtual Visits	
Target Beneficiary Population(s): All members, targeting members in rural areas and with high-risk chronic conditions	
Benefit description, including any limitations and prior authorization requirements: Our virtual visit program will help us engage members, improve access to care, reduce health care disparities within traditionally underserved populations and decrease avoidable ER, while directing members back to their PCP for in-person follow-up care and nonurgent health concerns. Members can initiate a virtual visit from home with an emergency medicine, family medicine, internal medicine, pediatrician or psychiatrist specialist who is board-certified and licensed in Mississippi. Virtual visits will enable direct access to care through web, mobile web or the mobile app and are available 24 hours a day, seven days a week. For individuals engaged in the program, ER visits decreased by 46% in a similar state to Mississippi since the program's inception in 2019. We expect to achieve similar reductions in Mississippi.	
Projected utilization in year one (total units): 1,470	**Price per unit:** $79.49
Gross value: $116,850	**Offsetting costs (provide amount and basis for estimate):** $282,500 based on experience in other states and literature research
Net Value (gross value minus offsetting costs): -$165,650	**Will a staffing investment be made for this Value-Add? [ ] Yes [X] No** **If yes, use the Proposed Value-Added Benefit: Staffing Chart to provide details.**

Proposed Value-Added Benefit: Summary Chart	
Benefit Name: Pest Control and Bed Bug Home Treatment	
Target Beneficiary Population(s): All MississippiCAN and CHIP members	
Benefit description, including any limitations and prior authorization requirements: As part of our effort to help members overcome barriers to improved health due to SDOH, we will offer pest control and bed bug home treatment as needed and assessed by our population health team. We will identify members through care management screening or assessment, or provider or self-referrals. Infested homes have negative effects on physical health and mental health, as well as economic consequences. Physical health effects include allergic reactions to bites and in some rare cases anaphylaxis (severe, whole-body reaction) and secondary infections of the skin from the bite reaction, such as impetigo, ecthyma and lymphangitis. Mental health impacts include anxiety and insomnia.	
Projected utilization in year one (total units): 100	**Price per unit:** $150
Gross value: $15,000 annually	**Offsetting costs (provide amount and basis for estimate):** $0 based on experience in other states and literature research
Net Value (gross value minus offsetting costs): $15,000	**Will a staffing investment be made for this Value-Add? [ ] Yes [X] No** **If yes, use the Proposed Value-Added Benefit: Staffing Chart to provide details.**

<table>
<tr><th colspan="2">Proposed Value-Added Benefit: Summary Chart</th></tr>
<tr><td colspan="2">Benefit Name: Nutrition Assistance – Community Care Package and Meal Service Program</td></tr>
<tr><td colspan="2">Target Beneficiary Population(s):
• Perinatal and postpartum members
• Members with high-risk chronic conditions
• Members in need of post-discharge care</td></tr>
<tr><td colspan="2">Benefit description, including any limitations and prior authorization requirements:
This program will provide high-quality, nutritionally tailored meals with menus designed by dietitians and professional chefs, tailored to health conditions. This program will give members the power to choose what they want to eat. These meals are nutritionally balanced, diabetes-friendly, have lower sodium and are renal-friendly and heart-friendly. The program offers vegetarian options, pureed meals for those with difficulty swallowing (dysphagia) and meals for cancer support (higher in protein and calories to help prevent weight loss). When we identify members in the target population, either through care management screening or assessment, provider or self-referrals, we will provide a tailored number of meals, as determined by the member's specific needs.</td></tr>
<tr><td>Projected utilization in year one (total units):
35,765</td><td>Price per unit: $6.99</td></tr>
<tr><td>Gross value: $250,000</td><td>Offsetting costs (provide amount and basis for estimate): $0 based on experience in other states and literature research</td></tr>
<tr><td>Net Value (gross value minus offsetting costs):
$250,000</td><td>Will a staffing investment be made for this Value-Add? [ ] Yes [X] No

If yes, use the Proposed Value-Added Benefit: Staffing Chart to provide details.</td></tr>
<tr><td colspan="2"></td></tr>
</table>

Proposed Value-Added Benefit: Summary Chart	
Benefit Name: Unlimited PCP or Patient-Centered Medical Home (PCMH) Medical Office Visits	
Target Beneficiary Population(s): All MississippiCAN and CHIP members	
Benefit description, including any limitations and prior authorization requirements: We will provide additional PCP visits with the PCP or PCMH beyond the covered 16 services. Continued access to care is essential for the health of all Mississippians, including supporting continued care for Mississippians with chronic comorbid conditions, providing preventive services to prevent further development of chronic conditions in the future and helping perinatal and postpartum members access the continued care they need.	
Projected utilization in year one (total units): 11,700 additional office visits	**Price per unit:** $88.25
Gross value: $1,032,525 annually	**Offsetting costs (provide amount and basis for estimate):** $1,032,525 based on experience in other states and literature research
Net Value (gross value minus offsetting costs): $0	**Will a staffing investment be made for this Value-Add? [ ] Yes [X] No** **If yes, use the Proposed Value-Added Benefit: Staffing Chart to provide details.**

Proposed Value-Added Benefit: Summary Chart	
Benefit Name: Independent Living Transitions Program for Younger Plan Members Ages 14 – 26	
Target Beneficiary Population(s): Adolescent members, including foster members	
Benefit description, including any limitations and prior authorization requirements: This program will use an interactive website to help teens learn about areas that have historically prevented them from achieving stable, independent lives. This program will provide specific, tailored information for teens to engage them in their health early as they transition to adulthood. This engaging, interactive program will teach the practical skills of managing bank accounts, securing housing, creating a resume, finding job training and applying for college. All teens, including teens in foster care, will have access to this program. When we identify members in the target populations through either care management screening or assessment, or provider or self-referrals, we will provide a tailored number of meals, based on their specific needs.	
Projected utilization in year one (total units): 1 (unit is buying license to platform)	**Price per unit:** $8,500
Gross value: $8,500	**Offsetting costs (provide amount and basis for estimate):** $0 based on experience in other states and literature research
Net Value (gross value minus offsetting costs): $8,500	**Will a staffing investment be made for this Value-Add? [ ] Yes [X] No** **If yes, use the Proposed Value-Added Benefit: Staffing Chart to provide details.**

Proposed Value-Added Benefit: Summary Chart	
Benefit Name: Tablets for Virtual Care Management and Social Supports	
Target Beneficiary Population(s): Available to MississippiCAN and CHIP members in need of either broadband support or devices to access telehealth services or SDOH supports. Members will be identified through care management screening, assessment tools, provider referrals or member self-referrals.	
Benefit description, including any limitations and prior authorization requirements: We will partner with T-Mobile to purchase tablets and unlimited data plans for our members identified by our care managers, assessment tools, provider referrals or member self-referrals as in need of devices for medical telehealth visits, educational supports or social isolation supports. This turnkey solution will allow us to preload the tablets with key health care apps, which will drive increased engagement and empower members with resources to support healthy behaviors. This solution will best fit with high-need, high-cost populations who would benefit from frequent digital engagement and intervention. Tablets will be locked down to exclusively preloaded health apps to meet regulations for most states. Several member populations will benefit from this program. We will use them for members in care management, high-risk maternity members, members identified in need of educational supports or social isolation supports. We can equip community-based organizations with tablets for member use.	
Projected utilization in year one (total units): 100	**Price per unit:** $50 per tablet and $40 monthly cost for data
Gross value: $53,000 annually	**Offsetting costs (provide amount and basis for estimate):** $135,600 based on experience in other states and literature research
Net Value (gross value minus offsetting costs): -$82,600	**Will a staffing investment be made for this Value-Add? [ ] Yes [X] No** **If yes, use the Proposed Value-Added Benefit: Staffing Chart to provide details.**

Proposed Value-Added Benefit: Summary Chart	
Benefit Name: Non-Emergency Transportation (NET) CHIP	
Target Beneficiary Population(s): CHIP members	
Benefit description, including any limitations and prior authorization requirements: The NET services for CHIP members will mirror the current benefit in place for MississippiCAN members. This benefit will comprise unlimited rides to and from Medicaid-covered services, gas mileage reimbursement, meals and lodging and commercial flights specific to health care services. The delegated vendor oversight manager can approve prior authorization requests for extended mileage beyond these current restrictions: • PCP, standalone pharmacy, dentist, vision and hearing screening trips over 50 one-way miles will require prior authorization. • Specialist trips will be capped at 150 miles. Extended mileage requests beyond 150 one-way miles will require prior authorization.	
Projected utilization in year one (total units): 2,500	**Price per unit:** $35
Gross value: $87,500 annually	**Offsetting costs (provide amount and basis for estimate):** $21,875 based on experience in other states and literature research
Net Value (gross value minus offsetting costs): $65,625	**Will a staffing investment be made for this Value-Add? [ ] Yes [X] No** **If yes, use the Proposed Value-Added Benefit: Staffing Chart to provide details.**

Proposed Value-Added Benefit: Summary Chart	
Benefit Name: Non-Emergency Transportation (NET) Support for Pregnant Members	
Target Beneficiary Population(s): Pregnant members	
Benefit description, including any limitations and prior authorization requirements: To help pregnant members access critical care and community resources, we will offer additional NET services as part of our comprehensive approach to maternal and child health. We will offer 10 one-way or 20 round-trip rides to social services. This may include, but is not limited to, food banks; Women, Infants and Children (WIC) programs; Medicaid office; Supplemental Nutrition Assistance Program – Education (SNAP-Ed) programs; or other participating health care providers, such as vision, dental and behavioral health and substance use providers who fall outside the state parameters. The current NET benefit does not cover transportation for social services. Prior authorization will be required through the member's care manager.	
Projected utilization in year one (total units): 3,000	**Price per unit:** $35
Gross value: $105,000 annually	**Offsetting costs (provide amount and basis for estimate):** $26,250 based on experience in other states and literature research
Net Value (gross value minus offsetting costs): $78,750	**Will a staffing investment be made for this Value-Add? [ ] Yes [X] No** **If yes, use the Proposed Value-Added Benefit: Staffing Chart to provide details.**

Proposed Value-Added Benefit: Summary Chart	
Benefit Name: Car Seats	
Target Beneficiary Population(s): Will be provided to moms based on needs; designed to augment the resources and supports our programs and partnerships provide to moms. Car seats will be provided for children in MississippiCAN, CHIP and foster care as their needs are identified by a care manager, assessment tools, provider referral or member self-referral.	
Benefit description, including any limitations and prior authorization requirements: This benefit will provide infant and child car seats to support child safety. Motor vehicle injuries are a preventable leading cause of death for children. Buckling children into age- and size-appropriate car seats reduces serious and fatal injuries up to 80%. The expense of car seats, however, causes many low-income families to go without car seats or to use old or unsafe car seats. Access to safe car seats can be a factor in a child being able to stay in their home or be returned to their home if Child Protection Services has intervened to keep the child safe. Our care managers will partner with Everyday Miracles to identify members in need of car seats. Many of the current maternal programs and community partnerships provide car seats to our members; however, if there is a member who needs a car seat, this benefit will provide it.	
Projected utilization in year one (total units): 300	**Price per unit:** $100
Gross value: $30,000 annually	**Offsetting costs (provide amount and basis for estimate):** $0 based on experience in other states and literature research
Net Value (gross value minus offsetting costs): $30,000	**Will a staffing investment be made for this Value-Add? [ ] Yes [X] No** **If yes, use the Proposed Value-Added Benefit: Staffing Chart to provide details.**

Proposed Value-Added Benefit: Summary Chart	
Benefit Name: GEDWorks	
Target Beneficiary Population(s): MississippiCAN and CHIP members seeking to earn high school equivalency or GED to support career development and personal empowerment.	
Benefit description, including any limitations and prior authorization requirements: Higher educational attainment is associated with better jobs, higher earnings, increased health knowledge, better self-reported health and fewer chronic conditions. Members with lower educational attainment are at a greater risk of adverse health outcomes such as obesity, cardiovascular disease, lung disease, mental health problems and premature death. In addition, students who drop out of high school are more likely to experience incarceration. This benefit will be provided to members seeking to earn high school equivalency or GED. The program will include: • Online access with comprehensive materials • Dedicated bilingual advisors • Dedicated GEDWorks advisor to work one on one with member • Unlimited study materials • Unlimited practice tests • Unlimited GED testing • Local Mississippi testing centers After the first year of the program, we will evaluate for completion statistics and potential expansion of the benefit. Access to the program is provided by the care management team in conjunction with the empowerment manager.	
Projected utilization in year one (total units): 40	**Price per unit:** $225
Gross value: $9,000 annually	**Offsetting costs (provide amount and basis for estimate):** $0 based on experience in other states and literature research
Net Value (gross value minus offsetting costs): $9,000	**Will a staffing investment be made for this Value-Add? [X] Yes [ ] No** **If yes, use the Proposed Value-Added Benefit: Staffing Chart to provide details.**

Proposed Value-Added Benefit: Staffing	
Title of Position: Empowerment Manager (SDOH Navigator)	
Value-Add to which Position will be Linked: GEDWorks	
Description of Position: The empowerment manager will support the GEDWorks value-added benefit in the following ways: • Helping connect members to job interviews and transportation • Providing interest and skill-based assessments that assess career path recommendations • Connecting to local agencies that offer real-life experience through internships that can be used to build a resume • Coordinating resume-writing support services • Coordinating interview coaching • Supporting high school equivalency (HSE) through the Department of Workforce Development's Adult Education, along with vouchers that cover the cost of the HSE exam • Providing free bus pass during initial 30 days on the job when the employer is located on a bus route • Developing innovative partnerships that create multiple networks for candidate referrals for job placement • Providing linkages to vital state economic development programs	
Number of Staff Expected to Fill this Position/Staffing Need: 1	
Employee(s) filling this position would be: **[ ] Hourly [X] Salaried**	**Employee(s) filling this position would be:** **[X] Full-Time [ ] Part-Time**
Expected Wage of Position (Hourly rate or salary): [redacted]	**Expected Location of Employee:** **[X] Mississippi [ ] Out-of-State**

Proposed Value-Added Benefit: Summary Chart	
Benefit Name: Diaper Vouchers	
Target Beneficiary Population(s): Mothers and fathers in MississippiCAN and CHIP, identified through care management, assessment tools, provider referral or member self-referral	
Benefit description, including any limitations and prior authorization requirements: Using dirty diapers or extending the use of a single diaper can cause health problems for a child and family. Diaper-related health issues are linked to outpatient pediatric visits, causing preventable stress on the health care system. Providing diapers and baby wipes to these families can relieve the financial cost for these families and enable them to allocate financial resources to other needed areas. Diaper vouchers will be distributed to mothers and fathers in need who are identified through care management, assessment tools, provider referral or member self-referral. These vouchers can be redeemed for a monthly supply of diapers and wipes. Members may use NET for baby related needs such as obtaining diapers.	
Projected utilization in year one (total units): 1,000	**Price per unit:** $25
Gross value: $25,000 annually	**Offsetting costs (provide amount and basis for estimate):** $0 based on experience in other states and literature research
Net Value (gross value minus offsetting costs): $25,000	**Will a staffing investment be made for this Value-Add? [ ] Yes [X] No** **If yes, use the Proposed Value-Added Benefit: Staffing Chart to provide details.**

Proposed Value-Added Benefit: Summary Chart	
Benefit Name: CPR/Parenting Classes	
Target Beneficiary Population(s): Mothers and fathers in MississippiCAN and CHIP, identified through care management, assessment tools, provider referral or member self-referral	
Benefit description, including any limitations and prior authorization requirements: Drowning is a leading cause of death for children ages 4 and under. By offering CPR certification for parents, we can decrease loss of life, prevent brain death and reduce recovery time. Parenting classes can improve parental empowerment and competency, improve child behavior, increase positive parenting practices, improve parent-child interactions, increase social connections, improve parental mental health and well-being and decrease use of corporal punishment and risk of child abuse. We will make these classes available for mothers and fathers identified through care management, assessment tools, provider referrals or member self-referrals.	
Projected utilization in year one (total units): 1,000	**Price per unit:** $25
Gross value: $25,000 annually	**Offsetting costs (provide amount and basis for estimate):** $0 based on experience in other states and literature research
Net Value (gross value minus offsetting costs): $25,000	**Will a staffing investment be made for this Value-Add? [ ] Yes [X] No** **If yes, use the Proposed Value-Added Benefit: Staffing Chart to provide details.**

Proposed Value-Added Benefit: Summary Chart	
Benefit Name: Group Prenatal Care	
Target Beneficiary Population(s): Pregnant members	
Benefit description, including any limitations and prior authorization requirements: This program will offer group prenatal care services such as the Centering Pregnancy Model. This benefit will be an opportunity to apply an evidence-based care model with the potential to improve important birth outcomes, address racial and ethnic disparities and achieve cost savings. Group prenatal care is an evidence-based innovative model shown to reduce preterm birth rates, especially among Black women. We will partner with a national organization to support model adoption at up to three provider practices in high-need areas of Mississippi.	
Projected utilization in year one (total units): 3	**Price per unit:** $37,530
Gross value: $112,590 annually	**Offsetting costs (provide amount and basis for estimate):** $0 based on experience in other states and literature research
Net Value (gross value minus offsetting costs): $112,590 annually	**Will a staffing investment be made for this Value-Add? [ ] Yes [X] No** **If yes, use the Proposed Value-Added Benefit: Staffing Chart to provide details.**

Proposed Value-Added Benefit: Summary Chart	
Benefit Name: Boys & Girls Club	
Target Beneficiary Population(s): MississippiCAN and CHIP children and adolescents	
Benefit description, including any limitations and prior authorization requirements: Access to fitness and physical activity is important for children's growth, strengthening bones, muscles, hearts and lungs and improving balance, posture and flexibility. Physical activity reduces children's risk of getting heart disease, cancer and type 2 diabetes later in life. Socialization for children is important for developing, helping children learn how to manage personal feelings, understand others' feelings and needs and interact in a respectful and acceptable way. In addition, socialization alleviates mental health strain caused by social isolation. The Boys & Girls Club provides physical fitness access to children and adolescents and provides caring mentors through programs designed to empower youth to excel in school and lead healthy, productive lives. These programs are based in sports and recreation, education supports, nourishing the arts, teaching about health and wellness, educating adolescents on workforce readiness and building character and leadership. All children and adolescent members will have access to this benefit.	
Projected utilization in year one (total units): 100	**Price per unit:** $100
Gross value: $10,000 annually	**Offsetting costs (provide amount and basis for estimate):** $1,000 based on experience in other states and literature research
Net Value (gross value minus offsetting costs): $9,000	**Will a staffing investment be made for this Value-Add? [ ] Yes [X] No** **If yes, use the Proposed Value-Added Benefit: Staffing Chart to provide details.**

Proposed Value-Added Benefit: Summary Chart	
Benefit Name: YMCA	
Target Beneficiary Population(s): MississippiCAN adults	
Benefit description, including any limitations and prior authorization requirements: Access to physical activity and exercise reduces risk of a heart attack, manages weight and lowers blood cholesterol level, blood pressure and risk for type 2 diabetes and some cancers. Physical activity results in stronger bones, muscles and joints, lowering the risk of developing osteoporosis and risk from falls. Members who are physically active have improved recovery from periods of hospitalization or bed rest, and improved mental health. The YMCA provides gym facilities and fitness programs for members to achieve their goals and lead a healthy lifestyle. This includes group exercise classes, such as yoga, Zumba and kickboxing, and personal training and nutrition counseling support. The YMCA offers programs such as Child Watch and Cool Kids Club to care for members' children as they work out. Access to the YMCA will be available for all adult members.	
Projected utilization in year one (total units): 100	**Price per unit:** $100
Gross value: $10,000 annually	**Offsetting costs (provide amount and basis for estimate):** $1,000 based on experience in other states and literature research
Net Value (gross value minus offsetting costs): $9,000	**Will a staffing investment be made for this Value-Add? [ ] Yes [X] No** **If yes, use the Proposed Value-Added Benefit: Staffing Chart to provide details.**

Proposed Value-Added Benefit: Summary Chart	
Benefit Name: Over-the-Counter (OTC) Monthly Allowance for Non-Prescription OTC/Hygiene Items	
Target Beneficiary Population(s): MississippiCAN and CHIP – available for all members	
Benefit description, including any limitations and prior authorization requirements: Access to OTC nonprescription items, such as pain relievers, children's medications, cold/flu medicine, dental care and feminine hygiene products is essential for sustaining good health. Members can obtain essential items to maintain good health and allocate their financial resources to other areas. We will identify members who need OTC vouchers through care management, assessment tools, provider referrals or member self-referrals.	
Projected utilization in year one (total units): $5,000	**Price per unit:** $20 per voucher
Gross value: $100,000	**Offsetting costs (provide amount and basis for estimate):** $0 based on experience in other states and literature research
Net Value (gross value minus offsetting costs): $100,000	**Will a staffing investment be made for this Value-Add? [ ] Yes [X] No** **If yes, use the Proposed Value-Added Benefit: Staffing Chart to provide details.**

Proposed Value-Added Benefit: Summary Chart	
Benefit Name: $25 Gift Card Incentive for Receiving COVID-19 Vaccine	
Target Beneficiary Population(s): Unvaccinated members over age 12	
Benefit description, including any limitations and prior authorization requirements: Vaccination against the COVID-19 virus is a simple, safe and effective way to protect against the virus, activating the body's natural defenses to resist infection and strengthen the immune system. The COVID-19 vaccine has been shown to prevent serious illness, hospitalization and death. To help members become protected from serious illness and to increase vaccination rates within the Mississippi community, we will give $25 gift cards to members over age 12 who are vaccinated in vaccination clinics hosted in community fairs and events.	
Projected utilization in year one (total units): 9,000	**Price per unit:** $25 gift card
Gross value: $225,000	**Offsetting costs (provide amount and basis for estimate):** $225,000 based on experience in other states and literature research
Net Value (gross value minus offsetting costs): $0	**Will a staffing investment be made for this Value-Add? [ ] Yes [X] No** **If yes, use the Proposed Value-Added Benefit: Staffing Chart to provide details.**

Proposed Value-Added Benefit: Summary Chart	
Benefit Name: Respite Services	
Target Beneficiary Population(s): Caregivers of children up to age 21 with a serious emotional disturbance (SED)	
Benefit description, including any limitations and prior authorization requirements: Family caregivers are essential for members with high needs, but the physical, emotional and economic burdens of caregivers frequently are not paired with any support. Caregiving is a highly demanding and stressful responsibility, and many family caregivers report "fair or poor health" and have one or more chronic conditions. We will partner with a community-based behavioral health services agency to pay for respite services to caregivers of children with SED, which is not covered in the Medicaid state plan. We will partner with the Division to provide training for respite providers. We will identify members for this program through this partnership and through our care managers.	
Projected utilization in year one (total units): 200	**Price per unit:** $250
Gross value: $50,000	**Offsetting costs (provide amount and basis for estimate):** $0 based on experience in other states and literature research
Net Value (gross value minus offsetting costs): $50,000	**Will a staffing investment be made for this Value-Add? [ ] Yes [X] No** **If yes, use the Proposed Value-Added Benefit: Staffing Chart to provide details.**

Proposed Value-Added Benefit: Summary Chart	
Benefit Name: One Pass	
Target Beneficiary Population(s): Open to all members in MississippiCAN and CHIP, but will target children and adults who are overweight or obese	
Benefit description, including any limitations and prior authorization requirements: Mississippi is a largely rural state, and many members are a far drive from a physical fitness facility. To supplement the Boys & Girls Club and YMCA benefits, we will provide members access to One Pass. One Pass provides access to 144 gyms and boutique fitness studios in Mississippi and offers thousands of on-demand and livestreaming fitness classes to our members. These classes will be unlimited for members, and we will provide specific content for individuals with disabilities, Parkinson's, multiple sclerosis and other conditions. Members can access these streaming fitness classes from multiple platforms at a time and can customize their workouts. Examples of these fitness classes include functional strength, mobility, cardio, meditation, yoga, Pilates and corrective and rehabilitation exercises. This benefit will be open to all members but will be targeted toward children and adults who are overweight or obese.	
Projected utilization in year one (total units): 39,519	**Price per unit:** $15.84 per person
Gross value: $625,981	**Offsetting costs (provide amount and basis for estimate):** $0 based on experience in other states and literature research
Net Value (gross value minus offsetting costs): $625,981	**Will a staffing investment be made for this Value-Add? [ ] Yes [X] No** **If yes, use the Proposed Value-Added Benefit: Staffing Chart to provide details.**

Proposed Value-Added Benefit: Summary Chart	
Benefit Name: Ambulance Treatment-in-Place Service	
Target Beneficiary Population(s): MississippiCAN and CHIP members residing in rural counties served by the ambulance provider	
Benefit description, including any limitations and prior authorization requirements: Because of the largely rural nature and lower number of providers in Mississippi, many members struggle with adequate access to care. Many members must drive over an hour one way to get to a local facility, and many times these facilities do not have the medical supports they need. This often drives up inappropriate ER use. To alleviate this problem, we will partner with an ambulance provider to provide an ambulance in rural areas with low medical facility access. These ambulances will function as mobile clinics, providing needed services to members struggling to obtain adequate medical access.	
Projected utilization in year one (total units): 250	**Price per unit:** $1,000
Gross value: $250,000	**Offsetting costs (provide amount and basis for estimate):** $250,000 based on experience in other states and literature research
Net Value (gross value minus offsetting costs): $0	**Will a staffing investment be made for this Value-Add? [ ] Yes [X] No** **If yes, use the Proposed Value-Added Benefit: Staffing Chart to provide details.**

Proposed Value-Added Benefit: Summary Chart	
Benefit Name: Backpacks and Blankets for Foster Children	
Target Beneficiary Population(s): All foster children	
Benefit description, including any limitations and prior authorization requirements: Foster children are often given trash bags to pack up their belongings as they move between homes, creating a traumatizing experience for these children. We will provide backpacks and blankets for all foster children and adolescents. The 17-inch backpacks are suitable for carrying books to school or belongings to a new home.	
Projected utilization in year one (total units): 1,200	**Price per unit:** $9.80
Gross value: $11,760	**Offsetting costs (provide amount and basis for estimate):** $0 based on experience in other states and literature research
Net Value (gross value minus offsetting costs): $11,760	**Will a staffing investment be made for this Value-Add? [ ] Yes [X] No** **If yes, use the Proposed Value-Added Benefit: Staffing Chart to provide details.**

Proposed Value-Added Benefit: Summary Chart	
Benefit Name: Trauma Kits for children with reactive attachment disorder (RAD), post-traumatic stress disorder (PTSD) and disruptive mood dysregulation disorder (DMDD)	
Target Beneficiary Population(s): All members 3 – 17 years old with a RAD, PTSD or DMDD diagnosis who have outpatient therapy more than once per week, three ER visits within 60 days or an inpatient admission	
Benefit description, including any limitations and prior authorization requirements: Self-soothing behaviors are common for children in need of regulating their emotional states. Some of these self-soothing behaviors can manifest in unhealthy self-soothing behaviors such as thumb-sucking; fingernail biting; pulling hair, eyebrows or eyelashes; head biting; alcohol or drug experimentation; or self-harm. We will provide a trauma kit for kids with RAD, PTSD or DMDD diagnoses, which will include a fidget spinner, separate lavender and citrus essential oils, kinetic sand and regulation card suggestions. This trauma kit will help children and adolescents use self-soothing techniques that are healthy for them and potentially replace any inappropriate or potentially injurious self-soothing behaviors.	
Projected utilization in year one (total units): 5,000	**Price per unit:** $8.25
Gross value: $55,687	**Offsetting costs (provide amount and basis for estimate):** $0 based on experience in other states and literature research
Net Value (gross value minus offsetting costs): $55,687	**Will a staffing investment be made for this Value-Add? [ ] Yes [X] No** **If yes, use the Proposed Value-Added Benefit: Staffing Chart to provide details.**

Proposed Value-Added Benefit: Summary Chart	
Benefit Name: Doulas for All	
Target Beneficiary Population(s): All pregnant members in MississippiCAN and CHIP	
Benefit description, including any limitations and prior authorization requirements: Doula care has been shown to improve health outcomes for mother and baby, including lower health care costs, reduced cesarean sections, decreased maternal anxiety and depression and improved communication between low-income, racially and ethnically diverse pregnant individuals and their health care providers. Doulas can provide physical comfort through touch, massage, breathing techniques, emotional assurance and encouragement. They can provide information about what happens during labor and the postpartum period, help facilitate communication between the pregnant individual and hospital staff, provide guidance and support for families and assist with breastfeeding. This doula benefit will be available to all pregnant members in MississippiCAN and CHIP.	
Projected utilization in year one (total units): 302	**Price per unit:** $1,300
Gross value: $390,000	**Offsetting costs (provide amount and basis for estimate):** $390,000 based on experience in other states and literature research
Net Value (gross value minus offsetting costs): $0	**Will a staffing investment be made for this Value-Add? [ ] Yes [X] No** **If yes, use the Proposed Value-Added Benefit: Staffing Chart to provide details.**

[END OF RESPONSE]

4.2.3.5: Performance Improvement Projects (Unmarked)

The Division is seeking to standardize Performance Improvement Projects in its next contracting cycle, ...

To respond to this requirement, the Offeror should make summary proposals of four (4) potential PIPs ...

We provide detailed charts of our Performance Improvement Projects and related staffing on the following pages.

[END OF RESPONSE]

Performance Improvement Project (PIP): Summary Chart
PIP Title: Sickle Cell Disease Management Decreasing Emergency Room Utilization
Target Beneficiary Population(s): The target population is selected through careful analysis of HEDIS®, utilization, care/disease management, member satisfaction surveys, CAHPS® and national benchmarks. Through the comprehensive analysis of utilization, enrollment claims, encounters, pharmacy and compliance, we will target eligible MississippiCAN members ages 5 – 64 during the measurement year. The members identified for this program are high utilizers of ER services for the management of sickle cell disease.
Overview of PIP Strategy and Goals: This proposed PIP will implement and evaluate interventions to decrease ER utilization using care management to coordinate care for Medicaid members ages 5 – 64 during the measurement year who were identified as individuals with high utilization of ER services for sickle cell disease. Based on our experience managing this population, we will implement the following interventions to determine whether there is a positive impact on reducing ER use and enhancing the quality of life and pain score of these members. Through care management, population health and pharmacy, we will talk with members about the importance of establishing a medical home and adhering to medication therapy. We will encourage members to use a nurse line (24 hours a day, seven days a week) and urgent care services, and we will assist in setting up transportation. Additional elements of our approach may include educating members before their first perceived emergency and talking with them about the appropriate use of primary care clinicians and urgent care. Further, we will build a robust primary care and urgent care network, conduct member profiling and escalate intervention intensity based on number of ER visits. Our year-over-year comparison goal is a 3% reduction of ER utilization from these members from the previous year rate.
Reason for choosing this PIP: We chose this PIP through identified opportunities and gaps in performance, prevalence of a condition, need for a specific service, member demographic characteristics, health risks and interest in the topic. The PIPs may be initiated to address the vulnerable populations as identified by state requirements and priorities such as reducing ER use. Sickle cell disease is a complex, lifelong condition with high-cost impacts to the individual and the health care industry. One in 12 Black individuals carry a sickle trait, and the disease affects one in 500 Black births. An opportunity for improvement exists in Mississippi. There are approximately 1 million Black individuals living in Mississippi, which means at least 2,500 Black individuals in Mississippi are living with sickle cell disease at any point in time (*mssicklecellfoundation.org*). Moreover, sickle cell disease is a major public health concern. Nearly 32% of patients with sickle cell disease are readmitted to the hospital within 30 days after discharge.
Tools for measuring impact: We will conduct a causal/barrier analysis using a fishbone (Ishikawa) method with each measurement to identify factors that contribute to the overutilization of ER in members who have sickle cell disease. Subject matter experts will conduct the barrier analysis quarterly and annually. The findings will be discussed and further analyzed via work groups that comprise functional leaders at the health plan, and during our Provider Advisory Committee and Quality Management Committee meetings. In addition, we will perform quantitative and qualitative analyses. If re-measurement does not demonstrate statistically significant improvement and performance does not exceed established goals, the quality improvement cycle will begin again. In such cases, we will evaluate each intervention, identify barriers interfering with the achievement of performance goals and revise the intervention, or replace or supplement it with new interventions to address identified barriers.
Will a staffing investment be made for this PIP? [X] Yes [ ] No **If yes, use the Performance Improvement Project (PIP): Staffing Chart to provide details.**

Performance Improvement Project (PIP): Summary Chart
PIP Title: Adolescent Well Care Visit (AWC)
Target Beneficiary Population(s): The target population will include CHIP members ages 12 – 21 eligible for a comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year. The target population will be selected through a careful analysis of HEDIS, utilization, care and disease management, member satisfaction surveys, CAHPS and national benchmarks.
Overview of PIP Strategy and Goals: This PIP will implement and evaluate interventions targeted at members ages 12 – 21 who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year. Despite the importance of these visits, few adolescents receive their recommended annual visit. This underutilization of services yields missed opportunities for prevention, early detection and treatment; therefore, increasing routine adolescent utilization is an important health care objective. Based on our experience with managing this population, the following interventions could be implemented: collaborating with providers to host Saturday clinics and after-hours clinics; providing resources to assist the clinics with making outreach calls to members who struggle with adherence; and transferring the member to the clinic to set up the appointment to increase member utilization of preventive screenings. Additional elements to our approach may include using care management to provide a bridge for children and families across multiple systems (e.g., schools, health care providers and community partners). In coordinating care, our care managers enable 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 (both telephonic and mailed) and obtaining feedback reporting of access and services. The benchmark used for this PIP is the NCQA® Quality Compass 50th Percentile. Our year-over-year goal is to increase compliance by 3% annually.
Reason for choosing this PIP: We selected these particular PIP topics through identified opportunities and gaps in performance, and we considered the prevalence of a condition, need for a specific service, member demographic characteristics, health risks and interest in the topic. Assessing physical, emotional and social development is important at every stage of life, particularly with children and adolescents (*brightfutures.aap.org*). Behaviors established during childhood or adolescence, such as eating habits and physical activity, often extend into adulthood. Well-care visits provide an opportunity for providers to influence health and development. For members ages 12 – 21, this is an opportunity to address social determinants of health, physical growth and development, emotional well-being, risk reduction (pregnancy, sexually transmitted infections, tobacco and e-cigarettes) and safety (firearm safety, substance use, seat belt use and texting while driving). Mississippi rates compare unfavorably to national rates on overall mortality, motor vehicle crash mortality, suicide, safety belt use, suicide attempts requiring medical attention, sexual experience and current sexual activity.
Tools for measuring impact: Subject matter experts will conduct a causal/barrier analysis quarterly and annually. The analysis will help identify behavioral determinants so that more effective social and behavioral change messages, strategies and activities can be developed. Work groups that comprise the Provider Advisory Committee and Quality Management Committee will discuss and further analyze findings. In addition, we will perform quantitative and qualitative analyses to determine statistical significance and address barriers and root cause(s). Improvement is evidenced in repeated measurements of the indicators specified for each PIP and involves comparing initial measurement against benchmarks and improvement from the baseline. Sustained improvement is the goal. If re-measurement does not demonstrate statistically significant improvement and performance does not exceed established goals, the quality improvement cycle begins again. In such cases, we evaluate each intervention, identify barriers interfering with the achievement of performance goals and revise the intervention, or replace or supplement it with new interventions to address identified barriers.
Will a staffing investment be made for this PIP? [X] Yes [ ] No **If yes, use the Performance Improvement Project (PIP): Staffing Chart to provide details.**

Performance Improvement Project (PIP): Summary Chart
PIP Title: Reducing Adolescent and Childhood Obesity
Target Beneficiary Population(s): The target population for this proposed PIP will include eligible CHIP members ages 3 – 17 who had an outpatient visit with a PCP or OB/GYN with evidence of BMI percentile, evidence of counseling for nutrition and counseling for physical activity documentation in the medical record. The target population will be selected through a careful analysis of HEDIS, utilization, care/disease management, member satisfaction surveys, CAHPS and national benchmarks.
Overview of PIP Strategy and Goals: The PIP will evaluate targeted providers and eligible Medicaid members 3 – 17 years of age who had an outpatient visit with a PCP or OB/GYN with evidence of BMI percentile documentation, evidence of counseling for nutrition and counseling for physical activity documentation. Based on barrier/analysis findings, we will educate/encourage health care professionals to adopt clinical practice guideline standards of care (evidence-based) for prevention, screening, diagnosis and treatment of overweight and/or obese children, adolescents and adults that will help them achieve and maintain a healthy weight, avoid obesity-related complications and reduce psychosocial consequences of obesity. We will provide health care professionals with materials and resources for distribution, such as path and coding guidelines, tracking tools such as patient care opportunity reports and protocols to guide decision making for obesity prevention. In addition, we will offer clinic support, community-based programs that offer members education on healthy lifestyles and the importance of developing healthy eating habits. The benchmarks used for this PIP is the NCQA® Quality Compass 50th Percentile. Our year-over-year goal is to increase compliance by 3% annually.
Reason for choosing this PIP: We select PIP topics through identified opportunities and gaps in performance, and we consider the prevalence of a condition, need for a specific service, member demographic characteristics, health risks and interest in the topic. According to the Centers for Disease Control and Prevention (CDC), more than half of all Americans live with a preventable chronic disease, and many such diseases are related to obesity, poor nutrition and physical inactivity. Mississippi at 37.3% has the second highest rate of adult obesity in the nation (Behavioral Risk Factor Surveillance System [BRFSS], 2016). Mississippi youth are at risk as well with an obesity rate of 18% and children at 21.9%. There are racial and ethnic disparities that are troubling for Mississippi, which cannot be ignored.
Tools for measuring impact: In our experience, using an array of analytic tools helps mine various data sets to assist in identifying performance improvement opportunities. Once an improvement opportunity is identified, we will work to make sure members receive the benefits of preventive care, early detection, tools to facilitate self-management and dedicated care coordination. Subject matter experts, staff with strong knowledge of statistical analysis, external community resources, the Provider Advisory Committee and the Quality Management Committee will discuss findings. Root causes are postulated, barriers to performance are identified and interventions are developed to specifically address the identified barriers and are likely to achieve improvements in quality. In addition, quantitative and qualitative analyses is performed to determine statistical significance. If re-measurement does not demonstrate statistically significant improvement and performance does not exceed established goals, the quality improvement cycle begins again. In such cases, we will evaluate each intervention, identify barriers interfering with the achievement of performance goals and revise the intervention, or replace or supplement it with new interventions to address identified barriers.
Will a staffing investment be made for this PIP? [X] Yes [ ] No **If yes, use the Performance Improvement Project (PIP): Staffing Chart to provide details.**

Performance Improvement Project (PIP): Summary Chart
PIP Title: Reducing 30-Day Psychiatric Inpatient Readmission Rates
Target Beneficiary Population(s): We used careful analysis of utilization, enrollment claims, encounters, pharmacy, compliance and care management assessments to determine the targeted population/subset for the PIP. The target population includes eligible MississippiCAN members 6 years of age and older who were hospitalized for treatment of select mental illnesses who readmitted to any mental health inpatient facility within 30 days of discharge from a facility.
Overview of PIP Strategy and Goals: The proposed PIP will look at interventions that deliver successful transitions to community care and play a key role in preventing early readmission. Time-limited care coordination interventions that link vulnerable individuals with sources of ongoing support during critical transition points appear to have an enduring positive impact in reducing rehospitalization and other adverse outcomes. Initiatives to reduce these rates should focus on care coordination and transitional efforts to gain appropriate outpatient care. Additional interventions may include collaboration with other coordinated care organizations for collaborative provider outreach and planning sessions. The goal is to achieve a 5% reduction in readmission rates in the first year and an additional 2% reduction in subsequent years.
Reason for choosing this PIP: We select PIP topics through identified opportunities and gaps in performance, and we consider the prevalence of a condition, need for a specific service, member demographic characteristics, health risks and interest in the topic. The Division has identified priority beneficiary populations for targeted improvement based on data analysis and feedback from members, providers, coordinated care organizations and community stakeholders. Around 5% of Mississippians have a serious mental illness (SAMHSA), and one in five (20%) adults experience mental illness (not serious mental illness) in a given year (NAMI). Research demonstrates that up to 13% of psychiatric patients are readmitted within 7 – 30 days after discharge. Hospitalization interferes with the normal functioning of individuals and families. Lost productivity in the home, at work or at school and lost independence are among the costs of hospitalization. Unplanned readmission adds to the costs and losses and is often viewed as a failure of the health care system. In the global context of contemporary psychiatric deinstitutionalization, the phenomenon of psychiatric readmission imposes important challenges, as it exposes the fragility of the behavioral health services network.
Tools for measuring impact: Through the development of collaborative work groups with state regulators and shareholders, we can design project goals or performance thresholds based on evidence-based clinical guidelines and professional literature, practical experience, industry standards and available national benchmarks. The collaborative work groups will review and analyze behavioral health data and medical care to determine real improvement by calculating statistical significance. This process helps to identify whether there was significant change in health/functional status, member satisfaction or processes. If re-measurement does not demonstrate significant improvement and performance does not exceed established goals, the quality improvement cycle begins again. In such cases, we will evaluate each intervention, identify barriers interfering with the achievement of performance goals and revise the intervention, or replace or supplement it with new interventions to address identified barriers.
Will a staffing investment be made for this PIP? [X] Yes [ ] No **If yes, use the Performance Improvement Project (PIP): Staffing Chart to provide details.**

Performance Improvement Project: Staffing	
Title of Position: Manager of Quality Improvement (QI)	
PIP to which Position will be Linked: The manager of QI will have oversight for developing and updating all PIPs.	
Description of Position: The manager of QI will be responsible for program measure development and monitoring, analyzing and reporting all clinical quality measures required by the state and accrediting bodies. The manager of QI will develop PIPs that meet all requirements of the state contract and external review guidelines.	
Number of Staff Expected to Fill this Position/Staffing Need: 1	
Employee(s) filling this position would be: **[ ] Hourly [X] Salaried**	**Employee(s) filling this position would be:** **[X] Full-Time [ ] Part-Time**
Expected Wage of Position (Hourly rate or salary): [redacted]	**Expected Location of Employee:** **[X] Mississippi [ ] Out-of-State**

[END OF RESPONSE]

4.2.3.6: Health Literacy Campaigns (Unmarked)

The Division is implementing a new Health Literacy Campaign strategy for the next contracting cycle. The ...

To respond to this requirement, the Offeror should make summary proposals of four (4) potential campaigns ...

We provide a detailed chart of four (4) health literacy campaigns and related staffing on the following pages.

[END OF RESPONSE]

Health Literacy Campaign: Summary Chart
Campaign Title: Healthy Moms, Healthy Babies
Target Beneficiary Population(s): The target population for this proposed campaign will include MississippiCAN members who are pregnant or have had a recent delivery. Black women are a priority population for the campaign.
Overview of Campaign Strategy and Goals: Our campaign strategy is to develop and distribute health education messaging that helps pregnant members access prenatal and postnatal care, improves the quality of care and emphasizes member voice and choice. This campaign will use culturally appropriate language, imagery and clear messaging. Our proposed campaign will: - Share resources available for support and build awareness about common health concerns - Educate expectant or postpartum members about appropriate prenatal and postnatal care and list specific actions they can take to maintain and improve health - Inform members about how they can find doulas and providers with whom they are comfortable - Provide information about preventing unintended pregnancies Our campaign goals will include reducing maternal and infant mortality, increasing healthier deliveries, decreasing premature births and improving health literacy.
Reason for choosing this Campaign: Maternal health, infant mortality and premature birth disparities, particularly for Black individuals in Mississippi, are a significant concern for the Division and for us. Mississippi-specific data shows that the Black infant mortality rate is 66.82% higher than white infant mortality rate. The prematurity rate is over 35% higher, and the pregnancy-related mortality ratio is nearly three times higher for Black women than for white women.
Information Delivery Channel(s) (mailings, social media, traditional media, email, etc.): We will deliver campaigns through multiple channels so that we can learn which touchpoints resonate with our target audience's needs and habits and adjust as needed. The Healthy Moms, Healthy Babies campaign will be delivered through the following channels: - Traditional: Mailers and coordinated care organization (CCO) outbound calls to eligible members - Digital: Member website, email and social media - In Person: Health education materials and messaging that provider partners and CCO case managers, community health workers and peer support specialists can share with members We will prioritize messaging to providers with a higher percentage of the Black population and community organizations such as Black faith-based, social, civic and professional organizations.
Tools for measuring engagement: Our tools and metrics to measure engagement will include: - Member engagement connecting with doulas - Member adherence with prenatal and postnatal care - Social Media: Number of clicks and likes for social media posts - Digital: Number of website visits and return visits; email open and click-through rate - Providers: Quantity of materials distributed and number of providers engaged in campaign - Peer to Peer: Meeting attendance and quantity of materials delivered - Mailings: Delivery rates and quantity of returned mail - Outbound Calls: Live calls completed and call reach rates
Tools for measuring impact: We will measure our campaign impact by improved outcomes, including: - Results from pre/post member survey related to pre/postpartum care - Reduction in maternal and infant mortality and decrease in premature births - Healthier deliveries, including a reduction in deliveries with low birth weights
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: Community Connections to Support Health
Target Beneficiary Population(s): Since lack of health literacy can exacerbate social determinants of health (SDOH) barriers, the target population for this proposed campaign will include MississippiCAN and CHIP members and their families facing SDOH, including minority and rural populations.
Overview of Campaign Strategy and Goals: This campaign will help members who are overwhelmed with basic human needs maintain their health literacy and we will build trust with our members by listening to and meeting their needs.
Reason for choosing this Campaign: As an individual's health-related social needs increase in number and complexity, their health literacy declines. With nearly nine out of 10 adults struggling to understand and use personal and public health information, limited health literacy results in higher morbidity and mortality. Increasing health literacy could prevent nearly 1 million hospital visits and save over $25 billion annually. Mississippi is ranked 50th in the nation for health literacy rates.
Information Delivery Channel(s) (mailings, social media, traditional media, email, etc.): We will deliver campaigns through multiple channels, including: - Traditional: Mailers - Digital: Member website, social media and email - In Person: Inbound calls from members and through outbound calls to assess SDOH needs. Care managers, community health workers and peer support specialists will be trained and equipped to help members with social need screening and navigation - Partner Organization: Materials and messaging that community-based partner organizations can share with their participants
Tools for measuring engagement: Our tools and metrics to measure engagement include: - Traditional: Delivery rates, quantity of returned mail - Digital: Number of website visits and return visits - Social Media: Number of clicks and likes for social media posts - Email: Open and click-through rate - In Person: Number of SDOH screenings and referrals, needs met - Partner Organization: Quantity of materials distributed, number of individuals engaged in SDOH discussion, member feedback, increased inbound calls for SDOH support and increased percentage of members screened for SDOH
Tools for measuring impact: Our campaign impact will be measured through: - Improved health outcomes - Increased gap closure for individuals with identified social needs and connected to SDOH services - Increase in the member's care plan adherence
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: Empowering Kids to Own Their Health
Target Beneficiary Population(s): The target population for this proposed health literacy campaign will include MississippiCAN and CHIP members ages 10 – 17 who are affiliated with a rural or community health center in a Mississippi region with high rates of adolescent obesity.
Overview of Campaign Strategy and Goals: This health literacy campaign will encourage parents and adolescents to complete well-child visits and immunizations and teach adolescents habits that support a healthy lifestyle and reduce the risk for obesity. The campaign will include: - Partnering with a rural or community health center to engage their adolescent patient population and deliver healthy lifestyle and well-being messaging - Developing age-appropriate materials that adolescents may want to share with parents and prompt action to adhere to recommended well visits and immunizations - Monitoring adolescent health outcomes for health center patients over time to identity changing trends in measures, such as body mass index (BMI) Our campaign goals will include increasing adolescent well-child visits and immunizations, improving nutrition and activity habits and teaching aspects of a healthy lifestyle.
Reason for choosing this Campaign: Many children missed regular well-child visits and recommended childhood vaccinations during the COVID-19 public health emergency. The Centers for Disease Control and Prevention (CDC) states that well-child visits are critical for tracking growth and development milestones, discussing any health concerns with a clinician and getting scheduled vaccinations to prevent illness. In addition, 22.3% of Mississippi youth ages 10 to 17 years are obese. Obesity has significant, negative physical and mental health impacts, including elevated blood pressure, increased risk for diabetes, breathing problems, depression, low self-esteem and bullying.
Information Delivery Channel(s) (mailings, social media, traditional media, email, etc.): We will deliver campaigns through multiple channels, including: - Digital: Email, text reminders, social media - Partner Communications: Materials for partner organization to share in person and online
Tools for measuring engagement: Our tools to measure engagement include: - Social Media: Number of clicks and likes for social media posts - Email: Open and click-through rate - Text: Delivery rates, open rates, click-through rates - Partner Organization: Quantity of materials distributed, number of patients engaged in campaign and number of campaign engagements/discussions with adolescents and parents
Tools for measuring impact: Our campaign impact will be measured through: - Improved adherence to adolescent well-child screenings and immunizations - Reduction in BMI longitudinally - Increase in adolescent referrals to weight loss support programs
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: Your Health in Mind
Target Beneficiary Population(s): The target population for this proposed campaign will include MississippiCAN members without a known behavioral health diagnosis or condition. This campaign will target the broader MississippiCAN population who may not be aware of common behavioral health conditions, such as anxiety and depression, and could benefit from support resources available.
Overview of Campaign Strategy and Goals: This campaign will include broad behavioral health education in multiple channels, connecting members to care with targeted support and education about available resources. Our campaign will aim to normalize that behavioral health is something all individuals should feel comfortable addressing and treating. The campaign will include: - Educating members about the importance of caring for their mental health - Understanding the signs and symptoms of common mental health conditions and their impact on physical health - Informing members about support resources available - Reducing the stigma associated with seeking mental health care This campaign's goal will include increasing the number of members accessing behavioral health support available through their CCO and community.
Reason for choosing this Campaign: Unmanaged behavioral health conditions can have a direct, negative impact on an individual's physical health. Reports from CDC show an increasing trend of Mississippians diagnosed with depressive disorder (20%) and reporting frequent mental distress (14%), defined as adults who report their mental health was not good 14 or more days in the past 30 days. The impact of the COVID-19 pandemic has amplified these concerns and caused an increase in reported social isolation and broader mental health conditions.
Information Delivery Channel(s) (mailings, social media, traditional media, email, etc.): We will deliver campaigns through multiple channels, including: - Email: Email campaign - Print Materials: Flyers and posters for use with community-based organizations (CBOs) and faith-based organizations (FBOs) and in provider offices - Digital: Quarterly Facebook posts - Radio: Radio advertisements
Tools for measuring engagement: Our tools and metrics to measure engagement will include: - Email: Email open and click-through rates - Print Materials: Number of flyers and posters distributed to CBO, FBO and provider partners - Digital: Number of likes and shares on Facebook - Radio: Potential reach with radio advertisements
Tools for measuring impact: Our campaign impact will be measured by using the following metrics for the member population without a known mental health diagnosis or condition: - Change in the number of members engaging with CCO behavioral health programs - Change in the number of members accessing behavioral health clinic services - Change in the number of individuals accessing community-offered behavioral health services - Reduction in ER visits for behavioral health-related issues
Will a staffing investment be made for this Campaign? [X] Yes [ ] No **If yes, use the Health Literacy Campaign: Staffing Chart to provide details.**

Health Literacy Campaign: Staffing	
Title of Position: Population Health Director	
Campaign to which Position will be Linked: All health literacy campaigns	
Description of Position: Provides visionary leadership and contributes to the successful advancement of culture, health equity and social responsibility principles.	
Number of Staff Expected to Fill this Position/Staffing Need: 1	
Employee(s) filling this position would be: [ ] Hourly [X] Salaried	**Employee(s) filling this position would be: [X] Full-Time [ ] Part-Time**
Expected Wage of Position (Hourly rate or salary): [redacted]	**Expected Location of Employee: [X] Mississippi [ ] Out-of-State**
Health Literacy Campaign: Staffing	
Title of Position: Health Equity Director	
Campaign to which Position will be Linked: All health literacy campaigns.	
Description of Position: Collaborates with internal and external stakeholders to reduce structural barriers to health services that disproportionately affect diverse communities, people with disabilities and people of all gender identities and sexual orientations.	
Number of Staff Expected to Fill this Position/Staffing Need: 1	
Employee(s) filling this position would be: [ ] Hourly [X] Salaried	**Employee(s) filling this position would be: [X] Full-Time [ ] Part-Time**
Expected Wage of Position (Hourly rate or salary): [redacted]	**Expected Location of Employee: [X] Mississippi [ ] Out-of-State**
Health Literacy Campaign: Staffing	
Title of Position: Empowerment Manager (SDOH Navigator)	
Campaign to which Position will be Linked: All health literacy campaigns	
Description of Position: Implements a community-based housing navigation and SDOH program to connect members with housing units, resources and support services to successfully maintain residency.	
Number of Staff Expected to Fill this Position/Staffing Need: 1	
Employee(s) filling this position would be: [ ] Hourly [X] Salaried	**Employee(s) filling this position would be: [X] Full-Time [ ] Part-Time**
Expected Wage of Position (Hourly rate or salary): [redacted]	**Expected Location of Employee: [X] Mississippi [ ] Out-of-State**
Health Literacy Campaign: Staffing	
Title of Position: Community Health Worker	
Campaign to which Position will be Linked: All health literacy campaigns.	
Description of Position: Serves as liaison to Medicaid members, confirming appropriate care is accessed and providing home and social assessments and member education.	
Number of Staff Expected to Fill this Position/Staffing Need: 5	
Employee(s) filling this position would be: [X] Hourly [ ] Salaried	**Employee(s) filling this position would be: [X] Full-Time [ ] Part-Time**
Expected Wage of Position (Hourly rate or salary): [redacted]	**Expected Location of Employee: [X] Mississippi [ ] Out-of-State**

[END OF RESPONSE]

4.2.3.7: Telehealth (Unmarked)

Telehealth has grown immensely during the COVID-19 pandemic. The Division is seeking innovative ...

Increasing Access to High Quality Care

We believe in the power of technology innovations to help connect our members to the proper care they need and to close the gaps in health equity. Because of the rural nature of Mississippi, the disparate health equity issues affecting members and the lower number of physicians per capita, **our team assessed the unique health and social determinants gaps Mississippians experience and created a telehealth continuum to meet each of these needs.**

Our telehealth solutions, such as direct-to-consumer virtual visits, telepsychiatry and telemonitoring services, will be integral to our efforts to promote the appropriate use of health care services, improve access to care and deliver needed services to members in the communities where they live. In addition to direct-to-consumer, we will value partnerships with other organizations that can promote access to high-quality virtual care. We will continually assess the impact of our telehealth initiatives on reducing inappropriate utilization, improving the member experience and health outcomes and giving providers the ability to deliver value-based services.

Promoting Telehealth: Educating Members and Providers

With a comprehensive provider network, we will continue to educate members and providers on the availability and use of telehealth — all while maintaining office-based care that meets the time, distance and availability standards in Appendix A, Draft Contract. We will promote telehealth and educate members and providers on its use through:

- **Member and provider materials,** including our member handbook, provider manual, websites and newsletters.
- **Virtual visit access for members.** Our virtual visits program will help us engage members, improve access to care, reduce health care disparities within traditionally underserved populations and decrease avoidable ER visits, while directing members to their PCP for in-person follow-up care and nonurgent health concerns. Members can initiate a virtual visit from any location via video and telephone or on their mobile device with an appropriate board-certified physician. Our virtual visits program will be available 24 hours a day, seven days a week.
- **Local telehealth solutions** including identifying high-quality telehealth providers who are familiar with the populations they serve. We will address chronic diseases, such as diabetes, by expanding telehealth reimbursement beyond what is covered under the MississippiCAN and CHIP benefits.
- **Network provider education** on how to access telehealth-related policies, reimbursement, coverage, eligibility, technology information and billing guidance located on our provider website. This will include guidance on audio-video or audio-only telecommunications system; virtual check-ins using recorded video or images from the member; electronic visits through an online patient portal; physical, occupational and speech therapy telehealth; chiropractic therapy; home health and hospice; and remote patient monitoring.
- **Care management staff** will be a key referral source for members. Our care managers will be familiar with our tools and the telehealth resources we support. When we identify a member with a clinical condition who can benefit from telehealth, the care manager will assess member readiness, deploy the device and educate the member on its use.
- **Staff who have contact with members,** including member services, nurse line staff, care managers, community health workers (CHWs) and peer support specialists (PSSs), will help members navigate telehealth home setup, assist with scheduling appointments and diagnostic tests and be available for technical assistance to bridge gaps in connecting members to providers.
- **Call center support** to help members with technical needs, including how to set up and use a telehealth platform, which telehealth platform fits their needs and connecting the member to any devices or broadband access if needed.

- **Success stories for telehealth utilization** published on our member and provider secure websites and newsletters.

The Telehealth Continuum: Tailored to the Unique Needs of Mississippians

Driving Innovation and Value

We tailored the telehealth platforms with the unique needs of Mississippians in mind. According to the Census Bureau, most Mississippi counties are defined as rural with a population of less than 2,500 people. In addition to Mississippi's rural nature, Mississippi has fewer physicians per capita than any other state, leading to physician shortages, particularly with specialists. Provider shortages exacerbate access to care challenges in rural areas, resulting in poor health outcomes for rural Mississippians. The poverty rate in rural counties is substantially higher than metro counties, and rural communities are at a disadvantage for receiving funding and are challenged by reduced access to care.

In addition, Mississippi struggles in almost every leading health outcome. There is a disproportionate burden of disease borne by racial and ethnic minority populations, particularly members who identify as Black or African American, and the rural and urban poor. Some examples of these alarming disparities are 9.2 per 1,000 live births die before their first birthday, 15% of Mississippians report having diabetes, 70% of adult Mississippians report being overweight and 43% of Mississippians report being told by a health professional that they have high blood pressure. Health disparities not only affect the groups facing health inequities, but limit overall improvements in quality care, the health status of the broader population, and results in unnecessary costs.

Telehealth Use Increases Due to the COVID-19 Pandemic

In a similar state, telehealth utilization mirrored national trends: volume increased 44 times, from less than 5,000 visits in 2019 to more than 220,000 in 2020, with anxiety, mood and adjustment disorders as the top visits. In 2021, we saw a decrease of 57% compared to 2020 but utilization was 18 times greater than the 2019 rate. In 2021, 75% of telehealth visits were related to behavioral health.

With all these unique barriers in mind, we will develop a telehealth continuum to seamlessly fill the gaps in care a Mississippian may experience due to their rural location, the short provider supply or lack of broadband or devices. The following figure depicts a rural Mississippian who has no access to internet, has no devices and must drive 60 minutes one way to see a provider. We demonstrate how our telehealth continuum will serve members who have these barriers to care and seamlessly bridge gaps in care.

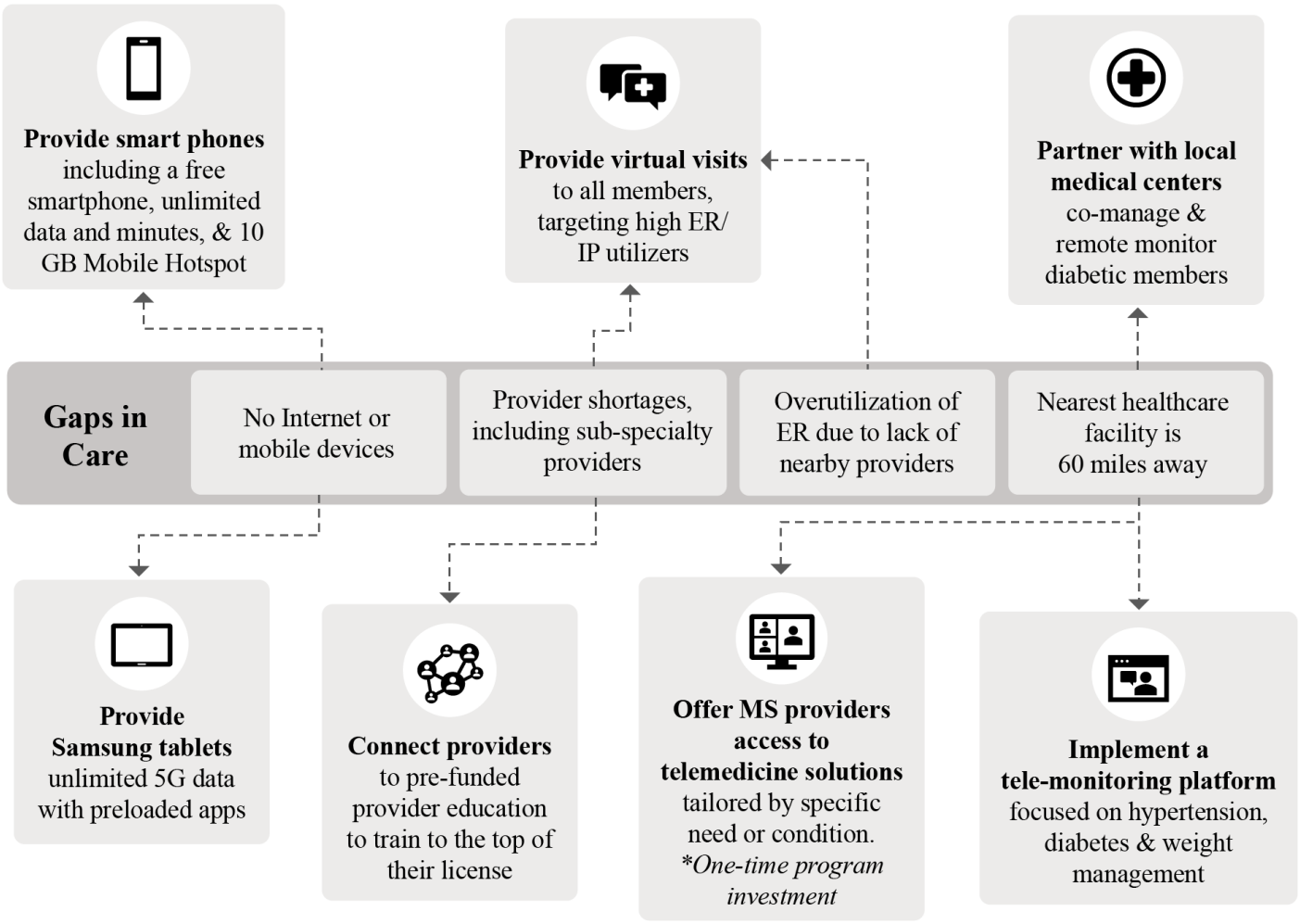


Figure 1. Our Tailored Telehealth Continuum.

We have extensive experience creating telehealth solutions for the members we serve. The use of telehealth has grown dramatically across all our health plans in recent years, demonstrating the growing way telehealth can enhance access to care and acceptance of the modality by Medicaid members. We have developed telehealth programs across the country, resulting in lessons learned about how to mitigate telehealth challenge areas and how to facilitate and achieve telehealth solution success.

Following are detailed descriptions of our telehealth platforms and supports.

Telehealth Platforms and Supports	
Virtual Supports	Our virtual visits program will help us engage members, improve access to care, reduce health care disparities within traditionally underserved populations and decrease avoidable ER and in-person visits, while directing members back to their PCP for in-person follow-up care and nonurgent health concerns. Members can initiate a virtual visit from home with an emergency medicine, family medicine, internal medicine, pediatrician or psychiatrist specialist who is board-certified and licensed in Mississippi. Virtual visits will enable direct access to care through web, mobile web or the mobile app and will be available 24 hours a day, seven days a week. For individuals engaged in the program, ER visits decreased by 46% and 38% in similar states since the program's inception in 2019. We expect to achieve similar reductions in Mississippi.
Provider-to-Provider	We wholly own a platform that will enroll specialists to serve as virtual consultants to PCPs. This is especially effective in rural areas where access to specialty care is

Telehealth Platforms and Supports	
	limited. Nurse practitioners and PCPs will have synchronous access to specialists who assist in co-managing health conditions beyond their knowledge.
Devices and Broadband Support	
Tablets for Virtual Care Management and Social Supports	For select members who require complex care management but lack digital connectivity, we will provide free tablets with unlimited data and messaging, preloaded with apps and contacts. These tablets will connect the member to telehealth supports, including remote patient monitoring apps, medical and behavioral health virtual apps and SDOH supports like education and social isolation.
Wireless Smartphones	We will partner with a wireless company to provide all eligible members with a free smartphone, which includes a data plan and unlimited text messaging. This program will help the member keep in contact with their care team, set up medical appointments and address SDOH needs.
Remote Patient Monitoring	
Virtual Diabetes and Hypertension Management	Remote patient monitoring (RPM) program designed to fit neatly with our care management program. This RPM program will target members with diabetes and hypertension.
Local Diabetes Monitoring and Management	This RPM partnership will include close communications with the medical staff of a local medical center to cross-refer patients and provide strong care management supports for these members. Remote patient monitoring will allow members who would typically need to travel far distances to the nearest provider for care stay in close contact with the clinical staff needed to help manage their care.
Maternal and Infant Health	
Maternity RPM and Education App	Chronic conditions, such as diabetes and high blood pressure, put pregnant people and their neonates at greater risk for poor outcomes. We will partner with a local public health organization and digital app to test the effect of digital education and remote monitoring for diabetes and high blood pressure throughout Mississippi.
Behavioral Health	
Behavioral Health Virtual Visits	This virtual visits platform is designed to connect the member to a real-time, live session with a licensed mental health professional to support their therapy needs.
Behavioral Health Self-Care and Peer Support App	This behavioral health app uses cognitive behavioral therapy and mindfulness to manage stress, depression and anxiety for our members.
Telehealth OUD/SUD/MAT Support	Opioid use disorder (OUD) and substance use disorder (SUD) virtual services, including Tele-MAT (medication-assisted therapy) for members who experience OUD.

Investing in a Stronger Mississippi Telehealth Community

Nurturing Local Partnerships

In addition to creating a tailored telehealth experience for members, **we believe in investing in community supports to bridge the access-to-care gaps experienced by rural members.**

In a state of similar size and composition, **we partnered with a large medical center to help care for our patients with diabetes across the state**. Since 2014, their Telehealth Remote Patient Monitoring (RPM) program has assisted patients with managing their chronic conditions by providing education, coaching and care coordination. This partnership includes close communications with the medical staff to cross-refer patients and provide strong care management supports for these members. Remote patient monitoring allows members who

would typically need to travel far distances to the nearest provider for care to stay in close contact with the clinical staff needed to help manage their care. This program has shown a dramatic reduction in A1C for people with diabetes and zero hospitalizations. **In addition, this program has shown a cost savings of over $300,000 within the first 100 patients in the program.**

In another state similar to Mississippi, we **provided a grant of $10,000 to a rural** community organization dedicated to supporting moms going through the emotional, mental and physical tolls of motherhood. This organization provides education, advocacy and supports for moms, including connecting moms to vital virtual community resources, such as Mommy Mentorship and Virtual Mommy Meet Ups.

To foster strong relationships and supports with the providers we have in-state, we will form a **strong partnership with a child mental health and psychiatry provider.** This program will connect PCPs who are high prescribers of anti-stimulants and antipsychotics to consultative and educational services. These supports will assist with mental health diagnostic clarification, medication adjustment, treatment planning and outpatient resources. PCPs will include doctors, nurse practitioners and physician assistants.

We will invest in a virtual smoking cessation program. This evidence-based smoking cessation program was created to **reduce the burden of tobacco on the pregnant and postpartum population.** They have brick and mortar locations throughout Mississippi and conduct their work through the FQHCs. Pregnant individuals will be paired with a tobacco treatment counselor, receive a Quit Kit with a breathalyzer device for remote carbon dioxide monitoring and a $25 diaper voucher monthly, for up to 12 months. Health plan care managers can use the virtual smoking cessation dashboard to receive tailored information about members.

In other similar states, we have provided large grants to organizations in communities to expand their statewide telehealth programs. One example is our commitment to invest in a state's statewide telehealth initiative to boost broadband access across members and provide technology to support telehealth platforms. We will invest in remote and virtual education programs for providers, allowing them to train to the top of their license on childhood obesity and sickle cell anemia.

The Member Experience: Seamless Connections Between Telehealth Supports

Advancing Population Health Outcomes

Below we illustrate the different medical and behavioral health scenarios a member may experience and how our continuum of telehealth seamlessly connects this member to the services she needs.

Meet Aniyah, a 23-year-old pregnant mother with a 2-year-old son. She lives in rural Mississippi and lacks access to internet and a data plan. She has chronic diabetes, unmanaged anxiety, and the nearest provider is a one-way, 60-minute drive. We provide three situations to demonstrate Aniyah's experience using our telehealth platform:

- Situation #1: Recently pregnant, Aniyah's anxiety has increased over her health.
- Situation #2: Aniyah needs support in managing her diabetes after an ER visit for unmanaged diabetes.
- Situation #3: It is 1:00 a.m., and Aniyah's 2-year-old son has an earache.

In each situation, we show how Aniyah is able to access the care she needs from the comfort of her home, and through these telehealth platforms, we can avoid larger health risks for her in the long term.

Aniyah | 23

Pregnant mother with a 2 year-old son

- **Located in Rural MS**
- **No internet, data plan, or mobile**
- **Unmanaged anxiety & chronic diabetes**
- **Nearest provider is 60 minutes away**

Situation #1: Recently Pregnant, Aniyah's anxiety has increased over her health.

Aniyah uses her provided tablet to connect with other expecting mothers through our technology-enabled prenatal & postpartum care platform. ▶ Using her tablet, Aniyah accesses behavioral therapy exercises via our behavioral telehealth program. ▶

Gaps Addressed:
- No internet or devices
- Behavioral health support
- Access to care
- Social isolation & support

Situation #2: Aniyah needs support in managing her diabetes after an ER visit for unmanaged diabetes.

Aniyah's PCP refers her to a local medical partner to obtain remote monitoring kit. ▶ Aniyah receives her remote monitoring kit in the mail & begins using it to monitor her diabetes. ▶ Our care manager, local medical center partner, & Aniyah's PCP track her progress & provide support. ▶

Gaps Addressed:
- No internet or devices
- Access to care
- Complex & chronic care management
- Diverted unnecessary ER visit

Situation #3: It's 1:00am, Aniyah's 2 year-old son has an ear ache.

Aniyah is considering a trip to the emergency room. ▶ Aniyah uses the provided tablet to connect with a Dr. through our virtual visit app. ▶ The Dr. writes her son a prescription to treat his ear ache. ▶

Gaps Addressed:
- No internet or devices
- Access to care
- Provider shortage
- Diverted unnecessary ER visit

[END OF RESPONSE]

4.2.3.8: Use of Technology (Unmarked)

The Division is aware that Offerors have access to numerous technologies that could be used to the benefit of ...

We are an industry leader in working with states to integrate comprehensive managed care information systems to better understand our members' health care needs, improve outcomes and aid providers in promptly receiving member data to enable better care. Located in our U.S. data centers, our Medicaid management information systems (MMIS) support our Medicaid partners in more than 25 states, serving nearly 7 million members.

We understand the importance of implementing and maintaining information technology systems of sufficient capability and capacity, and we will proactively identify needed expansion or upgrades to support our members, providers and the Division with expedient and continuous information technology operations.

Key elements of our proactive approach to assessing and addressing needs will include:

- System capability and capacity needs assessment using predictive modeling to forecast anticipated changes, in combination with continuous performance monitoring of key system indicators — we will use this information to proactively create plans to increase capacity before it is needed
- Flexible and scalable systems architecture that will enable us to quickly expand capacity without risk or material operational changes
- Continuous investments in our technology capabilities and access to significant national information technology resources

National Strength, Local Focus

With our national information technology (IT) support team — approximately 9,700 professionals nationwide — we maintain a solution that integrates disparate technologies and data sources to facilitate our services to our members and providers. Our information systems support the day-to-day management of key operations and support electronic sharing of clinical data to sustain the quality of care provided to our members.

Mississippi-Based Partnership with the Division and Other Stakeholders

Beyond operations, we will apply our expertise and technical resources to reducing cost, improving member care and outcomes and supporting providers to make our program stronger for everyone. Through our health plan chief information officer (CIO), we will maintain ongoing knowledge-sharing meetings to look at specific department challenges and opportunities and in which experts from our organization will share emerging technologies and technological efficiencies. Our health plan CIOs share cross-state information regularly on Medicaid technology best practices, innovating and enhancing efficiency across all our state partnerships.

We have partnered with states in developing new policies and programs — even those that require coordination with provider and member communities and other managed care entities. Because of the complexity of Medicaid policy and the diversity of our stakeholders, we understand the long-term view or "long game" effort to build shared roadmaps that support our dynamic Medicaid and health care environment, such as programs to address the opioid crisis and improve health care access equity.

Our health plan CIOs have partnered with state Medicaid agencies in a variety of ways, from establishing connectivity protocols to developing Health Information Technology Roadmaps in work groups tasked with defining a future state to identifying gaps and translating it all into an initiative. Further, they have been key participants in a state-wide industry work group, led by their states' Chambers of Commerce, to define cybersecurity roles for the Medicaid department, and they have helped define a data-driven approach to making provider quality ratings available to Medicaid recipients using data specific to Medicaid outcomes.

We recognize policy and technology are intertwined, and each informs the other. Based on this understanding, we will leverage our experience and commitment to define and develop technology that helps us support the Medicaid program and positively affect the lives of those we serve.

1. Data gathering and analysis

By gathering data from additional sources and applying a more specific level of analysis, we will continue to find opportunities to deliver results. The following examples demonstrate policy or technological enhancements the Division can apply to build enhanced data gathering and analysis tools:

- **Virtual Diabetes and Hypertension Management:** For members who live in rural areas or who have other barriers to accessing regular monitoring of their chronic conditions, we have initiated remote monitoring programs. Using our remote monitoring tool, we provide support for members and provide additional data sources that enable our care teams and providers to better target interventions.
- **Post-Acute Provider Real-Time Analytic Tool:** Our platform connects post-acute providers within the member journey to enable better transparency though real-time analytics. This solutioning connects clinical and nonclinical teams and promotes communication among caregivers in the care continuum. After an intervention in a similar state, it reduced the all cause 30-day readmission from 17.4% to 11.9% ($p<.0001$).
- **Identifying Each Member's Needs:** We use internal data collection and external research, along with standard evidence-based screening tools, to make sure we are identifying the unique needs of each member. The proposed process begins with outreach to MississippiCAN and CHIP members to assess their social, physical and behavioral health needs. Our service navigator engages with members through our member services center during an initial Health Risk Screening (HRS) and uses these opportunities to screen for SDOH barriers. Using our Real-Time Offering (RTO) model, during any member interaction our service navigator screens for SDOH and connects the member — in real time — to potential support resources. High-risk members referred for complex care management are further screened using our Comprehensive Health Assessment (CHA) tool for a more detailed assessment of SDOH needs. We use SDOH data collected by our provider partners using the Protocol for Responding to and Assessing Patients' Assets, Risks and Experiences (PRAPARE®).
- **Claims Pattern Identifier:** Our claims pattern identifier scans for unusual patterns in claims receipts, denials, rejections and cash paid at the state and provider level, identifying opportunities for early intervention, outreach and education to our provider community. This tool improves performance and reduces administrative costs while supporting provider satisfaction.
- **Geospatial Analysis:** We employ a real-time geospatial tool that overlays our membership on a map, and we can layer current and predicted weather events, pollution levels, disease outbreaks and other data that is tracked by location.

2. Efficacy of initiatives and programs

In our experience, even when overall program measures are met, we can still find room for improvement in subpopulations and specific targeted programs.

- **Prescription Data:** Historically, missing data only lowers HEDIS measures and results in unnecessary member outreach. We have implemented a program to capture additional data directly from pharmacy partners that would not otherwise be available in paid claims. We have improved scores and freed resources to outreach to additional members by supplementing standard data sources with additional pharmacy data.
- **Electronic Medical Record (EMR) Systems and Health Information Exchange (HIE):** Partnering directly with primary systems, we connect directly with EMR systems to pull information, including admission, discharge and transfer (ADT). We have experience working with 24 HIEs and 58 direct submitting health systems covering hundreds of hospitals. Further, we connect with national laboratories for results — all of which helps states establish effective data exchanges.
- **Social Determinants of Health (SDOH):** With 80% of health outcomes tied to social factors, using data to identify SDOH gaps for at-risk populations is critical to improve the health of individuals and communities. We developed a national Health Related Social Needs database that aggregates SDOH data from multiple

sources, including ICD-10 Z codes, SDOH-specific screens and SDOH resource and referral platforms. We bring this into a national database that provides visualizations and drilldown data and enables identification and monitoring of programs through multiple dimensions, including age, gender, location and need.

- **Claims Pattern Identifier:** As discussed, our claims pattern identifier scans for unusual patterns in claims receipts, denials, rejections and cash paid at the state and provider level. Through thousands of alerts provided annually, this tool facilitates rework savings. We can work with the Division in exploring additional data opportunities, either directly from providers or through intermediaries such as health information exchanges.
- **CovidCAST:** One stop dashboard that incorporates data from a surveillance network made up of low-latency indicators of COVID-19 activity at different geographies are found in private, public and academic data.

Visualizations of indicators provide better understanding of infection patterns, demographics and impact of social distancing and countermeasures, and predictive models forecast future COVID-19 cases 14 days in advance.

3. Transparency

We develop ways to share complex member data that complies with Centers for Medicare & Medicaid (CMS) interoperability and new clinical file standards. Combined with more transparency to data through easy-to-use dashboards, we deliver providers more member information via their EMR systems, facilitating both fuller views of member health status and improved care. We use Data Warehouse as a Service (DWaaS), cloud technologies and innovations in data storage and tools to enable real-time access to operational data, broader user communities and flexibility in implementations.

Real-Time Patient Information Integrator

Our real-time patient information integrator combines contemporaneous member medical records — including clinical, pharmacy, laboratory results, prior authorization and cost transparency — with existing EMRs to provide real-time insights on care needs aligned to the member's specific benefits and costs. This additional integrated information simplifies data access while increasing understanding of what a member needs at the point of care, assisting providers in determining care and treatment. Our real-time member information integrator enables providers to:

- Gain insights on member needs:
  - Eliminate blind spots in care by identifying potential care opportunities
  - Quickly check prior authorization for a member's medical plan
- Save time by reducing administrative work:
  - Quickly help members choose lower-cost care options and find program providers known for delivering quality, cost-effective care without leaving the EMR
  - Stay up to date with accurate, real-time member information, 24 hours a day, seven days a week
  - Reduce pre-visit prep time using the Gaps in Care service, which provides insight to preventive services a member needs
  - Stay current on member plan benefit changes, providers in the member's network and their expected out-of-pocket costs
- Improve satisfaction and results:
  - Simplify care and increase cost transparency to support higher member satisfaction
  - Improve quality of care provided, which may lead to higher CAHPS scores and Medicare and Medicaid Star ratings

- Improve provider ability to meet targets and earn incentives through the Medicare Advantage PCP Incentive Program

Our real-time member information integrator integrates with the following EMR platforms: Allscripts, Athena, Cerner, eClinicalWorks, Epic, NextGen and Practice Fusion. Access may depend on the individual health system.

Interoperability and Fast Healthcare Interoperability Resources Standard

The interoperability rules of the 21st Century Cures Act have established API standards for common data exchanges. The Fast Healthcare Interoperability Resources (FHIR) standard has presented a common format for the complex clinical information that is needed to support members. The benefits include standardization, real-time data exchanges and the ability to develop innovative experiences, with key use cases for Medicaid around transition of care data exchanges between the Division and managed care entities and between managed care entities and payers. The Payer-to-Payer API regulatory release time frame has been moved out as CMS clarifies components of data exchange. We are engaging in exercises around how those exchanges can be used to support Medicaid and are committed to working with other coordinated care organizations (CCOs) to support pilots to move us as an industry to these exchanges where possible.

State Data Dashboard and System Access

Departments often face situations requiring real-time access to data and key trending dashboards. We have two standard approaches to support the Division in these activities: an interactive reporting tool that shows metrics on key operations and front-end system access for reviewing specific records. Additional data access is available through DWaaS implementations.

A dashboard for the Division's day-to-day management of key operations will include:

- Eligibility, enrollment and disenrollment management and data exchange
- Grievances and appeals
- Utilization management
- Provider network management, credentialing, enrollment and confirmation file exchange
- Member and provider information access through secure online portals
- Report generation and transmission to facilitate standard and ad hoc reporting
- Care coordination and care management for physical health, social service support and behavioral health, including integration of pharmacy data
- Medical and behavioral health claims processing, edits, adjustments and adjudication
- Claims processing, edits, adjustments and voids
- Claims payment and coordination of benefits (COB) for claims with third-party liability (TPL)
- Financial management and accounting

Using an externally facing Tableau server, our state data access solution manages access to external stakeholders. Users who are granted access to the Division's reporting group only have access to Mississippi-related data based on the Secure Group, provisioning and Tableau permission settings.

Information Reporting and Analytics

Our proactive edit tool is a comprehensive, integrated analytical data warehouse using the latest Oracle Exadata Database platform that holds all Medicaid relevant information — including claims data (e.g., medical, pharmacy, vision and lab), member data, provider data, authorizations, external subcontractor data and predictive modeling information. It stores service-specific data, which includes behavioral health, long-term care, pharmacy, inpatient services and outpatient services. Our proactive edit tool:

- Supports quality management, performance management, compliance reporting and ad hoc reporting "as needed," with turnaround times averaging less than five business days
- Includes consolidated member census (common store of all members receiving care)
- Consolidates data for our predictive modeling and care management analytics solution for health risk modeling and stratification
- Consolidates relevant data for Inovalon EPSDT and HEDIS reporting and related analysis and monitoring

We are committed to transparency and accountability of our operations by providing the Division access to systems and information when it is needed in a secure and user-friendly manner. We will facilitate authorized remote connectivity to our systems and data, including subcontractor data, through our secure, HIPAA-compliant processes.

We commit to maintaining the security of all protected health information (PHI) and personal identifying information (PII) and to comply with all applicable state and federal regulations. Access methods to our systems and data vary based on the application, network location and security requirements, including via web browser, Citrix, and Citrix published desktops, direct query SQL and higher-order tools like Business Objects.

How Division Employees Receive Access to Our Systems

Access to all systems and databases is managed via an enterprise-wide entitlement process and application that manages and tracks access, access request workflow, approvals, reporting and periodic entitlement reviews. We will provide each authorized Division employee with an access profile. With this access to CCO provider network files and additional network reports, the Division can monitor for various measurements.

Designated Contact

Our designated contact will work with Division staff to set up the profiles through our secure process. Every access request from Division staff will be routed through approvals at the Division, the designated contact and our application or data owner at the corporate level. This way, access rights to applications, application roles and data are fully entitled and auditable. This is the same process we require of all employees.

Accessing Our Systems through Secure Applications

Division staff with secure profiles can connect to our systems in a variety of ways, depending on the specific system. Certain applications, such as our care coordination portal, are internet-facing and configured to use the digital identity management functionality in the Division's platform. For these applications, Division staff can log on as they would to any other web application, but authorization for application access and assignment of specific application roles will be granted through our secure entitlement process.

Other applications within our network core, such as our customer service desktop or utilization management platforms, are accessed over the internet via our Citrix portal and a secure RSA token that we issue. Certain applications — for example, a database query tool such as PL-SQL Developer or Toad — are accessible on our internal network only. Division staff will access these databases via a specifically configured Citrix-hosted Windows desktop, or alternately, from a company-issued Windows 10 laptop using our always-on VPN capability and a Smart Card (as our staff do).

In either case, our Citrix site and our internal platforms are not integrated with the Division's platform for access control due to contraindicated security and audit standards. However, the Citrix site does provide a common gateway to the commonly needed tools under a single user ID and password.

[END OF RESPONSE]

4.2.3.9: Potential Partnerships (Unmarked)

The Division is requiring consistent, deeply developed partnerships between contractors and local ...

The Offeror should also include potential partnerships to be utilized for Care Management closed-loop ...

The Offeror may not duplicate potential partners in answering either part of this request. The Offeror ...

We provide detailed charts of our Potential Partnerships and Care Management Partnerships on the following pages.

[END OF RESPONSE]

Potential Partnership: Summary Chart	
Name of Organization: Community Health Center Association of Mississippi (CHCAMS)	**Type of Organization (community-based organization or government):** Nonprofit Community-Based Organization

Goal of partnership:

Community Health Center Association of Mississippi (CHCAMS) (formerly the Mississippi Primary Health Care Association) is a nonprofit organization that comprises 21 community health centers in Mississippi. These community health centers are certified medical homes that serve over 303,000 patients in over 240 sites around Mississippi, including underserved communities.

Initiatives led by CHCAMS are wide ranging in terms of supports for Mississippians. The health centers provide complete preventive and primary health care services and are staffed by board-certified physicians, dentists, nurse practitioners, physician assistants, nurses, social workers and other clinical and nonclinical professionals. This allows them to provide a wide variety of services, including medical, dental, pharmacy, optical, social services, behavioral health, X-ray and laboratory, tobacco cessation, health and wellness and transportation. The CHCAMS offers educational and training activities and national and state-based advocacy.

Because CHCAMS is a vital resource across Mississippi and because they will serve our members, our goal is to align with CHCAMS on new medical and behavioral health trends occurring in the state. We look forward to creating a close partnership to strategize how to positively impact Mississippian health and wellness outcomes and provide supports to help achieve that goal.

Smart Goals:

- **Diabetes:** Using this partnership as a tool to increase testing hemoglobin A1C for our members with diabetes from 78% to 87.5% by the end of 2022.
- **COVID-19:**
  - We propose developing a CHCAMS partnership as a supplement to our universal goal of increasing vaccination rates in Mississippi.
  - Supporting CDC recommendations on mask usage, we will focus on increasing KN95 and surgical masks distribution to the community but will be flexible based on changing recommendations.
  - We look forward to working closely with the CHCAMS on how we can support transportation for Mississippians to and from vaccine sites. This can include financial support or helping increase the number of transportation vehicles available for CHCAMS sites.

Expected financial commitment to project/partnership:

We are enthusiastic to infuse a range of financial supports to this vital community organization in Mississippi. We commit to **financial support of $125,000 a year** to increase CHCAMS's ability to continue preventive and primary health care services to Mississippians statewide. Additional to financial supports, we will partner with CHCAMS to create joint strategies to positively move the needle for medical and social supports and support clinical staff at community events.

Scale of project (local, statewide):	**Population(s) targeted by the partnership:**
Statewide	All Mississippians, targeting members with large health equity disparities, including those with rural health access issues, higher experience in comorbid conditions and those who experience social determinants of health (SDOH) disparities. We support recruitment of health care professionals, particularly because Mississippi has a high provider shortage.

Potential Partnership: Summary Chart	
Name of Organization: Mississippi Home Corporation (MHC)	**Type of Organization (community-based organization or government):** Nonprofit Housing Agency
Goal of partnership: Mississippi Home Corporation (MHC) was created by the Mississippi Home Corporation Act of 1989 to provide supports for housing needs. Mississippi Home Corporation works to further private and public partnerships to create affordable housing for Mississippians and works in conjunction with the governor, the Mississippi Legislature and the U.S. Congressional delegation. Our goal is to provide a range of supports for the MHC to improve housing for our members, including advocating for members on their housing rights, connecting our members to needed legal sources and educating members on their rights. Smart goals: • Provide financial support to Rental Assistance for Mississippians Program (RAMP) applications to provide rental assistance and financial relief for renters • Partner with home buyer education efforts by providing supports for home buyer education classes and forwarding members to these education efforts • Partner with the Creating Housing Options in Communities for Everyone (CHOICE) Program, a partnership between the MHC, Mississippi Department of Mental Health, Mississippi Division of Medicaid, and Mississippi's Community Mental Health Centers. The CHOICE program provides rental assistance to make housing affordable for individuals with serious mental illness. This partnership would provide financial supports for rental application fees, rental security deposits, rental arrears, utility deposits and utility arrears. • Provide support for Housing Opportunities for Persons with AIDS (HOPWA), which would include supporting housing, social services, program planning and development costs. This effort includes, but is not limited to, the acquisition, rehabilitation or new construction of housing units, costs of facility operations, rental assistance and short-term payments to prevent homelessness.	
Expected financial commitment to project/partnership: Because housing is an essential SDOH component that directly impacts thousands of Mississippians, **we will commit $500,000 a year** to help MHC provide rental assistance; cover application fees, security deposits and utility deposits; and help members with past due bills. This funding will also help Mississippians get resources and support on home ownership with the goal of moving dependent Mississippians off state programs to become financially independent and stable. We plan to hold health fairs where housing organizations can bring mobile units to provide services on-site.	
Scale of project (local, statewide): Statewide	**Population(s) targeted by the partnership:** Our partnership will target members who do not qualify for Housing and Urban Development (HUD) federal support, supplementing the current federal program and catching members who are still in need of help but are unable to use the HUD program.

Potential Partnership: Summary Chart	
Name of Organization: American Diabetes Association (ADA), Mississippi Chapter	**Type of Organization (community-based organization or government):** Nonprofit Association
Goal of partnership: Mississippi is ranked first in the nation for overall diabetes prevalence, with an estimated 308,295 of adult Mississippians (13.6%) living with diabetes. Diabetes accounted for 1,083 deaths in Mississippi in 2016, and many Mississippians live with complications of type 2 diabetes, including lower extremity amputations, end stage renal disease, blindness, loss of protective sensation, heart disease and premature death. Our goal is to partner with the ADA, Mississippi Chapter, to achieve the Division of Medicaid's diabetic quality priorities, including decreasing hemoglobin A1C in Mississippi's diabetic population. The ADA is the national leader in diabetes education and advocacy. We propose partnering with the ADA, Mississippi Chapter, to provide additional diabetic education and empower members to take control of their care. Smart goals: • Increase testing hemoglobin A1C from 78% to 87.5% by end of 2022 • Work with the ADA to distribute education to our members with diabetes, which will range from pre-diabetes, type 1 and 2 diabetes, high blood pressure, skin complications, cardiovascular disease, chronic kidney disease, eye health, foot complications, gestational diabetes, ketoacidosis, hearing loss, neuropathy and stroke • We recognize that the caregivers of members with diabetes are vital to their care. We propose providing a range of caregiver support, including education on topics related to diabetes and comorbid symptoms, best practices in caregiving and mental health supports for the caregiver. • Partner with the ADA to host community events. We will provide educational materials for local Mississippians and raise support and awareness for this preventable disease. • Offer other supports, including lifestyle coaches, prevention services for the pre-diabetes population and SDOH supports, including transportation, nutrition assistance and gym membership access	
Expected financial commitment to project/partnership: To achieve the above goals, **we will financially commit to $100,000.**	
Scale of project (local, statewide): Statewide	**Population(s) targeted by the partnership:** Members who are either pre-diabetic or diabetic. Members who are not compliant based on HbA1c screenings or pharmacy adherence. Children at risk, including those in foster care, for developing type 2 diabetes in tandem with overweight/obesity and nutrition issues.

Potential Partnership: Summary Chart	
Name of Organization: Mississippi Association of Community Mental Health Centers (MACMHC)	**Type of Organization (community-based organization or government):** Community-Based Organization
Goal of partnership: Our goal is to strengthen the mental health system in Mississippi to better meet the needs of members with behavioral health and substance use disorders in the state. We propose partnering with the MACMHC to identify promising practices not currently provided under the Medicaid state plan and bring those to Mississippi with our national expertise on evidence-based practices and innovations as well as backed by a financial commitment for pilot programs. In other states, we have worked with members, providers, hospital systems and other local constituents and stakeholders to transform the crisis system into a community-based, recovery-oriented response system integrating peer supports and a no-force approach to care. We are happy to share our experience and expertise with the Division and MACMHC, including the creation of a Recovery Response Center, which has resulted in 91% consumer satisfaction rate in our markets.	
Expected financial commitment to project/partnership: To achieve the above goals, **we will financially commit to $100,000.**	
Scale of project (local, statewide): Statewide	**Population(s) targeted by the partnership:** Members with behavioral health need and/or substance use disorders.

Care Management Potential Partnerships: Summary Chart	
Name of Organization: Mississippi Department of Child Protection Services (MDCPS)	**Type of Organization (community-based organization or government):** Government Agency
Type of Referral(s) to be sent to this partner: Our goal is to establish a partnership with MDCPS to validate adequate protections for foster care and adoption members. This includes providing strong supports for MDCPS workers. With our specialized foster care program, we will have more direct communication with social workers and foster families. Based on reasonable grounds, we will refer members who: • May be victims of abuse, neglect or exploitation • May be at risk for significant harm • At risk for impairment of health or development We propose sharing data with MDCPS both at the case level and through sharing of raw claims data that can be matched within the MDCPS system. In partnership with MDCPS, we will determine community education needs regarding child safety, such as safe sleep or hot car deaths, and partner with MDCPS to educate the public on the dangers and solutions.	
Population target(s) for referral to this partner: Foster children/youth and families, CPS workers and adopted children and their families.	

Care Management Potential Partnerships: Summary Chart	
Name of Organization: Myrlie Evers-Williams Institute of Health Disparities	**Type of Organization (community-based organization or government):** State Government
Type of Referral(s) to be sent to this partner: The Myrlie Evers-Williams Institute is dedicated to the reduction of health disparities through community engagement. **The Institute accepts referrals to reduce SDOH, including food insecurities, education, health literacy, personal safety and connecting people to external community social resources.** **Food Insecurity:** EversCare Food Pantry provides emergency food to community members in need and provides monthly food drives to the broader community. **Education:** Supports the Graduate Training and Education Center (GTEC), provides medical residents to work with the Institute to gain a practical understanding of the SDOH and their impact on the lives of individuals Hosts the Rural Interdisciplinary Case Experience, which unites a pool of graduate students from multiple academic disciplines to address complex rural health issues **Personal Safety:** Partners with Safe Kids Mississippi to reduce the number of preventable injuries and deaths in the state. In connection with Safe Kids, the Institute travels throughout the state and offers a 32-hour, nationally certified course in child passenger safety.	
Population target(s) for referral to this partner: All Mississippians.	

Care Management Potential Partnerships: Summary Chart	
Name of Organization: Catholic Charities	**Type of Organization (community-based organization or government):** Nonprofit Community-Based Organization
Type of Referral(s) to be sent to this partner: We will provide referrals of chemically dependent pregnant individuals for housing, daycare, financial assistance, clothing, household assistance, infant items and comprehensive case management. We propose supporting the expansion of these services, which will include, but is not limited to, financial supports, education materials, case managers, volunteering, community activities, distributing water for the Jackson water crisis, collecting and distributing water bottles during winter storms and providing backpacks and school supplies during the beginning of school. We will support a kinship navigator that provides supports to family members, including those with foster children. We will collect community items to distribute to those in need, including socks, diapers, bottles and clothes for babies and moms.	
Population target(s) for referral to this partner: Chemically dependent pregnant individuals.	

Care Management Potential Partnerships: Summary Chart	
Name of Organization: Partnership with Local Hospitals	**Type of Organization (community-based organization or government):** Community-Based Hospitals
Type of Referral(s) to be sent to this partner: Mississippi is ranked first in the nation for overall diabetes prevalence and its suicide, mental distress and depression averages higher than the nation average. We will partner with local hospitals to cross-refer and closely monitor members with diabetes and behavioral health/substance use disorders. We propose cross-referring patients with diabetes to a local hospital to participate in their remote patient monitoring program. Remote patient monitoring will help members with diabetes manage their conditions, improve access to specialty services and help members who live in rural areas have constant contact with their care team remotely. In addition, we propose partnering with local behavioral health hospitals to create a behavioral health enhanced care management model, which will include daily case management calls and warm handoffs to the case manager in the facility. This behavioral health enhanced care management model closely supports our goal for a highly integrated physical-behavioral health model, where both medical and behavioral health clinicians work closely to have a coordinated system of care for the patient.	
Population target(s) for referral to this partner: Members with diabetes and any member being discharged from the behavioral health unit.	

[END OF RESPONSE]

RFQ# 20211210

Management Qualification

UnitedHealthcare of Mississippi, Inc.

United Healthcare Community Plan

MississippiCAN and CHIP RFQ

Table of Contents

4.3.1 Corporate Background and Experience

4.3.1.1 Corporate Background (Marked)

4.3.1.1.1 Biographical Information

Use the form included in Appendix F to respond to this section.

Our biographical information is provided after our narrative response to 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.

UnitedHealth Group is a health care and well-being company with a mission to help people live healthier lives and help make the health system work better for everyone. Within UnitedHealth Group, UnitedHealthcare's vision includes efficiently delivering the simplest experience and highest quality to our customers. **UnitedHealthcare serves 7,690,000 members in 31 states plus the District of Columbia** in supporting their Medicaid, CHIP and dual special needs plan (D-SNP) programs. UnitedHealthcare of Mississippi, Inc. operating as UnitedHealthcare Community Plan of Mississippi (UnitedHealthcare), is proud to be a part of such a compassionate culture and strong corporate structure that brings a wealth of resources to support local needs.

UnitedHealthcare is a segment of one of the largest, most technologically advanced health care and well-being companies in the world. We have served Mississippi through its CHIP contract since 2010, and MississippiCAN contract since 2011. This decade long partnership has made our company stronger by learning alongside a state partner with shared levels of compassion and commitment.

We plan to build upon the last decade together and accelerate our influence on the citizens of Mississippi. Our aim: to achieve operational excellence and drive value by leveraging advanced technology, enhancing products and benefits, nurturing local partnerships and employing top local talent — all to exceed expectations and raise standards through innovation.

Describe the Offeror’s Computer and Technological Resources

Achieving Operational Excellence

Innovation is a cornerstone of our organization and touches all our stakeholders, from our advanced provider solutions to our predictive analytics that help risk stratify our members to our automation, which enables us to integrate hundreds of data sources and process authorizations and payments instantaneously.

We maintain an integrated Management Information System (MIS) program. Shared across our national Medicaid customers, our advanced, scalable platform integrates all clinical and social service supports in full compliance with applicable state and federal regulations. Today, our shared platform supports multiple Medicaid markets with 7,000 concurrent users and more than 7.5 million members, adjudicating more than 500,000 claims every day. Locally, this translates into **3 million claims per year for MississippiCAN and CHIP.** This shared platform allows us to drive and benefit from economies of scale in both staff and infrastructure, enabling our core systems to stay current and maintained.

We achieve system consistency, stability and performance through a combination of load balancing software, advanced hardware and cloud and virtualization capabilities. We have implemented a secure private cloud environment that houses many of our system components. This architecture provides scalability and extensibility:

- Our information technology (IT) infrastructure scales system resources based on demand and volume fluctuations, enabling us to quickly adapt to changes, such as onboarding members, providers and networks. This allows us to support critical transactions, interfaces and real-time reporting needs. These

system resources are housed in a private cloud environment that is constantly expanding to accommodate new components and applications.

- Outside of our cloud environment, we provide scalability and extensibility to our virtualized machine architectures through:
  - Vertical scaling to add central processing units and disk storage to existing servers so we can increase the capacity of established machines
  - Horizontal scaling to add new front-end servers to increase machine footprints

This structure provides us the flexibility to add systems capacity, so we can quickly introduce routine upgrades, and maintain the latitude to plan for significant increases in computing needs without risk or material operational influence. Our architecture further provides an acceptable level of fault tolerance through its use of multiple servers and shared storage, allowing instant recovery from failures in these components.

Access to Technology Capabilities and Resources

Driving Innovation and Value

We have scalable enterprisewide IT resources and system redundancy to mitigate risks and handle significant changes such as membership growth, benefit modifications and external system integrations. Storage capacity across our information systems environment is currently over 150 petabytes (PB) (one petabyte is equivalent to all of the content in the U.S. Library of Congress — by its own claim the largest library in the world — multiplied by 50). Our parent organization, UnitedHealth Group, employs nearly 30,000 technology professionals responsible for computing hardware, software and communications across all lines of business. These resources are committed to maintaining the highest quality of service. All systems allow flexibility for local state nuances and their capabilities are extended to support our state and local partners.

Our Technology Overview

Nationally, across all lines of business and all claims platforms, UnitedHealthcare provides industry-leading technology support for our state and local programs.

Demonstrated Business Processing Capabilities

- $5.3 billion invested annually in technology and innovation
- 5+ billion claims processed annually
- 90% electronic transactions
- 1+ billion web and mobile transactions annually
- 1.4+ trillion computing transactions annually
- 140+ terabytes of secure external data transfers annually
- Manage health data for more than 230 million individuals

Access to Software Delivery Resources

- 12 million application development hours annually
- 9,200 global software developers
- 630 technology programs annually
- 44+ development programming languages
- 700 enterprise class applications

Established Infrastructure

- 100,000 servers and 200,000+ workstation computers

- 150 petabytes of data stored in secure data centers
- 200,000 data/voice ports
- 4,500+ applications supported

Optum Technology

Optum Technology, a wholly owned subsidiary of UnitedHealth Group, supports UnitedHealthcare by providing access to some of the world's most advanced health data science and analytics. Optum Technology's health care technology and high-volume capacity offer secure, scalable and seamless technology for UnitedHealthcare and our state partners. Optum Technology is already providing health and information services to one in five Americans with a time-to-value of 7.5 weeks (meaning that, on average, members begin deriving meaningful and measurable value from their UnitedHealthcare membership within 7.5 weeks). Many of these services are already in place in Mississippi and we are constantly expanding and enhancing to support Mississippi Division of Medicaid, our members and providers.

Secure Hosting	General Computing Infrastructure	Operational Performance Metrics
■ We host Individual Health Records (IHR) for 55 million individuals. ■ We have 1,000 security professionals examine more than 1T security signals generated across our IT system annually using our automated and manual methods. ■ Our Health Care Cloud supports our business needs to securely host work in our data centers and uses best-in-class services from public cloud service providers. ■ Our design assumes all data is sensitive and requires consistent and rigorous standards of data governance and security.	■ 1.4 trillion transactions each year ■ 83,000 servers ■ 110.8 PB of stored data across 161 PB of storage infrastructure ■ 99.999% system availability ■ Process more than 5 billion claims (including non-integrated entities [NIE] annually) ■ More than 1 billion web and mobile transactions annually ■ 427 computer instances (CIs) across eight mainframes (~110 MIPS) ■ 302 million Virtual Contact Center touchpoints	■ 2.4 billion inbound phone call minutes per year ■ 90 million annual visits to *myuhc.com* at an average of 2.2 million unique search users each month ■ 84 million annual visits to our secure provider portal at an average of 375,000 unique users each month ■ 330,000 voice and data ports ■ 280,000+ supported users ■ 8,900+ applications supported ■ Auto Adjudication: – Vision 98.23% – Pharmacy 99.99% – Dental 70% – Medical/behavioral average across all platforms is 89%

Under the direction of our Mississippi chief information officer, Michael Rogers, our technology support team maintains an integrated system of solutions that integrate various technologies aimed to seamlessly support health plan operations. These functions include, but are not limited to:

- Presenting the care team with timely, relevant and actionable information about populations and individual members
- Presenting the claim processing, member services and provider services teams with efficient systems to exceed operational performance requirements
- Providing health information technology capabilities to support alternative payment models (APMs) through real-time clinical data sharing
- Providing each employee with solutions for health plan operations using targeted, data-driven analyses to optimize performance and serve all stakeholders

Our health information technology solutions include a suite of applications to support integrated care models such as the patient-centered medical homes (PCMH), accountable care organizations (ACOs) and accountable care communities (ACCs).

Computer Resources to Support Health Plan Operations

At the center of our information systems architecture is Community Strategic Platform (CSP), our TriZetto Facets enrollment and claims platform. Using the latest Oracle Exadata X5 database technology, CSP includes interfaces that optimize the exchange of information to other key systems. The Oracle Exadata X5 platform is the latest, most advanced hardware for managing database loads, providing for the fastest in-memory databases with redundant hardware and fastest failure recovery times possible. The CSP is co-resident on the Exadata platform with our Strategic Management Analytic Reporting Tool data mart and our National Encounter Management Information System (NEMIS) encounters reporting system, improving data freshness for key reporting needs from a day or weeks to as little as real time.

The CSP is composed of multiple systems properly interfaced to support the delivery and management of integrated operational and clinical services. The CSP collects, analyzes, integrates and reports data for core functional areas, such as member management, including enrollment and disenrollment, care management, utilization management (UM), claims adjudication and payment, grievances and appeals and provider and network management.

Computer Resources to Support Member Management (Enrollment and Disenrollment)

As a current MississippiCAN and CHIP contractor, we accept and process daily enrollment, monthly enrollment and disenrollment reconciliation files via HIPAA-compliant ASC X12N 834 transactions. We process Division-initiated disenrollments in the same manner as any other termination. Within 24 hours of receipt of the 834 file, we update our eligibility and enrollment database, which interfaces with all other systems via CSP. Immediately upon completion of data load and validation, enrollment data are available to our downstream systems, including our provider portal and member portals, for online eligibility verification support and our interactive voice response (IVR) system for automated telephonic support of eligibility inquiries.

Upon assignment to UnitedHealthcare, members are provided unique member numbers that we use on all member-specific materials and for all member-related processing. Through our various interfaces, our systems cross-reference these numbers to other member-unique numbers, such as the Division's assigned ID number.

Computer Resources to Support Clinical and Quality Management

An interdisciplinary care management approach is central to our clinical model. We provide the tools to support the member, PCP, care managers and the care coordination team. CommunityCare, our care management collaboration platform, includes the member's ID, PCP information, a record of each service event, appointments, a record of all immunizations and the ability to capture notes and store attachments. CommunityCare integrates evidence-based medicine gaps in care and hospital admission; discharge and transfer messaging; and allows providers to input information about interactions with members such as post-ER discharge follow-up and care opportunity outreach. CommunityCare supports person-centered, integrated care by allowing access to each member's care community, including clinicians, guardians and social workers and presenting the care team with timely, relevant and workable information about the member, including information on all aspects of health.

Our utilization management (UM) system, the Integrated Clinical User Experience (ICUE) platform, is the system of record for medical service authorization data and coordination of behavioral and other health services. We use member and authorization data based on authorization transactions processed in ICUE and passed back to CSP for claims management and CommunityCare for care management activities.

ClaimSphere™ HEDIS® is Cognizant's NCQA certified real-time HEDIS solution. This tool enables us to uncover the root cause for low HEDIS scores and drive interventions and outreach. Standard system views provide us with insight through line of business analysis, gaps-in-care reporting, provider scorecards and drill-

down capabilities. Providers can view data generated from ClaimSphere and CommunityCare, through the UnitedHealthcare provider portal and within the provider's practice management system with secure electronic data interchange integration. Members can view their gaps in care using our secure member portal, *myuhc.com*, or our mobile application.

Our **Population Health Registry** in the CommunityCare platform gives providers and care communities a comprehensive view of the services used by any given care population. Using the Population Health Registry's member view, providers have the clinical history of the whole person, while the population view provides trends, themes and lists of members who need health-related interventions.

Computer Resources to Support Provider Services

We continue to pursue innovative solutions to streamline and simplify providers' administrative experience. Our most recent evolution of online tools is a cloud-based provider portal. At the foundation is a goal to create a single provider platform. The provider portal convenes multiple electronic resources on an easy to navigate dashboard, incorporating new applications to improve efficiencies for providers. Providers have a tab on the portal with icons that include, but are not limited to:

- Eligibility and Benefits Center
- Prior Authorizations
- Claims Management
- Medication Management Resources
- CommunityCare
- Physical Health and Behavioral Health Provisioning
- Credentialing Processes

Access to Member Records

To comply with HIPAA privacy requirements, all applications use role-based protocols to limit a team member's access and ability to edit records, reports and data to only the systems necessary for their role. Our security services and access control team manages appropriate access to our systems and platforms using the Secure provisioning tool. Secure requires three levels of approval, enabling efficient auditing and entitlement reviews. Automation advances replace manual processes and provide greater efficiencies to accommodate UnitedHealth Group's evolving technology landscape. Our data security team uses data filters to assign parameter-driven privileges so that only select member populations are viewable by the user.

Describe the Offeror's Current Products and Services

We began supporting state Medicaid programs in 1974. Through decades of competitive procurements and a proven ability to attract and retain Medicaid enrollees by delivering exceptional service, UnitedHealthcare today provides coordinated care services to 7,690,000 Medicaid, CHIP and D-SNP members in 31 states and the District of Columbia. Within these states, our Medicaid products now include programs supporting:

- Temporary Assistance to Needy Families (TANF)
- Children's Health Insurance Program (CHIP)
- Aged, Blind and Disabled (ABD)
- Special Needs Plans (SNP)
- Long-Term Services and Support (LTSS)
- Childless Adults and Programs for the Uninsured
- Management Services Organizations (MSO) and Administrative Service Organizations (ASO)

Each state has its own coverage guidelines and nuances, and we adapt to meet those needs. All clinical services are fully integrated and are included in our Business Continuity Plan so that they are seamlessly operable even during states of emergency.

We currently administer the full breadth of MississippiCAN and CHIP and have been doing so for over a decade. These include the defined benefits in Section 4 of the Draft Contract as stipulated by the State of Mississippi, Office of the Governor, Division of Medicaid State Plan, CHIP State Health Plan and Administrative Code. This includes enhanced and expanded services, and many value-added benefits. Most of these services are delivered by wholly owned and managed entities within our organization. When we subcontract services, we prioritize partners who are familiar with — and to — our community.

Medical Services

Through a large Mississippi Medicaid-enrolled network of providers, all medically necessary services are provided to MississippiCAN and CHIP members. These services are designed to meet members' needs and are delivered expeditiously so that care is not compromised. We use evidence-based criteria to make sure all medical services are rendered in a clinically appropriate and cost-effective manner. Our care management processes support ongoing utilization of these services, which include integration with other clinical services noted below. In addition to facilitating immediate needs of our members, we have a heightened focus on primary and preventive care to maximize the health status of all members. Our robust analytical tools use predictive modeling to capture members before they may be faced with an acute event.

Experience Providing Care to Medicaid Members

We have over 10 years' experience delivering medical services to MississippiCAN and CHIP members and we do so in a culturally competent fashion that is sensitive to barriers across the state. Our service delivery model includes geographic flexibility and flexibility between the MississippiCAN and CHIP populations. All care delivery models (utilization review, health services, quality, population health, medication management and other clinical programs) are under the oversight of our medical director, who is a board-certified pediatrician, residing in Mississippi, and former practicing physician at one of Mississippi's largest Federally Qualified Health Centers (FQHCs).

Brief Description of Services Provided

UnitedHealthcare administers the full breadth of MississippiCAN and CHIP. These services include, but are not limited to:

- Care management
- Claims processing
- Emergency services
- Post-stabilization care
- Well-child/baby care and immunizations
- Medical equipment

These services are fully integrated with behavioral health, substance use disorder services, vision care services, dental care services and pharmacy services. These are done in accordance with Medicaid and/or CHIP specificity where applicable (e.g., Early and Periodic Screening, Diagnosis and Treatment [EPSDT], Vaccines for Children). Medical office visits are covered without a quantity limitation.

We support our members and state partners in times of transition when there is a need to centralize clinical functions such as pharmacy and/or dental services. When functions such as these are centralized, we can flex our involvement to best support programmatic goals without compromising our commitments to providers and members. When we no longer fully manage a benefit, we can send and receive relevant files. This allows us to integrate outside data into our core clinical care delivery models and support our state partners with data to continue supporting their efforts.

When we see a need to expand the medical services we offer, we partner with providers to include non-covered services in their care plan — for example, we recently partnered with the University of Mississippi Medical Center's Center of Telehealth to expand what we offer high-risk diabetics. We have recognized the limitation of dental benefits and when a member's oral health affects other health, we work with dentists and oral surgeons to provide additional care so that members' nutrition is not compromised, which can lead to further physical deterioration.

Behavioral Health Services

United Behavioral Health, Inc. (operating under the brand name Optum), is a leading expert in care delivery and management for behavioral health and substance use disorders. We employ clinical experts who are leaders in evidence-based care and local Mississippi needs. Our executive director for behavioral health services is a Mississippi resident, with Mississippi clinical experience.

- **Experience Providing Care to Medicaid Members:** Optum has over 30 years of experience managing and administering behavioral health and substance use services. Optum holds URAC and NCQA accreditation and has pioneered advancements such as our outpatient practice management approach and rewards for excellence program — Platinum Designation — to improve the clinical impact and delivery of behavioral health services. Partnering with more than 140,000 clinicians and 5,000 care facilities nationwide, Optum offers one of the nation's largest specialized managed behavioral health and substance use disorder networks and includes subnetworks specific to populations with intellectual and developmental disorders, eating disorders, substance use/opioid use and telemental health. Optum serves 6 million Medicaid, uninsured and dual-eligible members in 28 states, including current MississippiCAN and CHIP members. We see the PCP as the medical home while utilizing the Community Mental Health Centers (CMHCs) as the cornerstone of our behavioral health and substance use disorders network in Mississippi. We partner with CMHCs and other behavioral health and substance use disorders providers to secure and expedite referrals, post-discharge follow-ups and medication management (short- and long-term maintenance). Through our relationships, we have brought CMHCs and inpatient behavioral health and substance use disorders providers together to develop collaborative approaches to support the behavioral health needs of our members and their medical homes.
- **Brief Description of Services Provided:** Optum provides utilization management (UM) for behavioral health and substance use disorders services, post-hospitalization planning, follow-up and care management, quality management, network management and development, dedicated provider services and specialized member services, including a 24-hour toll-free line for crisis triage. Optum delivers these services through our integrated model, which focuses on the whole health and needs of the person. A continuum of services is available, from community-based outpatient to inpatient and residential care. Good connections are at the foundation of our service delivery model and allow our case managers to access resources for our members.

Dental Services

Dental Benefit Providers, Inc. (DBP) is a wholly owned entity that has been a long-standing partner for MississippiCAN and CHIP and has a reputation for maximizing clinical outcomes and containing costs. DBP has a care management program focused on oral care; its local involvement has led to Mississippi leading the nation in preventive dental services. Close clinical oversight has reduced risks by preventing unnecessary sedations. Our Provider Relations model supports our dental providers and includes Mississippi-based support. These individuals are resources to dentists and assist with onboarding, various education and claims assistance.

- **Experience Providing Care to Medicaid Members:** DBP has a 35-year history serving Medicare and Medicaid members, providing care to MississippiCAN members for the past six years. DBP has experience serving all populations, including children, adults and seniors, members with special needs

and in long-term care. Currently, DBP provides dental coverage to over 24 million people nationwide through a network of more than 405,000 dentist access points, managed Medicare programs in 46 states and Medicaid plans in 16 states, including Mississippi.

- **Brief Description of Services Provided:** DBP provides clinical administration and dental network services for our MississippiCAN population. They provide education and outreach through their HEDIS® Annual Dental Visit initiative and more targeted programs such as the physician varnish initiative — designed to improve overall access, increase utilization and better manage dental disease, especially in children. Education, developed and implemented in partnership with the local team, includes various oral health topics, including infant and toddler oral health, children's oral health, maternal oral health, fluoride varnish, sealants, early childhood caries, the medical-dental connection, avoiding the ER and the importance of finding a dental home. They conduct outreach with practices and hospital programs with clinical programs that target early childhood caries and works with physicians to enlist them to provide screenings and varnish applications. Even during the COVID-19 pandemic, DBP has more than doubled the total members receiving oral evaluations (from 2,783 to 6,821) and topical fluoride varnish (from 8,711 to 21,565) since 2019.

Vision Services

MARCH® Vision Care is a wholly owned entity that specializes in vision care benefits administration for coordinated care organizations (CCOs), specifically for government-sponsored programs, such as Medicaid, Medicare and Medicare-Medicaid plans. They operate a model that supports providers and members and includes both professional optometric services, in addition to lens crafting and dispensing.

- **Experience Providing Care to Medicaid Members:** With over 20 years' experience in the public sector, the company administers vision benefits for more than 8 million members nationwide, including 6 million Medicaid members. MARCH provides customized service to MississippiCAN members and offers a broad range of fully customizable vision care programs. MARCH currently supports Mississippi members and they began providing services to MississippiCAN and CHIP members Jan. 1, 2017.
- **Brief Description of Services Provided:** MARCH's network of eye care professionals includes ophthalmologists, optometrists and opticians, who provide members with convenient access to care — including weekends and evening hours — in rural and urban areas. In 2021, UnitedHealthcare, through MARCH Vision Care, partnered with select Community Health Centers in Mississippi to improve HEDIS rates for diabetic retinopathy screening. Screening units were placed in these Centers free of charge so that high-risk Mississippians, regardless of payer source, could be screened for retinopathy.

Pharmacy Services

UnitedHealthcare acknowledges that Mississippi Medicaid will use a single pharmacy benefits administrator (PBA) for management and payment of pharmacy claims, authorizations and care delivery through a network of pharmacies. Following the direction of Section 1.3.7 (p. 18) of this RFQ, no information is being submitted to support capabilities of claims management, prior authorization processes or network development related to pharmacy services.

- **Experience Providing Care to Medicaid Members:** Formed in 1989, OptumRx is UnitedHealth Group's wholly owned medication management solution. OptumRx has grown from a pharmacy benefits manager (PBM) to its present state, which includes advanced analytics to help maximize member health by reducing unnecessary prescriptions ensuring medication adherence, reducing drug-drug interactions making sure medications align with medical diagnoses and much more. With 33 years of experience serving a broad spectrum of internal and external customers, including public and government entities, CCOs, Medicare and Medicaid plan sponsors, employer groups and third-party administrators, OptumRx

serves approximately 5 million members nationally through 60 local Medicaid programs. Services provided include enhanced clinical pharmacy services, retrospective drug utilization review and medication adherence programs. OptumRx's innovative services can adapt to the needs of any state's demands. Outside of traditional PBM activities to be assumed under Mississippi Medicaid's chosen PBA, OptumRx can serve a broad spectrum of clients, including Medicaid agencies, where PBM activities are excluded from managed Medicaid and CHIP programs. By focusing on clinical quality and total patient care, we can intake external claims activities to help improve member health outcomes and manage overall health care and utilization.

- **Brief Description of Services Provided:** UnitedHealthcare and OptumRx are committed to collaborating with and supporting the goals of Mississippi Medicaid and its chosen PBA. We have infrastructure designed to enhance health through drug utilization review programs such as Dose-Duration, Drug-Age, Drug-Drug Interaction Alerts, Narcotic Drug Utilization Review, Drug-Diagnosis Matching and PolyPharmacy Duplicate Therapy. Under our OptumRx services (and not related to PBM activities) we can offer medication management programs. These clinical programs can accept claims from any PBA and 1) enhance comprehensive medication management, 2) support hospital discharge planning, 3) improve HEDIS® rates for medication adherence and 4) facilitate follow-up medical appointments. Further supporting all clinical efforts, UnitedHealthcare has a Mississippi-dedicated clinical pharmacist who will work closely with the Division to support all pharmacy-related needs.

Rehabilitation Therapy Services

Optum Health Care Solutions (OHCS), a wholly owned entity, oversees quality of care rendered by these professionals and makes sure members have access to high quality, cost-effective treatment.

- **Experience Providing Care to Medicaid Members:** OHCS has supported the Mississippi Medicaid program since its inception; serving approximately 7 million members nationally through 47 Medicaid programs in 25 states. This includes network and utilization management programs in addition to quality and clinical monitoring. Today, OHCS manages nearly 43 million members across a wide spectrum of products and programs, including commercial, Medicare and Medicaid populations. Services to be provided are network access and utilization management activities for chiropractic care; physical, occupational and speech therapy; and complementary alternative medicine.
- **Brief Description of Services Provided:** OHCS manages contracts with a national network of physical therapists, occupational therapists and speech-language pathologists, along with inpatient and outpatient therapy facilities. Comprised of quality-focused, cost-effective health care practitioners supported by ongoing monitoring to verify optimal network size and quality of care, Mississippi's network consists of 88 chiropractors and 392 therapy providers. All practitioners must meet rigorous credentialing criteria that focuses on clinical performance, the practitioner's general professional standing and standards set forth by NCQA.

Payment Integrity Services

OptumInsight, a wholly owned subsidiary of UnitedHealth Group, is one of the largest health care information, technology, operational services and consulting companies in the world. Services to be provided include data analytics, technology and operational services, including payment integrity services for data mining; recovery; fraud, waste and abuse; and coordination of benefits and subrogation.

- **Experience Providing Care to Medicaid Members:** OptumInsight has invested over $2.5 billion in technology and innovation — constantly expanding partnerships focused on research and improving the health care system experience. They collaborate with four out of five hospitals in the United States and more than 100,000 physician practices and health care facilities and 31 state governments. They process

over 1.5 billion claims annually with a more than a 99% accuracy rate. Services are tailored to state government payers, including data and analytics technology, claims management and payment accuracy services and strategic consulting. OptumInsight serves approximately 300 health plans through cost-effective, technology-enabled solutions that improve efficiency. They understand and optimize growth while managing risk, delivering on clinical performance and compliance goals while managing and building strong care networks.

- **Brief Description of Services Provided:** OptumInsight provides subrogation; payment integrity; and fraud, waste and abuse services for our MississippiCAN and CHIP programs. Because of our subrogation and third-party liability (TPL) processes and procedures, in 2021, UnitedHealthcare reported provider savings of $8.36 billion locally. In addition, we employ a Mississippi-based investigator and two field-based representatives dedicated to educating providers on proper billing practices. With full knowledge of provider challenges and investigations related to MississippiCAN and CHIP, these individuals handle day-to-day provider matters related to Division inquiries and any observed concerns.

Non-Affiliate Subcontractors

eviCore

eviCore is an evidence-based health care solutions firm that conducts management services for outpatient advanced radiology and cardiology benefits by targeting utilization and quality.

- **Experience Providing Care to Medicaid Members:** Through the program, eviCore's advanced radiology modalities such as magnetic resonance imaging (MRI), magnetic resonance angiogram (MRA), computed tomography (CT) — including contrast and three-dimensional identity (3DI), positron emission topography (PET) — and nuclear medicine are monitored for quality and utilization. Working with us since 2009, eviCore provides health care management services to more than 4.6 million managed Medicaid members across 20 health plans, including Mississippi.
- **Brief Description of Services Provided:** eviCore provides radiology and cardiology utilization management services for MississippiCAN members and monitors quality of care associated with these diagnostic modalities.

Medical Transportation Management, Inc.

Medical Transportation Management (MTM) — a certified woman-owned business enterprise — has served as our chosen subcontractor for non-emergency transportation (NET) for the MississippiCAN program. We have recently enhanced this service to include trips for MississippiCAN mothers to places where baby formula and resources are provided and a no-cost transportation benefit for our Mississippi CHIP members.

- **Experience Providing Care to Medicaid Members:** MTM is committed to high-quality, innovative management of NET services while "thinking outside the box" to provide customized solutions that meet MississippiCAN members' unique needs. Leveraging 22 years of experience, MTM partners with clients to develop innovative solutions for accessing health care, increasing independence and connecting community resources in the most cost-effective manner. Since 1995, MTM has grown to serve more than 100 contracts in 29 states and the District of Columbia, serving 10 million members annually. MTM is responsible for transportation assurance for more than 680,000 Mississippians each month.
- **Brief Description of Services Provided:** MTM provides NET services for our MississippiCAN population. In 2022, this will expand to include the Mississippi CHIP population and transportation for mothers to secure resources for their babies. MTM arranges for airline travel when appropriate and facilitates mileage reimbursement for members who do not use NET.

Enhanced Services

In addition to the core services and benefits outlined in the Model Contract, as stipulated by Mississippi Division of Medicaid State Plan, CHIP State Health Plan and Administrative Code, we provide enhanced services that adapt to meet the needs of Mississippi. Among them are:

- Food insecurity programs
- Expanded telehealth coverage
- Technology-assisted disease management
- GED/education assistance
- Housing and utility assistance
- Unlimited office visits
- Texting campaigns
- Community grants
- Mobile applications customized for certain populations
- Enhanced maternity services
- Non-emergency transportation — CHIP
- Expanded foster care resources
- Employment assistance
- Disaster and emergency recovery programs
- Flexible prescription benefits (to the extent allowed)

Describe the Offeror's Intangible Assets

UnitedHealthcare's intangible assets represent years of investment in our business. From building a strong reputation to cultivating professional relationships and connections that enhance member care to putting in place a knowledgeable and well-trained professional staff to developing specialized tools and methods for high-quality care and service. Our efforts have resulted in a unique and exceptional health care and well-being organization. We combine our knowledge, experience and compassion — as an enterprise and as individuals — to make a meaningful difference in the communities where we live and work.

Knowledgeable and Well-Trained Professional Staff

For 48 years, UnitedHealthcare has been committed to the mission of helping people live healthier lives by providing solutions for Medicaid and CHIP across the country. We are honored to be a long-standing partner in Mississippi and to provide improved access and high-quality care to MississippiCAN and CHIP members in all 82 counties. We serve almost 200,000 members in the state and have adapted to meet the changes in both programs since their respective inceptions. UnitedHealthcare has built trusted and strategic relationships throughout Mississippi with our members, providers and numerous community- and faith-based organizations that affect the lives of our members and their families.

As a CCO serving MississippiCAN and CHIP, we understand the local culture, geography and health care delivery environment, enabling us to provide care to meet the needs of our members. Over the past 10 years, we have employed novel care management processes, implemented progressive payment models, engaged community partners and invested millions of dollars to improve the health of Mississippi, intentionally evolving our care approach to best meet the changing needs of our members.

Based in Ridgeland, Mississippi, our team is passionate about improving health in their home state. Our frontline staff and leadership team are long-term residents of this state and they have a wealth of experience in CCO operations enhanced with knowledge of local health care needs, including a deep understanding of challenges faced in both rural communities and underserved urban areas — we recruit employees based on their familiarity with Mississippi, community-based resources, underserved populations and knowledge of health equity challenges in our state.

Our established team of key personnel serving MississippiCAN and CHIP has direct experience serving our members in Mississippi. Our staff of approximately 20 has 338 years of combined experience, with our executive leaders averaging each 10 years of experience in Mississippi in their respective area of expertise, with

four having six or more years of tenure at our Medicaid health plan. All 11 of the administrative staff roles listed in this response are already staffed, with several incumbents having five to 10 years of direct MississippiCAN and CHIP experience. Our organizational structure celebrates Mississippi's people, ideas and experiences, with a team as diverse as the people we serve and a culture where all team members are appreciated, valued and able to reach their full potential. Our leadership team primarily consists of Mississippi-educated clinicians and professionals who have both clinical and management experience in our state.

Our local presence is further supported by relationships with key stakeholders at state agencies and organizations, including the Division of Medicaid, the Mississippi State Department of Health, provider groups and health systems, local health care professional groups and numerous community organizations. These close professional relationships help us to align the priorities set by the Division with the needs and priorities of other stakeholders. Our holistic understanding and partnership with organizations enables data sharing and fosters a united approach to creating lasting change in the communities we serve.

Quality Performance

As a state partner for over a decade, we have consistently achieved and maintained NCQA Accreditation. During our most recent NCQA site visit in January 2022, **we scored 100% with no adverse findings**. In Mississippi, we are one of seven plans across UnitedHealthcare — and the first CCO in Mississippi — to receive the NCQA Distinction in Multicultural Health Care. This distinction is presented to organizations that lead in providing culturally and linguistically appropriate services to successfully reduce health care disparities.

Member Satisfaction

One way we monitor patient satisfaction is with annual administration of the CAHPS survey. Providing feedback from our members on topics important to them such as ability to access care and how providers communicate with them during visits, the survey includes an assessment of a range of member interactions, including those with their health plan and their providers.

The NCQA includes CAHPS scores in their Health Plan Ratings methodology. UnitedHealthcare continues to be among the top-performing health plans. Our 2021 ratings demonstrated improvement from prior year performance in all areas, including overall patient experience, getting care, getting care easily and getting care quickly. We attribute this improvement to our community presence in addition to our ongoing annual training of our member services team, sharing best practice tools with providers aimed to improve the member experience and targeted education to our members on accessing needed care.

Provider Engagement

UnitedHealthcare has a strong reputation for supporting our network of providers. We have achieved this through technological solutions, face-to-face support, live events, readily adopted Alternative Payment Models (APMs) and pay-for-performance initiatives. We have a local Provider Advisory Council that is comprised of a rotating group of Mississippi providers and chaired by our medical director. This forum keeps local providers engaged and allows them to apply their insight to make suggestions to enhance our activities across the state.

Comprehensive Provider Network

UnitedHealthcare has the largest, most comprehensive provider network in Mississippi, exceeding access standards outlined in the model contract and the standards set forth by NCQA. Beyond accessibility, we focus on quality and efficiency, which we drive primarily through APMs and value-based provider agreements.

Nationally, we lead payment reform and practice transformation through our committed use of APMs. Our APMs include versions with no risk, such as those permissible and currently active in Mississippi, in addition to sophisticated models that are entirely outcomes-based and involve provider risk.

Specialized Tools and Methods

Through our many technology platforms, we have several tools and methods that are aimed at enhancing care and removing waste in the health care system. These include:

Customizable Algorithms for Risk Stratification

Our day-to-day care management approach includes customizable algorithms to risk-stratify individual members for a more selective intervention strategy. Using data gathered at intake, ongoing touchpoints, claims activity, provider health interfaces, geographical variations and weather events, this information creates an intensity level for each member that we use to create a clinically relevant care plan and goals. Depending on their needs and engagement, members are walked through how to achieve their goals, which may include periodic phone calls, home visits, engaging a provider on behalf of a member, advocating for public assistance or simply inviting a member to a community event that will be beneficial.

Algorithms to Detect Anomalous Claims Activity and Utilization

Our Care Provider Early Warning System (CP-EWS) monitors all claim activity and detects when certain utilization patters deviate from normal performance. This triggers an alert that results in a provider relations specialist reaching out to the provider to discuss the occurrence. If the activity was detected due to a provider error, the provider relations specialist assists the provider in resolving the error.

Customizable Algorithms to Simplify Authorization Requirements

Prior authorizations (PAs) are necessary to maintain proper evidence-based utilization. However, providers often see these as burdensome administrative tasks that take time. Our normal process is to remove authorization requirements for services when they reach a generally accepted approval rate within the state. We are aware that the Division is aiming to streamline and unify PA processes and we welcome the opportunity to collaborate with the Division to adjust our PA operations to best support MississippiCAN and CHIP.

Customizable Geospatial Capabilities

Immediately following the occurrence of hurricane Ida along the Mississippi Gulf coast, we implemented geospatial mapping. This capability allows us to identify at-risk members who may be vulnerable to various occurrences across the state. Capabilities include weather (both forecasted and real-time) events, pollution distribution and other locally identified threats. These data are overlayed with our members' residences; hovering over each "dot" on a display provides member-level demographic information that enables us to directly contact members who are at risk. We are expanding the technology to locate "member pockets" that need care interventions, such as COVID-19 vaccinations, which will allow us to deploy field-based interventions more precisely and effectively.

UnitedHealthcare Research & Development

UnitedHealthcare Research & Development (UnitedHealthcare R&D) exists to support local health plans in developing pilot and proof-of-concept programs. These programs begin with questions asked by employees on how we can better fulfill our mission of making the health system work better for everyone. The UnitedHealthcare R&D team helps formulate measures of success, create documents to submit for state approval, implement the intervention and measure change. Later this year, we are breaking ground on a 66,000 square foot housing project in Jackson, which is being funded, in part ($3 million), by our organization. The R&D team helped

develop the social determinant and clinical variables we are using to measure success — which will potentially lead to expanding a similar project along the Mississippi Gulf Coast.

Professional and Community Relationships

UnitedHealthcare has spent years cultivating relationships with community partners to expand care options for our members while developing deep and solid connections to the communities we serve. We see these relationships as intangible assets that have allowed us to advance our presence and promote MississippiCAN and CHIP.

Community Partnerships

We coordinate with community-based organizations (CBOs) and other health and social programs to meet our members in their own communities. We focus on developing partnerships with CBOs that can influence areas such as health equity, food insecurity, care transitions and population health. To help identify and address the unique needs of our members, we partner with organizations that can deploy resources such as mobile care units and large-scale food distributions. With our time and money, we support local professional associations that are committed to improving quality and access to health services. Ongoing examples include Community Health Center Association, Mississippi Rural Health Association, Community Mental Health Association and the Mississippi State Medical Association. When national organizations have local chapters, we use this as an opportunity to bring customized local care from national resources. Examples from 2021 include American Cancer Society, American Heart Association, March of Dimes, American Academy of Pediatrics and AARP.

We are engaged in collaborative partnerships and Joint Operating Committees (JOCs) with many Mississippi hospitals, behavioral health and substance use disorder providers, FQHCs, rural health clinics, community health centers, primary care practices and specialists. Effective care management is enhanced by nurturing strong partnerships with these organizations and supporting them with funding, structure, process, data and information to improve individual and population health.

School Partnerships

Schools are critical touchpoints for us, as most of our members are pediatric. Using schools as sites to provide services and health education continues to benefit our members. Over the last few years, our well-child outreach team reached over a thousand students and educated them on the importance of wellness exams. This included high schools across the state: Wingfield High (Jackson, Mississippi), South Delta Middle School (Anguilla, Mississippi), Terry High (Terry, Mississippi) and Callaway High (Jackson, Mississippi). In addition, the team provided educational information regarding the need for wellness exams and immunizations to middle and high school students at Jackson Public Schools Youth Health Symposium. In March 2020, we paused school visits due to the COVID-19 pandemic but are resuming them in 2022.

The well-child outreach team coordinates wellness screenings for high school sport teams. This innovative solution was implemented to address the barrier where many adolescents were noncompliant for wellness screenings because they had completed sports physicals and thought there was no need for the wellness exam. In 2021, wellness exams were completed for members of sports teams at Wingfield and Forest Hill High Schools (Jackson, Mississippi) in collaboration with Choices for Children mobile unit. We provided educational information regarding need for wellness exams, hygiene, healthy diet and immunizations to students.

Other Local Partnerships

Our ongoing aim to seek out partners in each region of the state aligns with focusing on priorities and public health goals articulated in the Division's strategic plan. The focuses include goals to reduce maternal and infant mortality and morbidity, promoting healthy lifestyles through population and evidence-based interventions to reduce the burden of diabetes and cardiovascular disease, and eliminating morbidity and mortality due to

vaccine-preventable diseases in children, adolescents and adults. To support population health goals and improve outcomes for MississippiCAN and CHIP members, we are actively involved in partnerships across the state to address social determinants of health. Recent examples include:

- **Tougaloo College/Delta HealthPartners Healthy Start Initiative (TC/DHP):** We are an active partner with National Healthy Start (NHS) to reduce infant mortality among high-risk and underserved residents. The TC/DHP initiative under NHS targets communities with high infant mortality rates and other adverse perinatal outcomes. The population focus is the underserved residents of the Mississippi Delta (Bolivar, Coahoma, Quitman, Sunflower, Tallahatchie, Tunica and Washington counties) and the aim is to promote health equity and mitigate challenges associated with poverty, unemployment, limited educational opportunities, extreme rural living and a weakened health care infrastructure.
- **EPSDT/Child Wellness Collaborative Efforts:** Our experienced EPSDT/Child Wellness team is managed by a leader who has a strong background in pediatric medicine. The EPSDT team falls under the leadership of our medical director, who is a board-certified pediatrician. The EPSDT/Child Wellness team consists of these leaders and clinical outreach coordinators. Together, the team works with our community partners to implement effective outreach events to facilitate completion of wellness exams. These events often include health fairs with community partners, welcoming school districts and faith-based organizations.
- **Our clinical transformation consultants (CTCs)** are embedded in large FQHCs throughout the state and support our PCMH and ACO providers. Their primary role is to collaborate with their clinics and the communities in which they are embedded to increase awareness and completion of wellness exams, preventive care and health activities shown to reduce readmissions and unnecessary ER use. Our 11-year partnerships with practices like Jackson-Hinds Comprehensive Health Center (JHCHC) and Coastal Family Health Center (CFHC) has been successful at engaging surrounding school districts and community groups to improve child wellness screening and immunization rates. The activities include:
  - **Children's Defense Fund's Health Fair:** A community health fair for children ages 4 and 5 in the Jackson Metro area to prepare for Kindergarten. Onsite wellness exams, immunizations, and health and nutrition education were provided by our team, in collaboraiton with the providers.
  - **Fun with Santa:** A community event in collaboration with the Boys & Girls Club to provide information on healthy food choices, dental care and exercise to after school students from the Jackson Public School District. Choices for Children Medical Clinic mobile unit was on-site to perform wellness exams.
  - **Siwell Middle School Career and Health Fair:** An event where educational information were provided to students regarding the need for wellness exams and immunizations. On-site wellness exams were completed via mobile unit collaboration with Choices for Children mobile unit.
  - **Back to School Bash and Community Health Fair:** The EPSDT/well-child outreach team provided information regarding the need for wellness exams, immunizations and nutrition in Lexington. On-site wellness exams were provided by Mallory Community Health Center.
  - **JPS Youth Health Matters Symposium:** A health fair for all Jackson Public Schools middle and high school students. The EPSDT/well-child outreach team provided educational information about wellness exams, diet and immunizations.
  - **Back-to-school immunization drive:** A combined effort with CFHC, Excel By 5, the Health and Safety Group, and UnitedHealthcare aimed at providing back to school supply drives, and on-site child and adolescent immunizations.
  - **Quinn Healthcare Children's Health Initiative Essay/Poster Contest:** A poster/essay contest to educate school age and high school students on the importance of completing wellness exams for

incentive rewards. Since 2019, this initiative has been successful at various schools in Hinds, Rankin and Madison counties.

Mississippi Public Health Institute Partnership
We have a long-standing partnership with the Mississippi Public Health Institute (MSPHI) and have engaged with them in a variety of health-focused initiatives. Shortly after the implementation of MississippiCAN and CHIP, we partnered with MSPHI to develop the Division's Oral Health Plan. We have continued to work in direct partnership with the Mississippi Department of Oral Health on the promotion of oral evaluation and dental varnish application to MississippiCAN members. **Since 2013, we have increased total members receiving oral evaluations from 1,215 to 8,472 and our topical fluoride varnish from 674 to 11,573.**

In January 2022, UnitedHealthcare invested $550,000 in MSPHI to improve maternal health equity and outcomes. This investment aims to improve maternal-child outcomes and reduce health inequities in Mississippi health care. In 2022, working with MSPHI, we will launch Babyscripts with five OB/GYN provider practices across Mississippi. Babyscripts is a digital app that employs digital education and remote monitoring for diabetes and high blood pressure among pregnant individuals.

Alternative Care Management Approach – Evidence-Based Home Visiting in the Delta Region
UnitedHealthcare has partnered with the Mississippi National Healthy Start Association to launch an evidence-based **home-visiting program for our members.** Implemented to seven underserved communities in the Mississippi Delta (Bolivar, Coahoma, Quitman, Sunflower, Tallahatchie, Tunica and Washington), a team of RNs, LCSWs and CHWs provide in-home visits and care coordination, focusing on improving metrics such as infant mortality and low birth weight.

Addressing Social Determinants of Health

Food Insecurity Initiatives
Farm to Fork has been our longest-standing initiative in Mississippi. Begun in 2012 to distribute free, locally grown, organic vegetables from designated facilities throughout the state to MississippiCAN and CHIP members, Farm to Fork provides nutritionally sound options to our members and individuals. Members can shop at designated Farmer's Markets and use our funds to get free locally grown produce. They receive information on healthy preparation for meals targeted to support diets designed to positively affect chronic conditions. We provide onsite coaching opportunities to members who participate in Farm to Fork to close any outstanding care gaps. **To date, Farm to Fork has served nearly 100,000 members statewide and distributed approximately 600 tons of food**. In the late Fall and early Winter, we host our holiday fresh food giveaways. These events are held across Mississippi and include free whole turkeys and fresh, locally sourced vegetables.

Our Fresh Produce Project helps provide nutritionally sound options to our members and their families who reside in food deserts by distributing free, locally grown, vegetables from designated facilities throughout the state. **To date, this program has served nearly 20,000 members statewide and distributed approximately 70 tons of food**.

A Benefit to the Community
"A number of recipients have confided that during COVID-19 last year the vouchers made the difference between having fresh fruits and vegetables and having no produce at all."
- Diane Claughton, president and co-founder South Mississippi Farmers Market Association

Housing and Employment Navigation Assistance

Increasing Access to High Quality Care

Under our Office of Population Health**,** we provide services to members in need of housing, utility and employment assistance. Our Mississippi-based Empowerment Manager (SDOH Navigator) collaborates with community health workers (CHWs), care managers and directly

with members and their families to coordinate resources to help members in times of need or transition. Our staff and community-based housing organizations like Continuum of Care (COC), regional and local housing authorities, public and private property owners participate in collaborative efforts with the members' assigned navigator. The Empowerment Manager (SDOH Navigator) identifies local housing trends, develops relationships and creates housing opportunities for members, prioritizing those with special needs.

In 2022, we will break ground on a 66,000 square foot housing project in Jackson, which is being funded, in part ($3 million), by UnitedHealthcare. In collaboration with Gulf Coast Housing Partnership, Inc. (GCHP) and JHCHC, the project is a redevelopment of the former Jackson Southwest Hotel. The project will hold 76 units of affordable housing and an onsite medical clinic staffed by JHCHC.

Teen Focus Groups

To identify incentives that will motivate parents and children within the ages of 10 – 14 and 15 – 18, we began having focus groups with teens. Since the inception of this initiative, we met with more than 3,500 teens statewide. Topics of discussion included healthy behaviors, nutrition and the importance of exercise. The teens were engaged and offered feedback on what types of activities teens are interested in and what types of incentives would motivate them and their parents to schedule wellness visit appointments. In addition to discussing incentives and activities, we asked the teens whether they completed their annual wellness visits and if not, what reasons kept them from closing those care gaps. The responses served as the foundation for creating our member incentive plans and helped us identify and overcome barriers for the teens.

Partnership with the American Cancer Society

In 2020, we joined the American Cancer Society's HPV Vaccination Health Plan pilot, which offers a new perspective on adolescent vaccine compliance and how to apply best practices to increase HPV vaccination rates. As a part of the pilot project, we implemented an adolescent vaccine incentive reward program that provides a $25 incentive reward card to members who complete their Tdap, Meningococcal and HPV #1 vaccines before age 13. After completion of the second HPV vaccine before age 13, members receive an additional $25 reward.

UnitedHealthcare Catalyst ™ in the Community

We believe that real change comes by investing in relationships, establishing long-term commitments and partnering at the community level. The UnitedHealthcare Catalyst is a community health initiative aimed to achieve health equity by supporting collaborative, cross-sector movement and directly addressing health inequity, community health disparities and unequal access to care. It is inclusive of all residents within the community and does not require UnitedHealthcare membership. For this initiative, UnitedHealthcare: 1) convenes a group of partner organizations that share equal leadership responsibilities and serve as the voices of community, 2) provides money, dedicated resources and staff for the collaborative, and 3) creates a model that is self-sustaining for years to come.

In 2021, we launched Mississippi's first UnitedHealthcare Catalyst in partnership with JHCHC and local businesses and community organizations to shift health care delivery away from the traditional of transactional care episodes characterized by disparate siloed efforts. For the initial year, we provided $250,000 and have engaged JHCHC, six local barber shops/hairdressers, eight churches, three fitness centers and four health-focused coalitions. Through community-based health interventions, we have reached more than 500 people in the early stages of the first year.

Partnering to Immunize Communities

It is important to us that residents of our communities are immunized against potentially deadly diseases. Our partnerships with organizations that provide vaccinations have been important in assuring community wellness. We have worked closely with CVS pharmacies to increase awareness around the need for flu vaccinations and to hold community flu vaccination events in six locations across Mississippi. Through these partnerships, **more than 20,000 Mississippians participated** and received flu shots and information on the role of vaccines in disease prevention.

COVID-19 community vaccination efforts have been one of the widest coordinated efforts in recent years. These efforts were coordinated as a special focus to help vulnerable populations understand the benefits of vaccination and how to access the vaccine. We listened to the specific needs of our state and local partners and identified where we can best provide support. Partners included FQHCs and the Mississippi State Department of Health – Office of Health Equity. We collaborated to offer community drive-through COVID-19 vaccination events in areas across the state.

Figure 1. COVID-19 testing at our free COVID-19 vaccination event at St. Paul MB Church in Cleveland, Mississippi — a perfect blend of partnerships between community organizations and FQHCs.

Vaccination hesitancy remains concerning, especially for high-risk racial, ethnic and geographic communities. To reduce vaccine hesitancy and increase community adoption of the COVID-19 vaccine among populations who have hesitancy, we are actively engaging and deepening our member and community conversations to help us to build trust, confidence and mutual respect with our most vulnerable populations who may be more hesitant to get vaccinated.

Our member services center has direct access to a Vaccine Locater so that when a member calls in with questions about their nearest vaccine location, we can provide them with information and address hesitancy.

We provide COVID-19 vaccination updates on our Community Connections call to provide ongoing and updated information to our community partners across the state. This biweekly call routinely reaches 40 to 50 community partners.

We work with community organizations to support Hispanic and Latino Mississippians expressing significant hesitancy toward the COVID-19 vaccine. The availability of credible vaccine information in different languages is often a significant contributor to vaccine hesitancy for Hispanic and Latino communities. Without language accessible information, Hispanic and Latino populations often go elsewhere for vaccine information, including

social media, leading to potential misinformation. UnitedHealthcare builds upon community partnerships to tailor and share culturally relevant messages and materials with diverse communities. We work directly with the language access director/coordinator with the Mississippi Department of Health Office of Preventive Health and Health Equity to support translation of vaccination information.

FQHC Partnerships

Traditionally, our community outreach teams have focused on event-centered activities like health fairs and tabling events with our FQHCS. We took an extra step and reimagined how we approach and conduct being active community partners with our FQHCs. In 2021, we started a quarterly roundtable where we invited FQHCs to a working lunch to develop partnerships with ongoing engagement. These sessions are built on the inclusion of health plan leadership and teams to increase active collaboration in community events, based on the specific needs from both partners' perspectives. During these sessions, we incorporate SDOH and population health opportunities with our co-developed community activities such as building a COVID-19 vaccination event for Hispanic and Latino communities. We intend to broaden participation within regions to increase engagement and knowledge exchanged at these working lunches.

Figure 2. In Jackson, our Hispanic community COVID-19 vaccination event with Family Health Care Clinic included Hispanic community orgs, Spanish-speaking support teams and the Mississippi Department of Health.

Faith-Based Organization Partnerships

Figure 3. Mask distribution giveaway at Cade Chapel MB Church in Jackson.

Faith-based organizations (FBOs) are proven community-oriented solutions for reaching members and achieving health equity. Our community partner relationships with FBOs play an integral part in providing connected care to communities across the state, and we have effectively used these to provide health care education, disaster response and direct health care services. In 2021, partner CBOs have included various churches in Jackson, Raymond, Vicksburg, Edwards and Hazlehurst.

Dr. Health E. Hound®

Dr. Health E. Hound is one of our most creative health education activities, incorporating games, physical activities, special guests, prizes and healthy snacks to encourage participation. We frequently partner with community organization to bring Dr. Health E. Hound to community events packed with health education for all members of the family. Events Dr. Health E. Hound frequents include:

- Educating 300 Boys & Girls Club youth and completing wellness exams
- KidzJam, which included door-to-door community outreach to more than 75 community members and completed over 20 wellness exams on-site

- Clinic Days, which educated youth and provided full wellness exams
- Fitness Fests, which educated over 1,000 community members
- Get Moving events provided to more than 500 HeadStart students

World-Class Reputation for Quality Applied Locally

America's Health Rankings® Report

Since 1989, America's Health Rankings has created increased awareness and action to address important trends in public health. This report is used by organizations across the country and is created by the UnitedHealth Group's United Health Foundation. The report provides one of the most comprehensive assessments of the nation's health on a state-by-state basis. It was developed in partnership with the American Public Health Association and is built on the World Health Organization's definition of health: "Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity."

The dynamic report highlights key drivers, cites specific areas for improvement and recommends key interventions known to affect health. UnitedHealthcare uses America's Health Rankings to devise and deliver targeted, meaningful solutions that address Mississippi health disparities.

The Advisory Board

Under the UnitedHealth Group structure through Optum, the Advisory Board exists to "make health care better." The organization partners with over 4,500 organizations and focuses on research and solutions to solve today's health care challenges such as care delivery models, health equity, quality, health disparities, workforce challenges, emergency response, disease management and health technology.

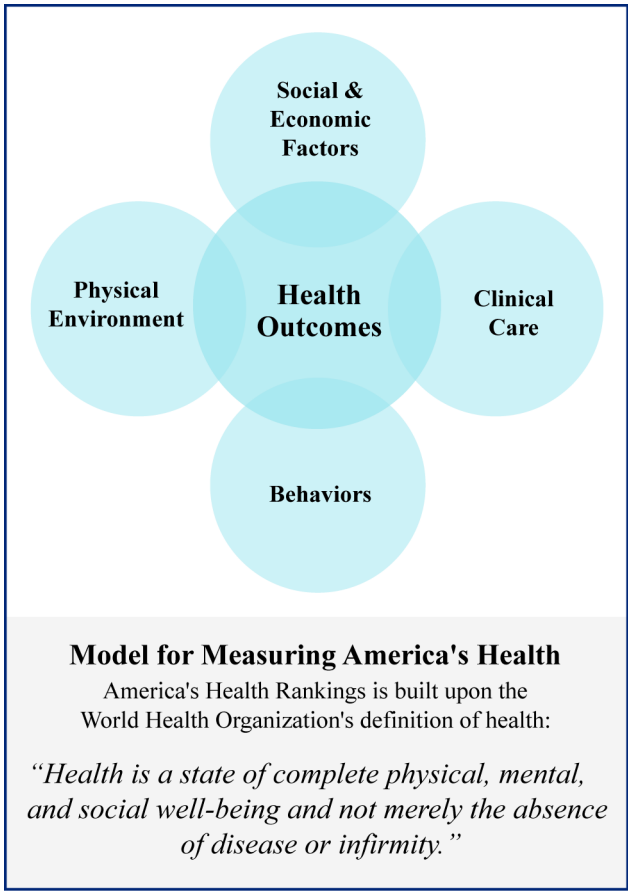


Figure 4. UnitedHealthcare measures the success of our member health outcomes using the America's Health Rankings model.

Corporate Accolades

As one of the country's leading health and wellness companies, our reputation ranks among our most important assets. For the 11th consecutive year, UnitedHealth Group, our parent company, was the top ranked company in the insurance and managed care sector on Fortune's 2021 "World's Most Admired Companies" list. The company ranked #1 on all nine key attributes of reputation:

- Innovation
- People management
- Use of corporate assets
- Social responsibility
- Quality of management
- Financial soundness
- Long-term investment value
- Quality of products and services
- Global competitiveness

In addition, the company was named to the "All-Star" list of Fortune's 2021 top 50 most admired companies. A trusted partner to the Division, we look forward to continuing to demonstrate our integrity and reputation in Mississippi. UnitedHealth Group has further been recognized nationally and worldwide:

- **Most Community-Minded:** In 2021 and for the 10th consecutive year, The Civic 50, a Points of Light initiative that highlights companies that improve the quality of life in the communities where they do business, ranked UnitedHealth Group one of America's 50 most community-minded companies. UnitedHealth Group was named the leader in the Healthcare Sector category for the fourth time overall.
- **Corporate Equality:** UnitedHealth Group received a perfect score of 100 on the Human Rights Campaign Foundation's Corporate Equality Index 2021, earning the distinction of one of the "Best Places to Work for LGBTQ Equality."
- **Disability Inclusion:** The Disability Equality Index® (DEI) named UnitedHealth Group one of the best places to work for disability inclusion in 2021.
- **Corporate Excellence:** Prospanica, an organization empowering Hispanic professionals for over 30 years, recognized UnitedHealth Group with the 2021 Brillante Award for Corporate Excellence. Recognizing outstanding contributions to the educational, economic and social well-being of the Hispanic community, the Corporate Excellence award honors a corporate partner with a proven track record of success in recruiting and retaining a diverse workforce.
- **Dow Jones Industrial Average:** UnitedHealth Group is a member of the Dow Jones Industrial Average, a blue-chip group of 30 companies deemed industry leaders.
- **World's Best Employer:** UnitedHealth Group was named to Forbes' list of 2021 World's Best Employers, in which 150,000 workers from 58 countries working for multinational organizations rated their willingness to recommend their employer to friends and family and evaluate other employers in their industries that stood out positively or negatively.
- **Best Large Employer:** UnitedHealth Group was named to Forbes' list of America's 500 Best Large Employers for 2021.
- **Top Company:** UnitedHealth Group ranked No. 11 on the 2021 LinkedIn U.S. Top Companies List, which professionals use identify the top workplaces to grow their careers.
- **Military Spouse Friendly®:** UnitedHealth Group is ranked No. 4 in the nation on the 2022 Military Friendly® Employers list and is a Top Ten 2022 Military Spouse Friendly® Employer.
- **Excellence in Health and Well-Being:** The National Business Group on Health honored UnitedHealth Group with a 2020 "Best Employers: Excellence in Health and Well-Being" top-tier Platinum award.
- **Fortune 500:** Fortune magazine ranked UnitedHealth Group No. 5 in the 2021 rankings of the 500 largest U.S. corporations based on 2020 revenues.
- **Leadership Band:** The Carbon Disclosure Project named UnitedHealth Group to its Leadership Band in 2020 for efforts to reduce greenhouse gas emissions.
- **Dow Jones Sustainability:** UnitedHealth Group has been named to the Dow Jones Sustainability World and North America Indices since 1999.

Describe any unique and/or innovative resources in which the Offeror specializes

UnitedHealthcare's culture empowers employees at all levels to think, ask questions and take initiative to create unique solutions. This is true for our Mississippi staff, and since our inception in 2010, we have invested in Mississippi communities, engaged community leaders, rewarded high-performing providers, supported in-state professional organizations, employed technological solutions and worked alongside various state partners to address the unique needs of Mississippians. Through these initiatives, **we have advanced health care**

outcomes, improved health equity and promoted economic security — all in the midst of a devastating pandemic and natural disasters.

Whether creating a telehealth continuum of solutions, such as direct-to-consumer virtual visits, telepsychiatry and telemonitoring services to meet the unique health and social determinants gaps Mississippians experience or investing in technological innovations from cloud deployment to reduce infrastructure costs, to Member Health Dashboards that integrate a member's health records, we are working to change the traditional health care approach of healing illness, focusing instead on meeting the individual member's holistic needs and earning the support of communities and improving efficiency while advancing population health. Our approach integrates all aspects of health — physical, behavioral, wellness and social determinants — to maximize health equity and affect health outcomes in a more meaningful way. Our holistic approach centers on five areas of focus:

- Advancing Population Health
- Driving Innovation and Value
- Increasing Access to High Quality Care
- Nurturing Local Partnerships
- Achieving Operational Excellence

Advancing Population Health Outcomes

Advancing Population Health Outcomes

UnitedHealthcare's population health approach includes predictive systems and algorithms that identify pockets of disparities, anomalies and even areas of weather-related risks. By focusing on population health, we can scale programs and care delivery models to best influence Mississippians across the entire state. We employ technology, promote medical homes and community organizations and provide value-added services — all of which prioritize the overall health and wellness of the individual and community.

Our tools synthesize data to identify trends and needs within the community. UnitedHealthcare's experienced, cross-trained staff ascertain food, housing and health services at every encounter. We use member-centered, integrated solutions to build upon resources specific to a member's health-related social needs, and as members' needs and availability of resources change, advancing health equity and addressing social determinants of health (SDOH) remain the foundation of our approach.

Beyond traditional medical providers, we look to local community organizations to support our population health approach. These include faith-based organizations, food pantries, community centers, housing and employment organizations, employers and other community organizations — all of which support the overall well-being of our members and their communities. Field-based care providers who provide home visits to members further enhance this community-based approach.

Our experience has shown that these partnerships and investments better reach our members and mitigate care avoidance.

Critical to advancing population health outcomes is addressing health inequity. According to the Mississippi State Department of Health, Mississippi is ranked close to last in most of the health outcomes. These health disparities are worse for those who have systematically faced obstacles to health related to conditions such as socioeconomic status, race, ethnicity and geographic location. Some areas where Mississippi scores are worse includes diabetes, hypertension, infant mortality and obesity. To align the Division's priorities with UnitedHealthcare's goal of improving the quality of life for our members, we developed our **Health Equity Program** to address health disparities, monitor access to care and enhance member experiences so every member has a fair opportunity to be as healthy as possible.

The Health Equity Program is a dual provider-member incentive program and will be led by our local health equity director. This leader will coordinate activities among various departments within the health plan, aimed at combatting disparities and inequity. The goal of UnitedHealthcare's Health Equity Program is to deploy programs and initiatives to **remove obstacles to care so health care is equitable for all and inclusive for those who have been traditionally underserved.** Our commitment to reduce health disparities includes deployment of innovative programs in Mississippi that draw on our knowledge of advancements in the industry to reduce health care disparities among the MississippiCAN and CHIP populations.

UnitedHealthcare's comprehensive data analysis drives action at the member, community and system levels. By integrating various sources of SDOH data with clinical, demographic and geographic data, our teams can assess member macro-level social needs, potential social service capacity issues and provider barriers to SDOH screening and referrals to better address SDOH needs for Mississippians. For example, we have implemented SDOH screening on key domains, including employment and found that a significant number of our members are experiencing unemployment or underemployment. Based on these findings, we developed a targeted employment program focused on the unemployed and underemployed. In response, we have hired an employment navigator to support members with employment.

Our SDOH action portfolio includes:

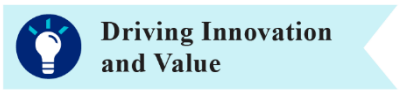
- **Find Help (SDOH Resource and Referral Tool):** Real-time data on SDOH barriers enables us to connect members to accountable networks of CBOs providing services and supports for underserved communities. As our staff engage with a member and identify a social need, we use the Find Help platform as our closed-loop SDOH referral tool. With Find Help, we will provide MississippiCAN and CHIP members with local resources to address their immediate needs and know when social services have been delivered. The Find Help application is available in 130 different languages, uses a closed-loop network model, allows the ability to text and email referral information directly from the application and includes a member facing website available for self-referral and improved reporting capabilities. Data from Find Help is aggregated into our national Health Related Social Needs database and integrated into our care management platform.
- **Targeted Member Interventions:** Informed by SDOH and clinical data stratification, we can identify a targeted number of members whose social and clinical needs require higher intensity engagement. For example, focused local solutions such as those addressing housing and complex health needs will provide housing support and wraparound services for high-cost members who are experiencing homelessness in selected parts of Mississippi.
- **Community Engagement and Investment Alignment:** Our comprehensive SDOH approach provides data and experience to influence and align investments in the community. Aggregated member data on demographics, geography and race, combined with SDOH data collected from screening tools, Z-codes and member or care manager feedback, is incorporated with data collected from FindHelp and service delivery patterns to provide a blueprint to where SDOH service gaps exist (e.g., where community-based services are at capacity and unable to meet the level of need). The power of this data will be in sharing it with counties, providers and community-based partners to support a comprehensive, aligned community investment strategy reflecting the needs and goals of the community, similar to our Catalyst program. This analysis drives our community investment

Figure 5. Our Community Engagement and Investment Framework

strategy, which seeks to convene cross-sector partners and use data to identify gaps, develop partnerships and implement community level interventions. Data collected will provide a roadmap on how to mitigate social barriers and improve member and community health. This data will support new and innovative alternative payment models with providers and CBOs. This type of analysis informed our community investments in efforts to address food insecurity in Mississippi:

- Investment of **$100,000 in the Mississippi Food Network** to provide students and their families with regular access to nutritious food at five school-based food pantries in the Jackson Public School District
- Investment of **$150,000 in the Metropolitan YMCAs of Mississippi** to expand the food access program to rural and low-wealth communities by adding four food distribution sites and purchasing a refrigerated mobile food truck

Driving Innovation and Value



Innovation is one of UnitedHealthcare's core values. We deploy our solutions in ways that affect overall health care delivery and communities where we serve members. For rural members who lack access to care, we have expanded our telemedicine and telemental health networks so members can receive care in the comfort of their home. Providers have access to psychiatry and mental health consultations at no cost to them or to members.

We are driving payment reform in Mississippi by increasing provider reimbursement based on the quality of care provided. Our tools span the spectrum of technology-readiness and sophistication. Where providers and members may not be ready for advanced electronic tools, our communication modalities include telephonic, digital, face-to-face, community-based and office-based, to encourage engagement and advance them to our innovative digital tools as they become ready.

According to our experience, the largest cost driver and health challenge facing Mississippi are problems around maternal-newborn health. To meet this challenge, **we invested more than $3.5 million in Mississippi this past year**, with nearly half dedicated to help reduce teen pregnancy, support pregnant members and care for the sick and well babies of Mississippi. In addition to maternal and neonatal health costs, we have seen diabetes, and diabetes-related diseases continue to influence the overall health status of Mississippi. In response, nearly all our value-based purchasing contracts include measures to improve diabetic care.

Powered by local clinical leadership and care management teams, our care management approach is person-centered and deeply rooted in Mississippi. Our teams live and work in the communities they serve, and they have access to tools and resources to help them deeply understand and address the needs of their communities. Implementing **innovative clinical solutions** supports members in accessing needed care and brings efficiency to care management and care delivery. For example, our care managers connect our membership to such innovative programs as:

- **Genoa Comprehensive Management:** To further comply with the terms of the SUPPORT Act and support a member's successful community tenure, eligible individuals can enroll in Genoa Healthcare's Comprehensive Medication Management and telemental health program, which connects individuals with a licensed pharmacist care manager to address pharmacological concerns and support adherence with medications in compliance with the SUPPORT Act. Through initial and ongoing support for both medical and behavioral health medication needs, this unique longitudinal program strengthens the individual's ability to maintain successful community tenure and actively participate in their wellness journey.
- **Livongo:** Remote monitoring devices aggregate real-world member data securely and effortlessly. Livongo then interprets members' health metrics, social determinants, preferences and clinical needs to

trigger timely actionable feedback to drive behavior change. Interventions include Health Nudges (education), five-day challenges and ongoing expert coaching.

- **Doctor Chat:** A chat-first virtual visit that targets high inpatient and ER users.
- **Care Angels Diabetes Path:** A voice-enabled virtual nurse assistant uses artificial intelligence to provide continuous remote care to help PCPs and members reverse diabetes through behavior, diet and medication changes. The virtual nurse assistant acts as a care manager to close HEDIS® gaps, make sure members are getting to needed appointments, taking medications and reducing ER visits.

Increasing Access to High-Quality Care

Beyond providing access to traditional health care services, UnitedHealthcare has developed a network and coalition of health-focused stakeholders across the state — both traditional and nontraditional providers committed to high-quality and needed services in Mississippi.

In 2013, UnitedHealthcare launched our Accountable Care Community model to support Mississippi members and providers. Participating providers have onsite and/or direct access to clinical transformation consultants who are RNs with tools to advance care and relationships with community resources to improve member well-being beyond the doctor's office. This model has evolved over the years to include hundreds of culturally sensitive providers who partner with us to improve physical and mental health, expedite access to care, address social determinants, combat barriers to care, reward members and financially incentivize providers to improve health outcomes. **Since its inception, our Accountable Care Community model has supported nearly 500,000 Mississippians** and we continue to expand and enhance our model to meet the changing needs of Mississippi members and communities.

We acknowledge that access to high-quality care does not translate into receiving care, so we directly engage our members to verify their basic needs, such as housing, food, clothing, are being met and quickly connect them to appropriate resources to meet those basic needs when a need is identified. More than a comprehensive network of high-quality providers, we provide our members with solutions that address their social needs leveraging relationships with community partners and faith-based organizations. We connect providers with community-based resources to address our members' non-medical needs, engaging and rewarding providers who have care models that facilitate better outcomes for Mississippians.

An important way that we increase access to high quality care includes **incorporation of telehealth into our care delivery strategy.** We promote traditional provider-to-patient and remote patient monitoring (RPM) approaches and implement virtual physician-to-physician consultation capabilities, which brings specialty care to underserved areas. UnitedHealthcare uses technology innovations to help connect our members to the proper care they need and to close the gaps in health equity. UnitedHealthcare has long supported telehealth for access to high-quality care wherever members live, whether health professional shortage areas, medically underserved areas or rural regions. In Mississippi, our telehealth use has increased from less than 5,000 visits in 2019 to more than 220,000 in 2020, with anxiety, mood and adjustment disorders as the top diagnoses. As in-person visits have become more available in 2021, telehealth volume decreased to 95,000 visits.

Because of the rural nature of Mississippi, the disparate health equity issues affecting our members, and the lower number of physicians per capita, we assessed the unique health and social determinants gaps Mississippians experience and created a **telehealth platform continuum** to meet each of these needs.

This includes providing free smartphones and tablets, in addition to apps and platforms to easily connect members to physical and behavioral services, remote monitoring platforms to support members with chronic

conditions and local partnerships and investments to create a strong community network of telehealth supports for our members.

We have partnered with the University of Mississippi Medical Center's Center for Telehealth to help manage many of our high-risk diabetics. The program covers remote-based services above the traditional Medicaid and CHIP fee schedules to include real-time interventions to mitigate blood sugar deviations, hospital readmissions, emergency room visits, and increasing comorbid conditions and side effects. Social determinants can be addressed in real time through video conferencing with physicians and nurse practitioners.

Achieving Operational Excellence

We have made significant investments around operational excellence, including an array of solutions ranging from employing our advanced risk-stratification techniques to identifying and engaging high-risk and high-cost members earlier to improving data sharing with providers and detecting waste and abuse in the health care system.

Understanding that we are stewards of taxpayer funds, we deploy sophisticated systems to support providers and members to improve outcomes and lower the total cost of care. The ultimate outcome of this is an experience that exceeds the expectations of our members, providers and state partners.

Supporting Providers in Alternative Payment Models

From national experience, we know health information technology and clinical engagement are foundational to support providers in their participation in value-based purchasing (VBP). We provide local clinical resources, supported by our medical directors who — in conjunction with our health care economics team, design reports to reflect provider progress toward quality goals and financial measures, and who meet regularly with practices to review results — identify opportunities for improvement and develop collaborative plans for members. To help providers who are participating in our alternative payment models (APMs), we provide reports and tools to help them improve their quality performance. These include:

- **Individual Health Records (IHR)** give providers the ability to view a unified record of their patients' health history — including lab results and prescribed medications — based on claims submissions enabling coordination of care.
- **Patient Care Opportunity Report (PCOR)** is a monthly Excel-based report that includes practice and provider-level HEDIS® care opportunities and provider incentive program performance with associated available earning potential.
- **Integrated Population Care Assistant (iPCA)** is a web-based clinical management system offering providers panel rosters, clinical updates such as ER and discharge notifications and member-level HEDIS care opportunities.
- **Point of Care Assist (POCA)** is available to providers using Epic, Cerner, Athena, eClinicalWorks, Practice Fusion, Allscripts and NextGen, this tool provides access to real-time data directly in the provider's EMR, including eligibility, quality care opportunities (refreshed biweekly), patient health history (13 months), specialty referral and real-time prescription benefit information.
- **Raw data feeds** are for providers who have established engines for stratifying and using data for population health.

For our more advanced APMs, we use health information technology to build capacity for providers improve quality through investments in technology. These investments enable real-time access to data at the point of service improves member outcomes, provider performance and capacity and supports delivery system transformation toward population health management.

Nurturing Local Partnerships

Sixty-four percent of our Mississippi members live in rural areas where health care resources range from minimal to none. To improve this, UnitedHealthcare collaborates with community-based organizations, faith-based organizations, local businesses, community centers and other local resources, supporting these organizations through funding, volunteering and donations of products that can improve community health. Many of our partnerships are not exclusive and we work with other CCOs to improve community health. Aligning goals within communities verifies long-term economic security and health equity for our members. These partnerships benefit our members as we continue to seek to address the complex roots of inequities by empowering members and families, advancing health system change and engaging communities.

Food insecurity affects Mississippi more than any other state in the nation. With more food deserts per capita, we have made food security a priority. We continue our hallmark Farm to Fork project, a partnership with Alcorn State University USDA Extension Program that distributes free, locally grown, organic vegetables from designated facilities throughout the state to MississippiCAN and CHIP members. To date, Farm to Fork has served nearly 100,000 members statewide and distributed approximately 600 tons of food. Around the holidays, we conduct our scheduled food distributions, which include fresh vegetables and free whole turkeys for our members.

Early and Periodic Screening, Diagnosis and Treatment

Our expansive community partnerships involve and engage key stakeholders to strengthen the preventive care paradigm with MississippiCAN and CHIP members. We engage community based organizations, schools, local barber shops, health clinics, churches and housing communities in the following ways to encourage members to obtain Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services.

Leading the Charge for Fresh Produce in our Urban Communities

"…the need for more programs like this one is great. Foot Print Farms is proud to have a community partner like UnitedHealthcare."

- Dr. Cindy Ayers Elliot, founder/president

- We partner with providers to host clinic days for members who are due or past due for well-child services. We will call members and schedule appointments during weekdays, after hours or on weekends during the event to enable working parents and their kids to participate.
- Mobile care is an innovative solution that helps drive convenient and accessible preventive care, reduce health disparities and support population health goals. We will continue supporting and partnering with providers who have this capability, such as Choices for Children, and various FQHCs. These mobile health units can be taken to community events to allow members to close EPSDT care gaps during the event. At an event that we co-hosted with Choices for Children in 2019, there were 145 additional wellness exams completed in one day.
- Quarterly, we mail reminders and flyers to remind members of due or past due screenings, offering to arrange transportation or aid in finding a PCP. We monitor member preventive care by race, ethnicity, age, geographic location and member language categories as a part of our health equity program. We target quarterly outreach efforts to those geographic locations with the lowest rates of participation.
- We have a long standing partnership with the Boys & Girls Club and Choices for Children. As an example of this partnership, we co-host a holiday health fair, which has afforded us the opportunity to complete around 20 wellness visits and provide education about healthy eating habits, accessing preventive dental services and the value of exercise.

- We partner with the American Cancer Society's HPV Vaccination Health Plan pilot, which allows our EPSDT team to collaboratively learn and apply best practices to design and implement quality improvement projects aimed at increasing HPV vaccination rates.
- Our poster and essay contest educates elementary, middle and high school students on the importance of completing wellness exams for incentive rewards. Since 2019, this initiative has been a successful partnership between our EPSDT team and Quinn Healthcare.
- Our EPSDT team and quality nurses have developed partnerships with multiple schools and local clinics to perform wellness screenings for high school sports teams. This innovative solution addresses a care barrier: many adolescents were noncompliant for wellness screenings because they had completed sports physicals and thought there was no need for a wellness exam.

Describe additional resources of the Offeror

UnitedHealthcare is a wholly owned subsidiary of UnitedHealth Group Incorporated, a public company whose diverse array of companies cover a wide variety of programs and services related to the health and well-being industry. As part of UnitedHealth Group, we have access to the expertise and resources of the nation's leaders in health care services, allowing us to continue to seamlessly support the MississippiCAN and CHIP membership and respond to the program's needs for innovative solutions to support new initiatives.

Our affiliated vendor-partners — United Behavioral Health, Inc. operating under the brand name Optum and OptumRx — are part of the UnitedHealth Group family of companies and share the same internal communication platform, corporate leadership, technology, infrastructure and corporate policies. This integration translates into more direct oversight and greater ability to take timely corrective action than in a typical external vendor/subcontractor relationship. The breadth of our enterprise capabilities enables us to provide fully integrated and seamless member care and provider support. Using the unified capabilities of our enterprise, we provide our Mississippi members with the most creative, innovative and fully integrated managed care model.

Seeking to spur innovation around health equity, UnitedHealth Group established a Health Equity Services Program more than a decade ago. This initiative has identified several opportunities to better understand our Medicaid members' unique needs, identify gaps in care and deliver tailored health solutions. Through that program, we locally develop health disparity action plans that focus on specific Mississippi populations and health measures that need improvement. Working with our resources listed above, we identify gaps in care for MississippiCAN and CHIP members and design culturally tailored interventions.

World-Class Resources in a Partnership for Success in Mississippi

Since 2010, UnitedHealthcare has brought world-class resources to Mississippi and partnered with key stakeholders across the state. Over the past few years, we have accelerated our investments and tools at a pace that is positively affecting health care and laying the foundation for a much healthier state. Earning the support of community partners, investing millions of dollars in Mississippi, growing our innovation locally and empowering our members with advanced tools positions us as a key differentiator in the years to come. We are not done yet and are ready to do more to create lasting change in Mississippi.

For 48 years, UnitedHealthcare has been committed to our mission of helping people live healthier lives by providing solutions for Medicaid programs and CHIP across the country. We provide managed care services to 7,690,000 Medicaid, CHIP and D-SNP members in 31 states plus the District of Columbia. UnitedHealthcare serves 95,000 children and young adults across 15 states who have experienced similar trauma, vulnerabilities and health care needs as those in the Substitute Care Program and we have been doing so for five years. Optum serves approximately 36.6 million individuals in both employer-sponsored and publicly funded behavioral

health programs through a comprehensive provider network with more than 233,500 clinicians and more than 3,000 facilities nationwide.

Our national and state-specific expertise guides us in developing programs to address health inequities and the needs of specialized populations, including children in foster/substitute care, people with intellectual and developmental disabilities, dual-eligible individuals and members in state-based and federal health exchanges and pilot innovations in social determinants of health. We are passionate about improving the lives of the children and adults we serve and bring this passion to our partnership with the Division.

Innovation is in UnitedHealthcare's core values. We pursue a course of continuous, positive and practical innovation, using our deep experience in health care to be thoughtful advocates of change and using the insights we gain to invent a better future that will make the health care environment work and serve everyone more fairly, productively and consistently. Innovation is not something we just value. It's behind everything we do as we seek to fulfill our mission of Helping People Live Healthier Lives and Helping Make the Health System Work Better for Everyone.

[END OF RESPONSE]

Biographical Information				
General Background Information				
Date Business was Established: August 06, 1990				
Legal Business Name as Reported to the Internal Revenue Service: UnitedHealthcare of Mississippi, Inc.				
Doing Business As Name (if applicable): Not applicable.		**Tax Identification Number (required):** 63-1036817		
Ownership Type (public company, partnership, subsidiary, etc.): Public Company				
Number of Personnel Currently Engaged in Operations: 214		**Total Number of Employees:** 350		
Professional accreditations pertinent to the services provided by this RFQ: NCQA Accredited Health Plan and NCQA Multicultural Health Care Distinction				
Location of the Principal Place of Business				
Address Line 1 (Street Name and Number): 795 Woodlands Pkwy				
Address Line 2 (Suite, Room, etc.):				
City: Ridgeland	**State:** MS	**Zip Code:** 39157	**County:** Madison	
Mailing Address (P.O. Box):	**City:**	**State:**	**Zip Code:**	**County:**
Location of place of performance of the proposed Contract				
Address Line 1: 795 Woodlands Pkwy				
Address Line 2:				
City: Ridgeland	**State:** MS	**Zip Code:** 39157	**County:** Madison	
Contractual Termination				
Has the Offeror been a party to any contractual termination within the past five (5) years? [ ] Yes [✓] No **If yes, attach a narrative explanation for each termination including date, market, population covered, circumstances of termination, and contact information for the state entity that was party to the contract.**				

[REST OF PAGE INTENTIONALLY LEFT BLANK]

4.3.1.2 Corporate Experience (Marked)

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

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

Our experience with the type of service to be provided by this RFQ and Medicaid experience is provided in the following pages.

AZ – AHCCCS Complete Care Integrated Services, Arizona Long Term Care (ALTCS), Division of Developmental Disabilities (DDD)

Corporate Experience: Current and/or Recent Client				
Client's Name: AHCCCS/ALTCS: Arizona Health Care Cost Containment System DDD: Arizona Department of Economic Security/Division of Developmental Disabilities				
Client Location				
Address Line 1: AHCCCS: 801 East Jefferson, MD 4100 ALTCS: 801 East Jefferson, MD 3900 DDD: 1789 W. Jefferson Street, 4th Floor, SW MD 2C91				
Address Line 2:				
City: Phoenix	**State:** AZ	**Zip Code:** AHCCCS/ALTCS: 85034 DDD: 85007	**County:** Maricopa	
Mailing Address (P.O. Box): AHCCCS: PO Box 25520 MD 4100 ALTCS: PO Box 25520 MD 3900 DDD: PO Box 6123 MD 2C91	**City:** Phoenix	**State:** AZ	**Zip Code:** AHCCCS/ ALTCS: 85002 DDD: 85005	**County:** Maricopa
Direct Contact for Client				
Name: AHCCCS/ALTCS: Jami Snyder DDD: Zane Garcia Ramadan				
Title: AHCCCS/ALTCS: Director DDD: Assistant Director				
Phone Number: AHCCCS/ALTCS: 602-417-4111 DDD: 602-542-0068		**Email Address:** AHCCCS/ALTCS: Jami.Snyder@azahcccs.gov DDD: ZRamadan@azdes.gov		
Work Details				
Number of covered lives: 480,434 (Q4 2021)				
Time period of contract: AHCCCS - Origination: 1982 Current Contract: Oct. 1, 2018 – Sept. 30, 2021 with three, two 2-year options to extend. Added additional two-year extension through 9/30/27.				

ALTCS - Origination: 1989
Current Contract: Oct. 1, 2017 – Sept. 30, 2024 with three renewal periods: one renewal of two years, and two renewals of one year each. Not to exceed a total contracting period of seven years.

DDD - Origination: 1988
Current Contract: Oct. 1, 2019 – Sept. 30, 2022 with extensions up to seven years, not to exceed 10 years.

Total number of staff hours expended during time period of contract: 1,890,720

Personnel requirements: Approximately 909 FTEs for the contract year which includes key required roles in the contract as well as staff performing care management, member and provider outreach, compliance, prior authorization, grievance and appeals, quality management and claims.

Geographic and population coverage requirements:
AHCCCS - Geographic: Maricopa, Pinal, Gila, and Pima counties
Population: Expansion, CHIP, SSI w/ Medicare, SSI w/o Medicare, TANF

ALTCS - Geographic: Central and North GSAs. Available in Apache, Coconino, Gila, Maricopa, Mohave, Navajo, Pinal and Yavapai counties.
Population: Coverage for qualified elderly, physically disabled and chronically ill

DDD - Geographic: Statewide coverage
Population: Provides supports and services to individuals diagnosed with one of the following developmental disabilities: Autism, Cerebral palsy, Epilepsy, Cognitive/Intellectual Disability or are under the age of six and at risk of having a Developmental Disability.

Publicly funded contract cost:
AHCCCS: Contract Year 2021 $2,046 million
ALTCS: Contract Year 2021 $394 million
DDD: Contract Year 2021 $220 million

Description of work performed under this contract

AHCCCS: Services include acute and primary care, audiology, behavioral health, birthing services, cancer screening and treatment, chiropractic, dialysis, durable medical equipment (DME), family planning, home health care, laboratory, medical checkups and care for children under age 21, oral evaluation and fluoride varnish for members six months to 35 months of age, vision, pharmacy benefits, podiatry, prenatal care, preventive services, radiology, therapies, transplant and other specialty services.

Covers Early and Periodic Screening, Diagnostic and Treatment (EPSDT) medical checkups, occupational therapy, audiology, speech therapy, hospital clinic services — as appropriate, regular examinations, immunizations, child delivery and newborn care, substance use and behavioral health services, laboratory and X-ray services — including tests to prevent birth defects, expanded vision care, podiatry, asthmatic care, limited dental services and other specialty care benefits. The contract is integrated with transportation and behavioral health. Covers children and youth with some medical complexity. With the recent inclusion of the Children's Rehabilitative Services contract, most medically complex cases are covered.

ALTCS: Services include acute and primary care, audiology, behavioral health, birthing services, cancer screening and treatment, chiropractic, dialysis, durable medical equipment (DME), family planning, home health care, laboratory, vision, pharmacy benefits, podiatry, prenatal care, preventive services, radiology, therapies, transplant and other specialty services. Nursing Facility, Hospice, Attendant Care, Assisted Living Facility, Adult Day Care Health Services, Home Health Services, such as nursing services, home health aide, and therapy, Case Management This program provides coverage to certain elderly, physically disabled and chronically ill people who are recipients of Medicaid.

DDD: This program provides coverage to residents who have chronic disabilities attributable to mental developmental disabilities, cerebral palsy, epilepsy, or autism manifested prior to age 18. Children under

6 years of age may be eligible for services, if it is demonstrated that the child is or will become developmentally disabled, members must be enrolled in ALTCS, which is part of AHCCCS. Services include acute and primary care, audiology, augmented communication devices, behavioral health, birthing services, cancer screening and treatment, chiropractic, dialysis, durable medical equipment (DME), early childhood intervention (ECI) service, family planning, home health care, laboratory, medical checkups and care for children under age 21, oral evaluation and fluoride varnish for members six months to 35 months of age, vision, pharmacy benefits, podiatry, prenatal care, preventive services, radiology, therapies, transplant and other specialty services.

CA – Medi-Cal Managed Care - Geographic Expansion

Corporate Experience: Current and/or Recent Client				
Client's Name: Department of Health Care Services, Office of Medi-Cal Procurement				
Client Location				
Address Line 1: Mail Stop Code 4200, 1501 Capitol Avenue, Suite 71.3041				
Address Line 2:				
City: Sacramento	**State:** CA	**Zip Code:** 95899	**County:** Sacramento	
Mailing Address (P.O. Box): PO Box 997413	**City:** Sacramento	**State:** CA	**Zip Code:** 95899	**County:** Sacramento
Direct Contact for Client				
Name: Francisco Mata				
Title: Contract Manager				
Phone Number: 916-633-0191	**Email Address:** Francisco.J.Mata@dhcs.ca.gov			
Work Details				
Number of covered lives: 26,406 (Q4 2021)				
Time period of contract: Origination: 2017 Current Contract: Oct. 1, 2017 – Sept. 30, 2022 (San Diego County) Oct. 1, 2017- Oct. 31, 2018 (Sacramento County) - Sacramento County early termination - Due to unique market dynamics in Sacramento County, UnitedHealthcare Community Plan of California, Inc. decided to terminate its contract with California Department of Health Care Services Oct. 31, 2018.				
Total number of staff hours expended during time period of contract: 118,560				
Personnel requirements: Approximately 57 FTEs for the contract year which includes key required roles in the contract as well as staff performing care management, member and provider outreach, compliance, prior authorization, grievance and appeals, quality management and claims.				
Geographic and population coverage requirements: Geographic: San Diego Population: TANF, CHIP, ABD, Expansion, LTSS				
Publicly funded contract cost: $445.7M from inception to date.				
Description of work performed under this contract				
This Medicaid program provided health care coverage for eligible Seniors and Persons with Disabilities (SPD)—which is like ABD, CHIP, California Children's Services (CCS), expansion and TANF beneficiaries in San Diego. Medically necessary services cover mild to moderate behavioral health, physical, pharmacy, vision care, and long-term services and supports. Other benefits include free health risk assessments (HRA), EPSDT screening and a Healthy First Steps Pregnancy Program — with				

member incentives for maintaining appropriate pre- and post-natal care and well-child immunization visits. The contract was integrated with behavioral health, transportation and LTSS.

CO – The Rocky Mountain Health Plan (RMHP), Prime and Child Health Plan Plus (Prime/CHP+)

Corporate Experience: Current and/or Recent Client				
Client's Name: Colorado Department of Health Care Policy and Financing				
Client Location				
Address Line 1: 303 East 17th Avenue, 11th floor				
Address Line 2:				
City: Denver	**State:** CO	**Zip Code:** 80203	**County:** Arapahoe	
Mailing Address (P.O. Box): Same as Above	**City:**	**State:**	**Zip Code:**	**County:**
Direct Contact for Client				
Name: Dr. Tracy Johnson, PhD				
Title: Medicaid Director				
Phone Number: 303-866-3058	**Email Address:** Tracy.Johnson@state.co.us			
Work Details				
Number of covered lives: 238,702 (Q4 2021)				
Time period of contract: Origination: 1974 Current RAE Agreement: 2018-2025 Note: Acquired by UnitedHealthcare in March 2017; contracts listed, including newly formed RAE contract – effective July 1, 2018 – June 30, 2025 (7-year procurement period).				
Total number of staff hours expended during time period of contract: 397,280				
Personnel requirements: Approximately 191 FTEs for the contract year which includes key required roles in the contract as well as staff performing care management, member and provider outreach, compliance, prior authorization, grievance and appeals, quality management and claims.				
Geographic and population coverage requirements: Geographic: Available in 22 counties in Western and Northern Colorado. Population: CHIP, Expansion, SSI w/Medicare, SSI w/o Medicare, TANF, ACO				
Publicly funded contract cost: 2021 Revenue $259M				
Description of work performed under this contract				
Rocky Mountain Health Plans (RMHP) has participated with the Colorado Medicaid program continuously since its founding in 1975. Their programs provide Child Health Insurance Plan (CHIP) benefits for children and pregnant women, well as all categories of eligibility in the Health First Colorado (Medicaid). RMHP is the sole Regional Accountable Entity (RAE) serving Colorado Region 1, which includes Western Colorado and Larimer County. RMHP offers MCO coverage and coordinates				

acute, primary and specialty care; pharmacy and all covered behavioral health services for all Medicaid enrollees in RAE Region 1.

On July 1, 2018, the RMHP RAE began providing behavioral health services as a capitated PIHP.

FL – Statewide Medicaid Managed Care (SMMC)

Corporate Experience: Current and/or Recent Client				
Client's Name: Agency for Health Care Administration				
Client Location				
Address Line 1: 2727 Mahan Drive				
Address Line 2:				
City: Tallahassee	**State:** FL	**Zip Code:** 32308	**County:** Leon	
Mailing Address (P.O. Box): Same as Above	**City:**	**State:**	**Zip Code:**	**County:**
Direct Contact for Client				
Name: Beth Kidder				
Title: Deputy Secretary, Medicaid				
Phone Number: 850-412-4006	**Email Address:** Beth.Kidder@ahca.myflorida.com			
Work Details				
Number of covered lives: 331,184 (Q4 2021)				
Time period of contract: Origination: 2013 Current Contract: Jan 1, 2019 – Dec. 31, 2024				
Total number of staff hours expended during time period of contract: 1,460,160				
Personnel requirements: Approximately 702 FTEs for the contract year which includes key required roles in the contract as well as staff performing care management, member and provider outreach, compliance, prior authorization, grievance and appeals, quality management and claims.				
Geographic and population coverage requirements: Geographic: Includes the following counties: Alachua, Baker, Bradford, Citrus, Clay, Columbia, Dixie, Duval, Flagler, Gilchrist, Hamilton, Hernando, Lafayette, Lake, Levy, Marion, Miami-Dade, Monroe, Nassau, Putnam, St. Johns, Sumter, Suwannee, Union and Volusia. Population: LTC, SSI w/o Medicare, TANF				
Publicly funded contract cost: $1,539,774,507				
Description of work performed under this contract				

This program provides health care coverage to TANF, SSI, LTSS and chronically ill Medicaid beneficiaries throughout the State of Florida. Additional benefits include other expanded services (e.g., over-the-counter medications, personal hygiene items and circumcision). The elderly, chronically ill and disabled people living in community and nursing home environments are members of this program — enabling those in the community to remain in the community, while avoiding nursing home placement. A wide range of community supports are provided, such as home health aide services, home-based therapies, respite care, adult day care, personal assistance/care, housekeeping, home modification and chore services.

HI – QUEST Integration (Hawaii Medicaid Program)

Corporate Experience: Current and/or Recent Client				
Client's Name: Hawaii Department of Human Services - Med-QUEST Division				
Client Location				
Address Line 1: 601 Kamokila Blvd., Room 518				
Address Line 2:				
City: Kapolei	**State:** HI	**Zip Code:** 96709	**County:** Oahu	
Mailing Address (P.O. Box): PO Box 700190	**City:** Kapolei	**State:** HI	**Zip Code:** 96709	**County:** Oahu
Direct Contact for Client				
Name: Judy Mohr Peterson, PhD				
Title: Administrator – Medicaid Division				
Phone Number: 808-692-8050	**Email Address:** JMohrPeterson@dhs.hawaii.gov			
Work Details				
Number of covered lives: 59,433 (Q4 2021)				
Time period of contract: Originated in 2015 Current contract duration: July 1, 2021 – December 31, 2026 with the potential for up to three additional 12-month periods or parts thereof.				
Total number of staff hours expended during time period of contract: 520,000				
Personnel requirements: Approximately 250 FTEs for the contract year which includes key required roles in the contract as well as staff performing care management, member and provider outreach, compliance, prior authorization, grievance and appeals, quality management and claims.				
Geographic and population coverage requirements: Geographic: Statewide (all counties/islands), which includes the islands of Hawaii, Kauai, Lanai, Maui, Molokai, and Oahu (Statewide) Population: TANF, CHIP, ABD, Expansion, and LTC				
Publicly funded contract cost: Estimated at $2B annual (SFY 7/1/21 to 6/30/22)				
Description of work performed under this contract				

Covers comprehensive medical, behavioral, LTSS, pharmacy coverage and other benefits. Contract effective July 1, 2021, continue the combination of earlier separate programs: QUEST (non-ABD) and QExA (ABD including dual eligible and LTSS). Other benefits include medically necessary services, such as non-emergent medical transportation, personal care attendants, home delivered meals, home modifications, homeless coordination services, personal emergency response system and a 24-hour nurse line. Physical and behavioral health is provided using an integrated, member-centric approach. Behavioral health services for the serious mental illness (SMI) population are carved out to another program and DD/ID populations have certain services provided through the State of Hawaii Department of Health Developmental Disabilities Division. Certain transplants, once the pre-transplant services are completed, are carved-out to a separate transplant program (SHOTT).

LTSS-Specific: LTSS population receives specific services to support their needs as assessed and documented in a care plan, and as approved by the State of Hawaii Medicaid agency. Services include placement in a nursing facility, alternative long-term care setting, or in the member's own home.

Effective July 1, 2021, UnitedHealthcare is providing value-added services including non-dual adult dental preventative services and a community transition program for individuals coming out of the correctional system.

IA – Iowa Health Link (Medicaid) - Expired Contract

Corporate Experience: Current and/or Recent Client				
Client's Name: Iowa Medicaid Enterprise, Department of Human Services				
Client Location				
Address Line 1: 100 Army Post Road				
Address Line 2:				
City: Des Moines	**State:** IA	**Zip Code:** 50315		**County:** Polk
Mailing Address (P.O. Box): Same as Above	**City:**	**State:**	**Zip Code:**	**County:**
Direct Contact for Client				
Name: Michael Randol				
Title: Director of Medicaid				
Phone Number: 515-256-4621		**Email Address:** MRandol@dhs.state.ia.us		
Work Details				
Number of covered lives: N/A				
Time period of contract: Origination: 2016 Current Contract: April 1, 2016 – Mar. 31, 2019 with two 2-year extensions to run through 2023. On June 30th, 2019, the health plan terminated this contract due to rate negotiations. However, UnitedHealthcare maintains a presence in Iowa serving commercial, dual-eligible and Medicare populations.				
Total number of staff hours expended during time period of contract: N/A - Expired Contract				
Personnel requirements: N/A - Expired Contract				
Geographic and population coverage requirements: Geographic: Statewide Population: CHIP, CSHCN, expansion, LTSS/LTC/HCBS, foster care, Medicaid for Employed People with Disabilities (MEPD), Medicare Assistance (dual eligible), SSI, BH and TANF				
Publicly funded contract cost: N/A - Expired Contract				
Description of work performed under this contract				
This state funded program provided coverage to CHIP, CSHCN, expansion, foster care, LTSS/LTC/HCBS, Medicaid for Employed People with Disabilities (MEPD), Medicare Assistance (dual eligible), SSI, BH and TANF beneficiaries. The program offered comprehensive care for these population types, to include all waiver populations. Services included medical, behavioral health, pharmacy, vision, waiver benefits for multiple waivers including brain injury and intellectual disability,				

physical disability, HIV/Aids and non-emergent transportation. Care managers (e.g., RNs, community outreach and behavioral health clinicians) delivered hands-on care management, including risk assessments and individualized plans of care with monitoring and oversight. Enrollment was mandatory for most populations and voluntary for Native Americans. The contract was integrated with behavioral health, transportation and LTSS. The contract covered children and youth with medical complexity.

IN – HoosierCareConnect (Medicaid)

Corporate Experience: Current and/or Recent Client				
Client's Name: Indiana Family and Social Services Administration				
Client Location				
Address Line 1: 402 W Washington St.				
Address Line 2:				
City: Indianapolis	**State:** IN	**Zip Code:** 46204		**County:** Marion
Mailing Address (P.O. Box): PO Box 7083	**City:** Indianapolis	**State:** IN	**Zip Code:** 46207	**County:** Marion
Direct Contact for Client				
Name: Allison Taylor				
Title: Director, Indiana Medicaid				
Phone Number: 317-233-4455		**Email Address:** Allison.Taylor@fssa.in.gov		
Work Details				
Number of covered lives: 3,636 (Q4 2021)				
Time period of contract: Origination: 2021 Current Contract: April 1, 2021 – March 31, 2025				
Total number of staff hours expended during time period of contract: 106,080				
Personnel requirements: Approximately 51 FTEs for the contract year which includes key required roles in the contract as well as staff performing care management, member and provider outreach, compliance, prior authorization, grievance and appeals, quality management and claims.				
Geographic and population coverage requirements: Geographic: Available in 92 counties (Statewide) Population: ABD				
Publicly funded contract cost: $30M - 12 months from 4/1/2021 go-live (9 months of actuals + 3 months of estimates)				
Description of work performed under this contract				
Managed Care Entity for Indiana aging, blind, and disabled program called Hoosier Care Connect providing comprehensive managed care services at risk.				

KS – KanCare Managed Care 2.0

Corporate Experience: Current and/or Recent Client				
Client's Name: Kansas Department of Health and Environment				
Client Location				
Address Line 1: 900 SW Jackson Avenue, Suite 900				
Address Line 2:				
City: Topeka	**State:** KS	**Zip Code:** 66612		**County:** Shawnee
Mailing Address (P.O. Box): Same as Above	**City:**	**State:**	**Zip Code:**	**County:**
Direct Contact for Client				
Name: Sarah Fertig				
Title: Director of Medicaid				
Phone Number: 785-296-3563		**Email Address:** Sarah.Fertig@ks.gov		
Work Details				
Number of covered lives: 170,680 (Q4 2021)				
Time period of contract: Origination: 2013 Current Contract: Jan. 1, 2019 – Dec. 31, 2021 with two, 1-year extensions				
Total number of staff hours expended during time period of contract: 1,058,720				
Personnel requirements: Approximately 509 FTEs for the contract year which includes key required roles in the contract as well as staff performing care management, member and provider outreach, compliance, prior authorization, grievance and appeals, quality management and claims.				
Geographic and population coverage requirements: Geographic: Covers statewide Population: TANF, CHIP, LTC, DD/DV, SSI w/ Medicare, SSI w/o Medicare				
Publicly funded contract cost: $1,401,151,202 annually, average of contract duration (2019 – 2021)				
Description of work performed under this contract				
Covers medical, behavioral health, long-term care, pharmacy, dental, vision and non-emergent transportation. Care managers (e.g., RNs, social workers, community health workers and behavioral health clinicians) deliver telephonic and face-to-face care management, including comprehensive health risk assessments, care coordination, assistance with addressing social determinants of health, and development of person-centered plans of care with ongoing support to improve health and well-being. The contract is integrated with behavioral health, transportation and long-term services and supports. The contract covers children, youth, needy families, pregnant women, aged, blind and disabled, as well				

as seven home and community-based waivers through an 1115 waiver. The seven waivers include Physical Disability, Frail Elderly, Brain Injury, Technology Assisted Children, Intellectual/Developmental Disability, Severe Emotional Disturbance and Autism.

KY – Kentucky Medicaid/KCHIP

Corporate Experience: Current and/or Recent Client				
Client's Name: UnitedHealthcare of Kentucky, LTD				
Client Location				
Address Line 1: 9100 Shelbyville Road				
Address Line 2:				
City: Louisville	**State:** KY	**Zip Code:** 40222	**County:** Jefferson	
Mailing Address (P.O. Box): Same as Above	**City:**	**State:**	**Zip Code:**	**County:**
Direct Contact for Client				
Name: Krista Hensel				
Title: Chief Executive Officer				
Phone Number: 214-282-3366	**Email Address:** Krista_Hensel@uhc.com			
Work Details				
Number of covered lives: 58,863 (Q4 2021)				
Time period of contract: Origination: 2021 Current Contract: Jan. 1, 2021 – December 31, 2024 – Contract may be renewed at the completion of the initial contract period for 6 additional 2-year periods upon the mutual agreement of the Parties.				
Total number of staff hours expended during time period of contract: 316,160				
Personnel requirements: Approximately 152 FTEs for the contract year which includes key required roles in the contract as well as staff performing care management, member and provider outreach, compliance, prior authorization, grievance and appeals, quality management and claims.				
Geographic and population coverage requirements: Geographic: Available in 120 counties (Statewide) Population: Expansion, CHIP, SSI w/ Medicare, SSI w/o Medicare, TANF				
Publicly funded contract cost: CY 2021 Revenues: ~$550,000,000				
Description of work performed under this contract				
UnitedHealthcare of Kentucky, Ltd. is a limited partnership and is domiciled in Kentucky with its main administrative offices in Lexington. It was licensed as an HMO in 1986 and remains in good standing. Our executive leadership team will have full governing authority of the UnitedHealthcare Medicaid program. In addition, we will establish a Medicaid Advisory Board to advise the executive team to make sure that the voices of our community, providers and stakeholders are heard and their feedback incorporated is into our operations.				

LA – Acute Care (Medicaid)

Corporate Experience: Current and/or Recent Client				
Client's Name: Louisiana Department of Health				
Client Location				
Address Line 1: 628 N. 4th St				
Address Line 2:				
City: Baton Rouge	**State:** LA	**Zip Code:** 70802	**County:** East Baton Rouge	
Mailing Address (P.O. Box): Same as Above	**City:**	**State:**	**Zip Code:**	**County:**
Direct Contact for Client				
Name: Ruth Johnson				
Title: Undersecretary (previously Medicaid Director)				
Phone Number: 225-999-0944	**Email Address:** Ruth.Johnson@la.gov			
Work Details				
Number of covered lives: 511,360 (Q4 2021)				
Time period of contract: Origination: 2012 Current contract is from Feb 1, 2020 – Dec. 31, 2022				
Total number of staff hours expended during time period of contract: 1,329,120				
Personnel requirements: Approximately 639 FTEs for the contract year which includes key required roles in the contract as well as staff performing care management, member and provider outreach, compliance, prior authorization, grievance and appeals, quality management and claims.				
Geographic and population coverage requirements: Geographic: Covers statewide Population: Expansion, BH, SSI w/o Medicare, TANF				
Publicly funded contract cost: $9,932,415,845 for entire contract				
Description of work performed under this contract				
This Medicaid program provides health care coverage throughout the state for traditional Medicaid beneficiaries, to include the chronically ill, SSI and TANF. Benefits include core benefits and services, such as audiology services, inpatient and outpatient hospital services, ambulatory surgical and ancillary medical services, laboratory and X-ray services, surgical dental services, diagnostic services, organ transplant, behavioral health medication management, early periodic screening, diagnostic and treatment (EPSDT), emergency medical services, communicable disease services, durable medical equipment, prosthetics, orthotics and certain supplies, emergency dental, emergency and non-emergency medical				

transportation, home health and personal care services, hospice services, pregnancy-related services, nurse midwife services, pediatric and family nurse practitioner services, chiropractic services, rural health services, immunizations, end stage renal disease, optometrist services, podiatry, and rehabilitative and therapy services, and behavioral health services for inpatient and outpatient therapies.

MA – Senior Care Options (SCO)

Corporate Experience: Current and/or Recent Client				
Client's Name: Executive Office of Health and Human Services MassHealth Office of Long-Term Services and Supports; MassHealth at Elder Affairs				
Client Location				
Address Line 1: One Ashburton Place, 5th Floor				
Address Line 2:				
City: Boston	**State:** MA	**Zip Code:** 02108	**County:** Suffolk	
Mailing Address (P.O. Box): Same as Above	**City:**	**State:**	**Zip Code:**	**County:**
Direct Contact for Client				
Name: Corinne Altman Moore				
Title: Director of Integrated Care – Office of Long-Term Care Services and Supports				
Phone Number: 617-573-1601	**Email Address:** Corinne.Altmanmoore@massmail.state.ma.us			
Work Details				
Number of covered lives: 22,496 (Q4 2021)				
Time period of contract: Origination: 2004 Current Contract: Jan. 1, 2016 – Dec. 31, 2022				
Total number of staff hours expended during time period of contract: 800,800				
Personnel requirements: Approximately 385 FTEs for the contract year which includes key required roles in the contract as well as staff performing care management, member and provider outreach, compliance, prior authorization, grievance and appeals, quality management and claims.				
Geographic and population coverage requirements: Geographic: Available in nine counties: Bristol, Essex, Hampden, Middlesex, Norfolk, Suffolk, Plymouth and Worcester where 90% of the eligible population resides. Population: LTC, Expansion (Franklin County)				
Publicly funded contract cost: Average annual revenue (past five years) - $785M				
Description of work performed under this contract				
Provides a Fully Integrated Dual Special Needs Plan (FIDE SNP) that contracts with the federal government and Massachusetts Medicaid to deliver and coordinate all Medicare and Medicaid covered benefits in an integrated fashion. Members must: * Be at least 65 years old				

* Be eligible for MassHealth Standard

UnitedHealthcare SCO's goal is to keep elders as independent as possible. We use a high-touch integrated care management approach combining medical, behavioral health, home and community-based services (HCBS), pharmacy and social services. The contract is integrated with behavioral health, transportation and LTSS.

MD – HealthChoice (Medicaid)

Corporate Experience: Current and/or Recent Client				
Client's Name: Maryland Department of Health				
Client Location				
Address Line 1: 201 West Preston Street				
Address Line 2:				
City: Baltimore	**State:** MD	**Zip Code:** 21201	**County:** Baltimore City	
Mailing Address (P.O. Box): PO Box 800	**City:** Cambridge	**State:** MD	**Zip Code:** 27613	**County:** Dorchester
Direct Contact for Client				
Name: Tricia Roddy				
Title: Assistant Medicaid Director Health Care Financing				
Phone Number: 410-767-5809	**Email Address:** Tricia.Roddy@maryland.gov			
Work Details				
Number of covered lives: 167,672 (Q4 2021)				
Time period of contract: Origination: 1997 Current Contract: Jan. 1, 2021 – Dec. 31, 2021 (Annual Renewal)				
Total number of staff hours expended during time period of contract: 488,800				
Personnel requirements: Approximately 235 FTEs for the contract year which includes key required roles in the contract as well as staff performing care management, member and provider outreach, compliance, prior authorization, grievance and appeals, quality management and claims.				
Geographic and population coverage requirements: Geographic: Statewide Population: TANF, Expansion, ABD				
Publicly funded contract cost: $752M in Capitation Revenue				
Description of work performed under this contract				
Services are provided for adults and children, including children with special needs. Covered services include primary and specialty physician care, prescription drugs, diagnostic services, inpatient and outpatient services, home health, hospice, emergency services, OB/GYN care and eye exams. Our adult value-added benefits include adult dental and vision care (e.g., exams, one pair of glasses every two years and one replacement pair, if needed within a two-year period). Most long-term care, behavioral health, substance use disorder and transportation services are carved out, and delivered in FFS Medicaid.				

MI – Michigan Medicaid

Corporate Experience: Current and/or Recent Client				
Client's Name: Bureau of Medicaid Program Operations and Quality Assurance, Michigan Department of Community Health				
Client Location				
Address Line 1: Medical Services Division, 400 S. Pine St.				
Address Line 2:				
City: Lansing	**State:** MI	**Zip Code:** 48913	**County:** Ingham	
Mailing Address (P.O. Box): Capital Commons Center, 400 South Pine Street	**City:** Lansing	**State:** MI	**Zip Code:** 48933	**County:** Ingham
Direct Contact for Client				
Name: Kate Massey				
Title: Medicaid Director				
Phone Number: 517-241-7882	**Email Address:** MasseyK4@michigan.gov			
Work Details				
Number of covered lives: 297,086 (Q4 2021)				
Time period of contract: Origination: 1996 Current Contract: Jan. 1, 2016 – Sept 30, 2021 with three 1-year extensions				
Total number of staff hours expended during time period of contract: 867,360				
Personnel requirements: Approximately 417 FTEs for the contract year which includes key required roles in the contract as well as staff performing care management, member and provider outreach, compliance, prior authorization, grievance and appeals, quality management and claims.				
Geographic and population coverage requirements: Geographic: Covered counties include: Alcona, Allegan, Alpena, Antrim, Arenac, Barry, Bay, Benzie, Berrien, Branch, Calhoun, Cass, Charlevoix, Cheboygan, Clare, Crawford, Emmet, Genesee, Gladwin, Grand Traverse, Gratiot, Hillsdale, Huron, Ionia, Iosco, Isabella, Jackson, Kalamazoo, Kalkaska, Kent, Lake, Lapeer, Leelanau, Lenawee, Livingston, Macomb, Manistee, Mason, Mecosta, Midland, Missaukee, Monroe, Montcalm, Montmorency, Muskegon, Newaygo, Oakland, Oceana, Ogemaw, Osceola, Oscoda, Otsego, Ottawa, Presque Isle, Roscommon, Saginaw, Sanilac, Shiawassee, St. Clair, St. Joseph, Tuscola, Van Buren, Washtenaw, Wayne, and Wexford Population: TANF, Expansion, CRS, SSI w/ Medicare, SSI w/o Medicare				
Publicly funded contract cost: $8,276,136,060				

Description of work performed under this contract
This state-funded program provides comprehensive health care coverage in 65 counties throughout Michigan. Services are those covered by Medicaid and other expanded services, emergency and urgent care, home health, hospice, inpatient hospital care, outpatient health care, podiatry, skilled nursing facilities, chiropractic services, outpatient health care, supplies — DME, prosthetic devices, diagnostics, diabetes — self-monitoring and training, and preventive care (e.g., screenings and blood tests). Medical appointment transportation is provided for an unlimited number of trips. Members receive an enhanced vision benefit. The contract is integrated with behavioral health and transportation. The contract covers children and youth with medical complexity.

MO – HealthNet (Medicaid)

Corporate Experience: Current and/or Recent Client				
Client's Name: Missouri Department of Social Services				
Client Location				
Address Line 1: 615 Howerton Court				
Address Line 2:				
City: Jefferson City	**State:** MO	**Zip Code:** 65102	**County:** Cole	
Mailing Address (P.O. Box): PO Box 6500	**City:** Jefferson City	**State:** MO	**Zip Code:** 65102	**County:** Cole
Direct Contact for Client				
Name: Todd Richardson				
Title: Director – MO HealthNet Division				
Phone Number: 601-359-6050	**Email Address:** Todd.Richardson@dss.mo.gov			
Work Details				
Number of covered lives: 256,688 (Q4 2021)				
Time period of contract: Origination: 2017 Current Contract: July 1, 2020 – June 30, 2021 with one, 1-year option to extend				
Total number of staff hours expended during time period of contract: 696,800				
Personnel requirements: Approximately 335 FTEs for the contract year which includes key required roles in the contract as well as staff performing care management, member and provider outreach, compliance, prior authorization, grievance and appeals, quality management and claims.				
Geographic and population coverage requirements: Geographic: Statewide Population: TANF, Expansion, CHIP				
Publicly funded contract cost: $876.8M revenue from 7/1/2020-6/30/2021				
Description of work performed under this contract				
Covers medical, behavioral health, dental, vision and non-emergent transportation. Care managers (e.g., RNs, community health workers and behavioral health clinicians) deliver hands-on care management, including risk assessments and individualized plans of care with monitoring and oversight. Enrollment is voluntary for most populations in Case Management. The contract is integrated with behavioral health — except for Foster Care/Adoption Subsidy members (Behavioral Health benefit to Foster Care population is carved out to FFS Medicaid). Pharmacy is carved out to FFS Medicaid for all members.				

MS – CAN, CHIP

Corporate Experience: Current and/or Recent Client				
Client's Name: Mississippi's Division of Medicaid (DOM)				
Client Location				
Address Line 1: 550 High Street, Suite 1000				
Address Line 2:				
City: Jackson	**State:** MS	**Zip Code:** 39201	**County:** Hinds	
Mailing Address (P.O. Box): Same as Above	**City:**	**State:**	**Zip Code:**	**County:**
Direct Contact for Client				
Name: Drew Snyder				
Title: Executive Director				
Phone Number: 601-359-9562	**Email Address:** Drew.Snyder@medicaid.ms.gov			
Work Details				
Number of covered lives: 187,261 (Q4 2021)				
Time period of contract: CAN: Origination: 2011 Current Contract: July 1, 2017 – June 30, 2020, with two, one-year extensions CHIP: Origination: 2010 Current Contract: Aug. 1, 2019 – July 31, 2022 with two 1-year extension options				
Total number of staff hours expended during time period of contract: N/A - Provided Separately				
Personnel requirements: N/A - Provided Separately Approximately 300 FTEs for the contract year which includes key required roles in the contract as well as staff performing care management, member and provider outreach, compliance, prior authorization, grievance and appeals, quality management and claims				
Geographic and population coverage requirements: Geographic: Statewide Population: CAN: TANF, SSI w/o Medicare CHIP: CHIP				
Publicly funded contract cost: Approximately $975,000,000 per year				

Description of work performed under this contract
CAN: Provides statewide health care coverage throughout Mississippi for Medicaid beneficiaries, including the most vulnerable ABD/SSI and TANF members of the Medicaid population. Also includes pregnant moms, and the state's foster children in Child-Protective Services. It features full state Medicaid benefits, including optional services, and enhanced benefits beyond Medicaid FFS. These enhancements support a medical home model that connects enrollees with a primary care provider (PCP) and case managers to ensure enrollees receive the best and most appropriate level care, as and when needed. The contract is integrated with behavioral health, pharmacy, vision, dental, and transportation. The contract covers children and youth with medical complexities, low-income adults. CHIP: Provides state-wide high quality, accessible health care and customer service throughout the state of Mississippi for CHIP eligible populations (children < 21 years of age within families who meet income requirements). Medical coverage provides a broad range of services (e.g., inpatient and outpatient hospital care, outpatient professional services, diagnostics such as laboratory and x-ray, behavioral health services, ambulance, pharmacy services, PT/OT/SLP, vision and dental services). The program design connects members with a primary care provider (PCP), specialty care, and case managers to ensure enrollees receive appropriate levels of care.

NC – Prepaid Health Plan Services (Medicaid)

Corporate Experience: Current and/or Recent Client				
Client's Name: Department of Health and Human Services, Division of Health Benefits				
Client Location				
Address Line 1: 1950 Mail Service Center				
Address Line 2:				
City: Raleigh	**State:** NC	**Zip Code:** 27699-1950	**County:** Wake	
Mailing Address (P.O. Box): Same as Above	**City:**	**State:**	**Zip Code:**	**County:**
Direct Contact for Client				
Name: Sarah Gregosky				
Title: Deputy Director of Standard Plans				
Phone Number: 919-527-7027	**Email Address:** Sarah.Gregosky@dhhs.nc.gov			
Work Details				
Number of covered lives: 367,881 (Q4 2021)				
Time period of contract: Origination: 2021 Current Contract: July 1, 2021 – June 30, 2024, plus two optional 1-year extensions (up through June 30, 2026).				
Total number of staff hours expended during time period of contract: 646,880				
Personnel requirements: Approximately 311 FTEs for the contract year which includes key required roles in the contract as well as staff performing care management, member and provider outreach, compliance, prior authorization, grievance and appeals, quality management and claims.				
Geographic and population coverage requirements: Geographic: Statewide Population: CHIP, LTC, SSI w/o Medicare, TANF				
Publicly funded contract cost: $1.468B of revenue for 2022 - this includes the impact of declining membership in the latter half of 2022 due to the expected end of the PHE.				
Description of work performed under this contract				

Provides a statewide Medicaid program, which works closely with the State to improve the overall health and well-being of North Carolina Medicaid beneficiaries, both adults and children who are enrolled with the State's Standard Medicaid and CHIP (known as North Carolina Health Choice). The program provides whole person, coordinated care, which addresses both medical needs and social supports and services. Covered services include hospitalization, preventative healthcare, immunizations, health education, non-emergent medical transportation, vision care, prescription drug coverage, personal care, home healthcare, durable medical equipment, medically necessary supplies, and transplant services.

NE – Heritage Health (Medicaid)

Corporate Experience: Current and/or Recent Client				
Client's Name: Nebraska Medicaid and Long-Term Care Department of Health and Human Services				
Client Location				
Address Line 1: 301 Centennial Mall South				
Address Line 2:				
City: Lincoln	**State:** NE	**Zip Code:** 68509	**County:** Lancaster	
Mailing Address (P.O. Box): PO Box 95026	**City:** Lincoln	**State:** NE	**Zip Code:** 68509	**County:** Lancaster
Direct Contact for Client				
Name: Jeremy Brunssen				
Title: Deputy Director – Finance & Program Integrity				
Phone Number: 402-540-0380	**Email Address:** Jeremy.Brunsen@nebraska.gov			
Work Details				
Number of covered lives: 120,347 (Q4 2021)				
Time period of contract: Origination: 1996 Current Contract: Jan. 1, 2017 – Dec. 31, 2021— with two possible one-year extensions. This is a 5-year contract with two possible one-year extensions split between three MCOs. The State of Nebraska exercised the first of the two extensions in 2020, with the contract now going through the end of 2022.				
Total number of staff hours expended during time period of contract: 397,280				
Personnel requirements: Approximately 191 FTEs for the contract year which includes key required roles in the contract as well as staff performing care management, member and provider outreach, compliance, prior authorization, grievance and appeals, quality management and claims.				
Geographic and population coverage requirements: Geographic: Statewide Population: TANF, Expansion, CHIP, LTC, SSI w/o Medicare				
Publicly funded contract cost: The NE 2021 Medicaid annual premiums for UHC ML, inclusive of the Children's Health Insurance Program (CHIP), are $683,071,324 ($25,904,799 of this amount is related to CHIP).				

Description of work performed under this contract
Services include physical health, behavioral health, pharmacy, and transplant benefits. This includes: * Inpatient and outpatient hospital services * Ambulatory surgery service * Emergency room * Urgent care * Clinical and anatomical laboratory services, radiology * FQHC and RHC services * Indian Health Services * EPSDT * Physician services * Home health care and private duty nursing services * Rehabilitation * Physical, occupational and speech therapy * DME and medical supplies * Hearing aids and care * Family planning * Diabetic supplies * Podiatry, chiropractic therapy, vision services * Non-emergency ambulance transportation * Ambulance services * Skilled/rehabilitative and transitional nursing facility services * Hospice services — except when provided in a nursing facility * Flu vaccinations

NJ – New Jersey Medicaid

Corporate Experience: Current and/or Recent Client				
Client's Name: Division of Medical Assistance and Health Services				
Client Location				
Address Line 1: 7 Quakerbridge Plaza				
Address Line 2:				
City: Trenton	**State:** NJ	**Zip Code:** 08625	**County:** Mercer	
Mailing Address (P.O. Box): P.O. Box 712	**City:** Trenton	**State:** NJ	**Zip Code:** 08625	**County:** Mercer
Direct Contact for Client				
Name: Jennifer Jacobs				
Title: Medicaid Director				
Phone Number: 609-588-2600	**Email Address:** Jennifer.Jacobs@dhs.state.nj.us			
Work Details				
Number of covered lives: 401,930 (Q4 2021)				
Time period of contract: Origination: 1995 Current Contract: July 1, 2021 – June 30, 2022 (Annual Renewal)				
Total number of staff hours expended during time period of contract: 1,599,520				
Personnel requirements: Approximately 769 FTEs for the contract year which includes key required roles in the contract as well as staff performing care management, member and provider outreach, compliance, prior authorization, grievance and appeals, quality management and claims.				
Geographic and population coverage requirements: Geographic: Statewide Population: TANF, Expansion, CHIP, LTC, SSI w/ Medicare, SSI w/o Medicare				
Publicly funded contract cost: $2,498,673,902				
Description of work performed under this contract				
Provides a broad package of health services that cover medically necessary care, such as inpatient and outpatient hospital care, physician services, laboratory tests and X-rays, home health care and nursing facility care. The contract covers children and youth with medical complexity. Behavioral health benefits are integrated for LTSS and individuals with developmentally disabilities.				

NM – Centennial Care - Expired Contract

Corporate Experience: Current and/or Recent Client				
Client's Name: Medical Assistance Division. New Mexico Human Services Department				
Client Location				
Address Line 1: 2025 S. Pacheco Street				
Address Line 2:				
City: Santa Fe	**State:** NM	**Zip Code:** 87504-2348	**County:** Santa Fe	
Mailing Address (P.O. Box): PO Box 2348	**City:** Santa Fe	**State:** NM	**Zip Code:** 87504-2348	**County:** New Mexico
Direct Contact for Client				
Name: Nicole Comeaux				
Title: Medicaid Director				
Phone Number: 505-827-6253	**Email Address:** nicole.comeaux@state.nm.us			
Work Details				
Number of covered lives: N/A				
Time period of contract: Origination: 2008 Current Contract: Jan.1, 2014 – Dec. 31, 2018 Sold in its entirety on Sept. 1, 2018 - With state approval, the New Mexico Community Plan sold all of its rights under its Medicaid Contract to Presbyterian Health Plan, Inc. (an unrelated third party), pursuant to an Asset Purchase Agreement. The State, the plan and the purchaser entered into a separate agreement, which, among other things, terminated the Medicaid Agreement 4 months early, effective Sept. 1, 2018.				
Total number of staff hours expended during time period of contract: N/A - Expired Contract				
Personnel requirements: N/A - Expired Contract				
Geographic and population coverage requirements: Geographic: Statewide Population: CHIP, dual eligible, expansion, LTSS, SSI and TANF				
Publicly funded contract cost: N/A - Expired Contract				
Description of work performed under this contract				

Statewide Medicaid health plan offered a broad package of health care services to include physical health, behavioral health, long-term care, foster care, pharmacy, dental and transportation. Medically necessary care was covered, such as inpatient and outpatient hospital care, physician services, laboratory tests and x-rays, home health care and nursing facility care.

NV – Nevada Medicaid

Corporate Experience: Current and/or Recent Client				
Client's Name: State of Nevada Department of Health and Human Services, Division of Health Care Financing and Policy				
Client Location				
Address Line 1: 1000 East William Street, Suite 118				
Address Line 2:				
City: Carson City	**State:** NV	**Zip Code:** 89701	**County:** Carson	
Mailing Address (P.O. Box): Same as Above	**City:**	**State:**	**Zip Code:**	**County:**
Direct Contact for Client				
Name: Suzanne Bierman				
Title: Medicaid Administrator				
Phone Number: 702-668-4200	**Email Address:** Suzanne.Bierman@dhcfp.nv.gov			
Work Details				
Number of covered lives: 308,750 (Q4 2021)				
Time period of contract: Origination: 1997 Current Contract: January 1, 2022 – December 31, 2026 with the possibility of a 2-year extension				
Total number of staff hours expended during time period of contract: 586,560				
Personnel requirements: Approximately 282 FTEs for the contract year which includes key required roles in the contract as well as staff performing care management, member and provider outreach, compliance, prior authorization, grievance and appeals, quality management and claims.				
Geographic and population coverage requirements: Geographic: Clark County and urban Washoe County Population: TANF, Expansion, CHIP				
Publicly funded contract cost: 2021 revenue equals approximately $1.1 Billion 2022 expected revenue equals approximately $800 million				
Description of work performed under this contract				

Covers the state of Nevada's TANF, TANF Expansion, child health assurance program (CHAP) and CHIP members. Available through an extensive, stable, provider network, medically necessary services are targeted to enrollees' medical, behavioral and social needs, providing a consistent medical home and continuity of care. Services include readily accessible obstetrical care, member incentive programs, EPSDT screenings, well-child, immunizations, early prenatal/postpartum care, adult preventive care, behavioral health services, and programs to address social determinants of health, such as transitional and permanent housing.

Our health education wellness division offers bilingual instruction on pregnancy, asthma, cholesterol, diabetes, high blood pressure, weight management and smoking cessation. Other benefits include a 24-hour telephone nurse service, telemedicine access, extended-hour clinics, mobile medical services, supplemental non-emergency transportation and added non-covered medical benefits.

The contract is integrated with behavioral health and social to include housing programs, which exhibits positive results in lowering the cost of medical care.

NY – New York Medicaid, Essential Plan Program, New York Medicaid Advantage, Child Health Plus

Corporate Experience: Current and/or Recent Client				
Client's Name: New York Medicaid: Division of Health Plan Contracting and Oversight State of New York Department of Health Essential Plan Program, New York Medicaid Advantage Child Health Plus: Office of Health Insurance Programs, State of New York Department of Health				
Client Location				
Address Line 1: New York Medicaid, Essential Plan Program, New York Medicaid Advantage: Corning Tower, Room 2001, Empire State Plaza Child Health Plus: Corning Tower, Room 1482, Empire State Plaza				
Address Line 2:				
City: Albany	**State:** NY	**Zip Code:** 12237	**County:** Albany	
Mailing Address (P.O. Box): Same as Above	**City:**	**State:**	**Zip Code:**	**County:**
Direct Contact for Client				
Name: New York Medicaid, Essential Plan Program, New York Medicaid Advantage: Jonathan Bick Child Health Plus: Gabrielle Armenia				
Title: New York Medicaid, Essential Plan Program, New York Medicaid Advantage: Director – Division of Health Plan Contracting and Oversight Child Health Plus: Director of Child Health Plus Enrollment				
Phone Number: New York Medicaid, Essential Plan Program, New York Medicaid Advantage: 518-474-5515 Child Health Plus: 518-473-0566		**Email Address:** New York Medicaid, Essential Plan Program, New York Medicaid Advantage: Jonathan.Bick@health.state.ny.us Child Health Plus: Gabrielle.Armenia@health.ny.gov		
Work Details				

Number of covered lives: 527,848 (Q4 2021)

Time period of contract:
New York Medicaid:
Origination: 2005
Current Contract: Mar. 1, 2019 – Feb. 29, 2024

Essential Plan Program:
Origination: 2016
Current Contract: Jan 1, 2021 - Dec 31, 2025 (contract renewal in internal DOA)

New York Medicaid Advantage: The Medicaid Advantage plan sunset effective 12/31/21.
Origination: 2010
Current Contract: Jan. 1, 2015 – Dec. 31, 2020 - Services were being provided under informal extension pending execution of new contract.

Child Health Plus:
Origination: 1997
Current Contract: April 1, 2019 – Sept. 30, 2024

Total number of staff hours expended during time period of contract: 1,572,480

Personnel requirements: Approximately 756 FTEs for the contract year which includes key required roles in the contract as well as staff performing care management, member and provider outreach, compliance, prior authorization, grievance and appeals, quality management and claims.

Geographic and population coverage requirements:
New York Medicaid:
Geographic: Includes 48 out of 62 counties in the state. The 48 counties include the 5 NYC boroughs – Bronx, Kings, Queens, New York, and Richmond. It also includes Nassau and Suffolk counties on Long Island. The remaining 41 counties are throughout the rest of state. No coverage outside of the covered service area. Urgent/Emergent services available outside of the covered service areas in the US and US territories. US territories include, District of Columbia, Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands and American Samoa.
Population: TANF, Expansion, BH

Essential Plan Program:
Geographic: Includes 49 out of 62 counties in the state. The 49 counties include the 5 NYC boroughs – Bronx, Kings, Queens, New York, and Richmond. It also includes Nassau and Suffolk counties on Long Island. The remaining 42 counties are throughout the rest of state.
Population: BHP (Basic Health Plan)

New York Medicaid Advantage: The Medicaid Advantage plan sunset effective 12/31/21.
Geographic: Was available in 6 counties. Coverage was available outside of the US.
Population: Was SSI w/ Medicare

Child Health Plus:
Geographic: Includes 40 out of 62 counties in the state. The 40 counties include the 5 NYC boroughs – Bronx, Kings, Queens, New York, and Richmond. It also includes Nassau and Suffolk counties on Long Island. The remaining 33 counties are throughout the rest of state. No coverage outside of the United States. Urgent/Emergent coverage available in US and US territories; District of Columbia, Puerto Rico, the Virginia Island, Guam, the Northern Mariana Islands and America Samoa.
Population: CHIP

Publicly funded contract cost:
New York Medicaid: $16.1B over 5 years, Approximately $3.2B Annually

Essential Plan Program: $2.4B over 5 years, Approximately $480M Annually

New York Medicaid Advantage: Approximately $15M over 5 years, Approximately $3M Annually

Child Health Plus: $500M over 5 years, Approximately $100M Annually

Description of work performed under this contract

New York Medicaid:
Offers medically necessary covered services, including dental. The contract is integrated with behavioral health and LTSS. The contract covers TANF adults; SSI adults and children with income eligibility up to 133% FPL and children and youth with medical complexity. The health plan covers both physical health and behavioral health services for adults and children. Transportation is carved out to the state FFS, except for non-emergency transportation for behavioral health home and community-based services and supports. Voluntary Foster Care Agency children are covered by the plan effective July 1, 2021.

Essential Plan Program:
Covers physical health and pharmacy. Vision services and dental are available through the Essential as a standard benefit for Essential Plan for those aged between 19 and 64. There are no copays for Dental and Vision Services. The contract is integrated with behavioral health. Non-Emergency Ambulance Transportation is available between facilities. The contract covers adults 19-64 with income between Below 100% of the FPL and up to 200% FPL. The health plan covers both physical health and behavioral health services for adults. Monthly premiums were eliminated effective June 1, 2021. Emergency Services are covered worldwide when medically necessary and treated in a hospital. Urgent Care is covered outside of the covered service area.

New York Medicaid Advantage: The Medicaid Advantage plan sunset effective 12/31/21.
Offered medically necessary covered services in the counties of Nassau and New York City. Medicare benefits were covered through the members' Medicare program. Medicaid benefits were coordinated with Medicare and covered through the plan. The contract was integrated with behavioral health.

Child Health Plus:
Provides medically necessary services, including dental and prescription coverage. The contract is integrated with behavioral health. The contract covers children and youth with medical complexity. The contract covers children and youth under age 19.

OH – Covered Families and Children and the Aged, Blind or Disabled (ABD)

Corporate Experience: Current and/or Recent Client				
Client's Name: Ohio Department of Medicaid				
Client Location				
Address Line 1: 50 West Town Street, Suite 400				
Address Line 2:				
City: Columbus	**State:** OH	**Zip Code:** 43215	**County:** Franklin	
Mailing Address (P.O. Box): Same as Above	**City:**	**State:**	**Zip Code:**	**County:**
Direct Contact for Client				
Name: Roxanne Richardson				
Title: Deputy Director Managed Care				
Phone Number: 614-752-0503	**Email Address:** Roxanne.Richardson@medicaid.ohio.gov			
Work Details				
Number of covered lives: 359,779 (Q4 2021)				
Time period of contract: Origination: 2005 Current Contract: January 1, 2022 – June 30, 2022				
Total number of staff hours expended during time period of contract: 1,751,360				
Personnel requirements: Approximately 842 FTEs for the contract year which includes key required roles in the contract as well as staff performing care management, member and provider outreach, compliance, prior authorization, grievance and appeals, quality management and claims.				
Geographic and population coverage requirements: Geographic: Statewide Population: TANF, Expansion, ABD, SSI w/o Medicare, AFK				
Publicly funded contract cost: $1.3B				
Description of work performed under this contract				
UnitedHealthcare Community Plan of Ohio, Inc. ensures timely access to all services covered by Ohio Medicaid under the state plan and outlined in Ohio Administrative Code 5160-26-03 and The Ohio Department of Medicaid Ohio Medical Assistance Provider Agreement for Managed Care Plan. Covered services include, but are not limited to, primary care and specialty services, inpatient and outpatient hospital services, prescription drugs, laboratory services, well-child visits and immunizations, maternity and pregnancy care, vision care, dental care, transportation, telemedicine, and behavioral health services.				

PA – UnitedHealthcare Community Plan for Families, UnitedHealthcare Community Plan for Kids

Corporate Experience: Current and/or Recent Client				
Client's Name: UnitedHealthcare Community Plan for Families: Office of Medical Assistance Programs (OMAP) Bureau of Managed Care Operations Division of Monitoring and Compliance UnitedHealthcare Community Plan for Kids: Department of Human Services, Office of Children's Health Insurance Program				
Client Location				
Address Line 1: UnitedHealthcare Community Plan for Families: Commonwealth Tower, 303 Walnut Street, 6th Floor UnitedHealthcare Community Plan for Kids: 1142 Strawberry Square Tower				
Address Line 2:				
City: Harrisburg	**State:** PA	**Zip Code:** 17101	**County:** Dauphin	
Mailing Address (P.O. Box): Same as Above	**City:**	**State:**	**Zip Code:**	**County:**
Direct Contact for Client				
Name: UnitedHealthcare Community Plan for Families: Gwendolyn Zander UnitedHealthcare Community Plan for Kids: Patricia Allan				
Title: UnitedHealthcare Community Plan for Families: Director, Department of Human Services (DHS) Office of Medical Assistance Programs (OMAP) UnitedHealthcare Community Plan for Kids: Director of the Office of CHIP, DHS				
Phone Number: UnitedHealthcare Community Plan for Families: 717-787-1871 UnitedHealthcare Community Plan for Kids: 717-705-0542		**Email Address:** UnitedHealthcare Community Plan for Families: GZander@pa.gov UnitedHealthcare Community Plan for Kids: PMallan@pa.gov		
Work Details				

Number of covered lives: 307,764 (Q4 2021)

Time period of contract:
UnitedHealthcare Community Plan for Families:
Origination: 1989
Current Contract: Effective Jan. 1, 2022 – Dec. 31, 2022 (Annual Renewal). Contract term may be modified to accommodate HealthChoices RFA Implementation schedule where necessary.

UnitedHealthcare Community Plan for Kids:
Origination: 1999
Current Contract: Mar.1, 2020 - June 30, 2022.
The Department has the option of extending the Contract on the same terms and conditions for three additional six-month periods.

Total number of staff hours expended during time period of contract: 807,040

Personnel requirements: Approximately 388 FTEs for the contract year which includes key required roles in the contract as well as staff performing care management, member and provider outreach, compliance, prior authorization, grievance and appeals, quality management and claims.

Geographic and population coverage requirements:
UnitedHealthcare Community Plan for Families:
Geographic: Provides health care coverage in 32 counties (i.e., Adams, Allegheny, Armstrong, Beaver, Bedford, Berks, Blair, Bucks, Butler, Cambria, Chester, Cumberland, Dauphin, Delaware, Fayette, Franklin, Fulton, Greene, Huntingdon, Indiana, Lancaster, Lawrence, Lebanon, Lehigh, Montgomery, Northampton, Perry, Philadelphia, Somerset, Washington, Westmoreland and York) in the Commonwealth for disabled adult, Medicaid expansion and TANF beneficiaries.
Population: TANF, Expansion

UnitedHealthcare Community Plan for Kids:
Geographic: CHIP is offered in 52 out of 67 Counties in the Commonwealth of PA. CHIP is not present in Snyder, Juniata, Tioga, McKean, Potter, Elk, Clearfield, Centre, Union, Cameron, Clinton, Lycoming, Northumberland, Mifflin, Wayne.
Population: CHIP

Publicly funded contract cost:
UnitedHealthcare Community Plan for Families:
CY21 annual reported revenue for the Medicaid product is $1.467B

UnitedHealthcare Community Plan for Kids:
CY21 annual reported revenue for the CHIP product is 58.6M

Description of work performed under this contract

UnitedHealthcare Community Plan for Families:
Covers unlimited visits to PCP; personal care available 24 hours a day, seven days a week; Emergency room care, when needed; immunizations; prescriptions and dental services; EPSDT screenings and treatment, vision exams and eyewear. Specialty care includes asthma care, cancer awareness, diabetes control and support, healthy heart programs, a well-mother/well-baby program, teenage pregnancy, AIDS, substance use prevention, smoking cessation, and other community/health supports.

UnitedHealthcare Community Plan for Kids:
Provides health care coverage in 52 counties in the Commonwealth for CHIP beneficiaries and includes free or low-cost health insurance to children under age 19 who meet eligibility requirements. Eligible children are enrolled and provided with all CHIP-covered inpatient, outpatient, diagnostic, pharmacy, dental, vision and mental health services. Services include immunizations; DME; well-child exams; laboratory and X-ray; hospital care; physical, occupational and speech therapy; case management for children with special needs; behavioral health care; vision care, including glasses, frames, and contact

lenses; tobacco cessation benefits; sports physicals and other specialty services. Behavioral services are covered by the CHIP program via Optum Behavioral Health. Emergency transportation is available. CHIP enrollees with special needs may be transitioned to Medicaid depending upon condition. Pennsylvania Medical Assistance provides extensive medical and mental health coverage for children with special needs that may not be available or may be limited through CHIP.

RI – RIte Care, Rhody Health Partners (Adult SSI), RIte Care (Expansion)

Corporate Experience: Current and/or Recent Client				
Client's Name: State of Rhode Island, Executive Office of Health and Human Services				
Client Location				
Address Line 1: Virks Building, 3 West Road				
Address Line 2:				
City: Cranston	**State:** RI	**Zip Code:** 02920	**County:** Providence	
Mailing Address (P.O. Box): Same as Above	**City:**	**State:**	**Zip Code:**	**County:**
Direct Contact for Client				
Name: Kristin Pono Sousa				
Title: Acting Medicaid Program Director				
Phone Number: 401-462-2395	**Email Address:** KSousa@ohhs.ri.gov			
Work Details				
Number of covered lives: 97,652 (Q4 2021)				
Time period of contract: Origination: 1994 Current Contract: March 1, 2017 – June 30, 2022 with five, one-year options to extend				
Total number of staff hours expended during time period of contract: 305,760				
Personnel requirements: Approximately 147 FTEs for the contract year which includes key required roles in the contract as well as staff performing care management, member and provider outreach, compliance, prior authorization, grievance and appeals, quality management and claims.				
Geographic and population coverage requirements: Geographic: Statewide RIte Care Population: TANF & CHIP Rhody Health Partners (Adult SSI) Population: SSI w/o Medicare RIte Care (Expansion) Population: Expansion				
Publicly funded contract cost: $560,000,000 on average for all RI Medicaid contracts.				
Description of work performed under this contract				

RIte Care: Covers comprehensive member care for Rhode Island Medicaid populations including medical, behavioral health and pharmacy services. The contract is integrated with behavioral health and provides preventive services (e.g., minor modifications, personal care attendants and homemakers). The contract covers families, pregnant women, children and youth with medical complexity (children with special health care needs). RIte Care Medicaid child members born after May 2000 are offered dental services by UnitedHealthcare Dental, which is a separate contract.

Rhody Health Partners (Adult SSI): Covers comprehensive member care for aged, blind and disabled Medicaid beneficiaries. The contract is integrated with behavioral health and provides preventive services (e.g., minor modifications, personal care attendants and homemakers). This is a state-funded program that provides health care coverage throughout the state of Rhode Island for ABD, expansion and SSI beneficiaries. It covers comprehensive member care for all Rhode Island Medicaid populations; medical and behavioral health, and pharmacy services are offered. Care managers (e.g., RNs, community outreach and behavioral health clinicians) deliver hands-on care management, including risk assessments and individualized plans of care with monitoring and oversight.

RIte Care (Expansion): This is a state-funded program that provides health care coverage throughout the state of Rhode Island for Medicaid Expansion members. It covers comprehensive member care for all Rhode Island Medicaid populations; medical and behavioral health, and pharmacy services are offered. The contract is integrated with behavioral health and provides preventive services similar to LTSS (e.g., minor modifications, personal care attendants and homemakers). Medicaid Expansion was added as an amendment to the main Medicaid contract Jan. 1, 2014.

TN – TennCare - Medicaid/CHIP

Corporate Experience: Current and/or Recent Client				
Client's Name: Division of TennCare				
Client Location				
Address Line 1: 310 Great Circle Road, 4th Floor				
Address Line 2:				
City: Nashville	**State:** TN	**Zip Code:** 37243	**County:** Davidson	
Mailing Address (P.O. Box): Same as Above	**City:**	**State:**	**Zip Code:**	**County:**
Direct Contact for Client				
Name: Steven Smith				
Title: Director of Medicaid				
Phone Number: 615-507-6444	**Email Address:** Stephen.M.Smith@tn.gov			
Work Details				
Number of covered lives: 504,500 (Q4 2021)				
Time period of contract: Origination: 1994 Current Contract: Jan. 1, 2014 – Dec. 31, 2022				
Total number of staff hours expended during time period of contract: 2,121,600				
Personnel requirements: Approximately 1,020 FTEs for the contract year which includes key required roles in the contract as well as staff performing care management, member and provider outreach, compliance, prior authorization, grievance and appeals, quality management and claims.				
Geographic and population coverage requirements: Geographic: Statewide Population: TANF, CHIP, LTC, DD/DV				
Publicly funded contract cost: $1,954,000,000 Annually				
Description of work performed under this contract				
Provides services to all mandatory Medicaid eligibility groups and some categorically and medically needy voluntary groups, including children, pregnant women, the aged and individuals with disabilities. Children who are eligible include: * Uninsured, children under the age of 19, who are TennCare eligible and with family incomes less than 200% of the federal poverty level * TennCare eligible and meet "medically eligible" criteria (e.g., a health condition that makes the child uninsurable)				

* Those who are no longer eligible for TennCare Medicaid and are either uninsured or medically eligible

Services include, inpatient hospital, physician, outpatient hospital, ambulance, physical therapy, nursing care, speech therapy, DME, home health care, hospice, hearing, vision, behavioral health and non-emergency transportation. Pharmacy and dental services are provided but carved out. The contract is integrated with behavioral health, non-emergency medical transportation (i.e., elderly, individuals with physical disabilities, individuals with intellectual/developmental disabilities in conjunction with Employment Community First (ECF), etc.). We provide care management and/or care coordination to infants, children and adolescents, including those with complex needs or special needs and support for preventive and wellness screenings for those under 21 years old in accordance with Bright Futures care recommendations. Beginning Jan. 1, 2021, CoverKids population integrated into MCO contract. CoverKids includes children under age 19 and Mothers of unborn eligible who do not qualify for TennCare but meet the condition of the State Child Health Plan under Title XXI of the Social Security Act State Children's Health Insurance Program.

TX – Texas STAR (Medicaid), Texas CHIP, Texas STAR+Plus, Texas STAR Kids

Corporate Experience: Current and/or Recent Client				
Client's Name: Texas Health and Human Services Commission				
Client Location				
Address Line 1: 4900 Lamar Blvd.				
Address Line 2:				
City: Austin	**State:** TX	**Zip Code:** 78751	**County:** Travis	
Mailing Address (P.O. Box): Same as Above	**City:**	**State:**	**Zip Code:**	**County:**
Direct Contact for Client				
Name: Stephanie Stephens				
Title: Director of Medicaid (Texas)				
Phone Number: 512-707-6096	**Email Address:** Stephanie.Stephens01@hhsc.state.tx.us			
Work Details				
Number of covered lives: 395,839 (Q4 2021)				
Time period of contract: Texas STAR (Medicaid): Origination: 2006 Current Contract: September 1, 2021 – Aug. 31, 2022 Texas CHIP: Origination: 2007 Current Contract: September 1, 2021 – Aug. 31, 2022 Texas STAR+Plus: Origination: 1998 Current Contract: September 1, 2021 – Aug. 31, 2022 Texas STAR Kids: Origination: 2016 Current Contract: September 1, 2021 – Aug. 31, 2022				
Total number of staff hours expended during time period of contract: 3,704,480				
Personnel requirements: Approximately 1,781 FTEs for the contract year which includes key required roles in the contract as well as staff performing care management, member and provider outreach, compliance, prior authorization, grievance and appeals, quality management and claims.				

Geographic and population coverage requirements:
Texas STAR (Medicaid):
Geographic: Covers Nueces, Harris, Jefferson, and Hidalgo counties
Population: TANF

Texas CHIP:
Geographic: Covers Nueces, Harris, and Jefferson counties
Population: CHIP

Texas STAR+Plus:
Geographic: Covers Harris, Jefferson, Nueces, Travis, MRSA NE, and MRSA Central counties
Population: LTC, DD/DV

Texas STAR Kids:
Geographic: Covers Harris, Hidalgo, Jefferson, MRSA Northeast, and MRSA Central counties
Population: Star Kids

Publicly funded contract cost:
Texas STAR (Medicaid): $797,777,225
Texas CHIP: $18,051,299
Texas STAR+Plus: $2,498,587,405
Texas STAR Kids: $610,301,471

Description of work performed under this contract

Texas STAR (Medicaid):
The State of Texas Access Reform (STAR) is a Texas Medicaid Managed Care Program for pregnant women, newborns, children, and parents with limited income. Services cover EPSDT medical checkups, occupational therapy, audiology, speech therapy, case management for children with special needs, hospital clinic services — as appropriate, regular examinations, immunizations, child delivery and newborn care, substance use and behavioral health services, laboratory and X-ray services, including tests to prevent birth defects, expanded vision care, podiatry, asthmatic care, dental services and other specialty care benefits. The contract is integrated with behavioral health and transportation. The contract covers adults, children, and youth.

Texas CHIP:
Services include medical care for children; immunizations; DME; well-child exams; laboratory and x ray; hospital care; physical, occupational and speech therapy; case management for children with special needs; behavioral health care; vision care, including glasses, frames and contact lenses; tobacco cessation benefits; sports physicals and other specialty services. A CHIP perinate program is included in this coverage. The contract is integrated with behavioral health and transportation.

Texas STAR+Plus:
The program is for eligible people 18 and over, SSI, SSI-related seniors and those with disabilities or specific long-term illnesses covered under Medicaid. Services offered include acute and primary care, audiology, behavioral health, birthing services, cancer screening and treatment, chiropractic, dialysis, durable medical equipment (DME), family planning, home health care, laboratory, vision, pharmacy benefits, podiatry, prenatal care, preventive services, radiology, therapies, transplant and other specialty services. The contract is integrated with behavioral health, transportation and long-term services and supports (LTSS).

Texas STAR Kids:
The STAR Kids program provides acute and LTSS benefits to children and young adults with disabilities. LTSS includes private duty nursing and personal care services, medical care for children, Community First Choice services for those members who qualify for the following services: EPSDT medical checkups, occupational and physical therapy, audiology, speech therapy, hospital clinic services — as appropriate, regular examinations, immunizations, substance use and behavioral health services, laboratory vision care and other specialty care benefits. The contract is integrated with behavioral health, transportation and LTSS. The contract covers children and youth with medical complexity.

VA – Managed Long-Term Services and Supports (MLTSS)

Corporate Experience: Current and/or Recent Client				
Client's Name: Virginia Department of Medical Assistance Services				
Client Location				
Address Line 1: 600 E. Broad Street				
Address Line 2:				
City: Richmond	**State:** VA	**Zip Code:** 23219	**County:** Henrico	
Mailing Address (P.O. Box): Same as Above	**City:**	**State:**	**Zip Code:**	**County:**
Direct Contact for Client				
Name: Karen Kimsey				
Title: Director, Department of Medical Assistance Services				
Phone Number: 804-786-8099	**Email Address:** Karen.Kimsey@dmas.virginia.gov			
Work Details				
Number of covered lives: 30,696 (Q4 2021)				
Time period of contract: Origination: 2017 Current Contract: July 1, 2017 – Dec. 31, 2022, with up to five, one-year auto-renewals through 2027.				
Total number of staff hours expended during time period of contract: 1,017,120				
Personnel requirements: Approximately 489 FTEs for the contract year which includes key required roles in the contract as well as staff performing care management, member and provider outreach, compliance, prior authorization, grievance and appeals, quality management and claims.				
Geographic and population coverage requirements: Geographic: Statewide Population: LTC, DD/DV				
Publicly funded contract cost: Revenues for UHC of Virginia Medallion (CHIP/TANF), CCC Plus (LTSS) and Medicaid Expansion: 2019 = $922.6M annually 2020 = $1,091.7M annually 2021 = $1,245.9M annually				
Description of work performed under this contract				

Provides statewide health care coverage throughout Virginia for LTSS members, including children and adults with disabilities and complex needs. General types of services covered include medical, behavioral health, home and community-based services, nursing facility, adult day healthcare, community mental health recovery services, addiction recovery treatment services, pharmacy, vision services, hearing, and transportation.

WA – Washington Apple Health

Corporate Experience: Current and/or Recent Client				
Client's Name: Health Care Authority – Health Care Services				
Client Location				
Address Line 1: 626 8th Avenue SE				
Address Line 2:				
City: Olympia	**State:** WA	**Zip Code:** 98504	**County:** Thurston	
Mailing Address (P.O. Box): PO Box 45530	**City:** Olympia	**State:** WA	**Zip Code:** 98504	**County:** Thurston
Direct Contact for Client				
Name: Jason McGill				
Title: Assistant Medicaid Director				
Phone Number: 360-725-1681	**Email Address:** Jason.Mcgill@hca.wa.gov			
Work Details				
Number of covered lives: 263,008 (Q4 2021)				
Time period of contract: Origination: 2012 Current Contract: Jan. 1, 2020 – Dec. 31, 2021 (Annual Renewal)				
Total number of staff hours expended during time period of contract: 667,680				
Personnel requirements: Approximately 321 FTEs for the contract year which includes key required roles in the contract as well as staff performing care management, member and provider outreach, compliance, prior authorization, grievance and appeals, quality management and claims.				
Geographic and population coverage requirements: Geographic: 17 counties in Washington Population: Expansion, CHIP, BH, SSI w/o Medicare, TANF				
Publicly funded contract cost: 1,213,138,000				
Description of work performed under this contract				
The program covers disease management, care and case management, customer service and benefit administration—to include physical, behavioral health and pharmacy benefit management; implementation of health homes; claims payment; network contracting; maintenance and reporting; quality improvement and oversight; contract compliance; credentialing; vendor oversight and program integrity functions. It covers those in the Community Options Program Entry System (COPES) for adults' program. Personal care and case management services are available for eligible adults and children living in their own home, community-based residential facilities (adult family homes and				

assisted living) and skilled nursing facilities. Additional services provided by the waiver may include client training, skilled nursing, home-delivered meals, personal emergency response systems, home modification, specialized medical equipment, home health aides, transportation, adult day care, community transition services and nurse delegation.

WI – BadgerCare Plus Standard Health Plan

Corporate Experience: Current and/or Recent Client				
Client's Name: Division of Medicaid Services				
Client Location				
Address Line 1: 1 West Wilson Street				
Address Line 2:				
City: Madison	**State:** WI	**Zip Code:** 53701		**County:** Dane
Mailing Address (P.O. Box): P.O. Box 309	**City:** Madison	**State:** WI	**Zip Code:** 53701	**County:** Dane
Direct Contact for Client				
Name: Lisa A. Olson				
Title: Medical Director				
Phone Number: 608-266-1865		**Email Address:** Lisaa.Olson@dhs.wisconsin.gov		
Work Details				
Number of covered lives: 242,280 (Q4 2021)				
Time period of contract: Origination: 1986 (BadgerCare Plus); 2005 (Medicaid SSI) Current Contract: Jan. 2, 2022 – Dec. 31, 2023 with annual rate changes				
Total number of staff hours expended during time period of contract: 715,520				
Personnel requirements: Approximately 344 FTEs for the contract year which includes key required roles in the contract as well as staff performing care management, member and provider outreach, compliance, prior authorization, grievance and appeals, quality management and claims.				
Geographic and population coverage requirements: Geographic: Covering all 72 counties in the state (Every Rate Region of Coverage) Population: Parents, Kids, Childless Adults & Medicaid SSI (With/Without Medicare)				
Publicly funded contract cost: 2022 revenue: $639 million (Source: DOA)				
Description of work performed under this contract				
UHC provides quality health care to Childless adults, parents, or caretakers with a household income at or below 100% of the Federal Poverty Level (FPL) and children and pregnant women with income at or below 300% of the FPL when deemed eligible to participate in BadgerCare Plus Coverage. This Medicaid fee-for-service program calls for copayments between $0.50 and $3.00 depending on the cost of the service received. UHC waives copays for its BadgerCare Plus and Medicaid SSI members. Copays are waived by the health plan for medical, vision, MHSA, and dental benefits administered				

within UHC designated service delivery areas. Services not requiring copayments include case management services; emergency services; family planning services, including sterilizations; HealthCheck; HealthCheck "other services"; home care services; hospice care services; immunizations; independent laboratory services; injections; services for ventilator-dependent enrollees; pregnancy-related services; preventive services with an A or B rating from the U.S. Preventive Services Task Force; school-based services; substance use day treatment services and surgical assistance.

UHC members may still incur copays for services covered by Medicaid carved-out services such as Retail Pharmacy, Chiropractic services, Transportation, and Dental services received in Regions 1-4.

The "Medicaid SSI" program provides the same benefits as Medicaid FFS (e.g., medical, dental, mental health/substance use, vision, and prescription drug coverage) at no cost to enrollees through a care management model. SSI-related Medicaid enrollees receive coverage from Wisconsin Medicaid because of a disability determined by the Disability Determination Bureau. Enrollees must meet the following criteria:
* Medicaid-eligible individuals living in a service area that has implemented an SSI managed care program.
* Individuals ages 19 and older (e.g., individuals enrolled in Wisconsin Medicaid and SSI or receive SSI-related Medicaid).
* Special provisions, such as prescription drugs (carved out of managed care), are included for continuity of care purposes.
* UHC Community Plan of WI provides managed care coverage in all 72 counties in WI.

4.3.2 Ownership and Financial Disclosure Information

4.3.2.1 Information to Be Disclosed

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

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

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

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

[REST OF PAGE INTENTIONALLY LEFT BLANK]

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

Section 1(a): Legal Entities with Ownership Interest and/or Managing Control Identification				
This response applies to an entity with: [ ] Managing Control [**X**] 5% or More Ownership Interest (percentage owned: 100%)				
Effective Date of Ownership: **6/30/2000**				
Legal Business Name as Reported to the Internal Revenue Service: **UnitedHealthcare, Inc.**				
Doing Business As Name (if applicable): **N/A**		Tax Identification Number (required): **41-1922511**		
Primary Business Address				
Line 1 (Street Name and Number): **9800 Health Care Lane**				
Address Line 2 (Suite, Room, etc.): **N/A**				
City: **Minnetonka**	State: **MN**	Zip Code: **55343-4522**	County: **Hennepin County**	
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:				
City:	State:	Zip Code:	County:	
Business Location				
Address Line 1: **N/A**				
Address Line 2:				
City:	State:	Zip Code:	County:	
Business Location				
Address Line 1: **N/A**				
Address Line 2:				
City:	State:	Zip Code:	County:	
Business Location				
Address Line 1: **N/A**				
Address Line 2:				
City:	State:	Zip Code:	County:	

Section 1(b): Individuals with Ownership Interest and/or Agents/Managing Control

The following individuals must be reported on this form:

- **All individual owners with 5% or more direct/indirect ownership**
- **All officers and directors of the disclosing Offeror**
- **All managing employees of the disclosing Offeror**
- **All authorized and delegated officials**

If there is more than one individual with ownership/control interest that should be reported, copy and complete this page for each individual.

Last Name	**First Name**	**MI**	**Suffix**
Parnell	James	M	

Title	**Social Security Number (required)**	**Date of Birth (MM/DD/YYYY)**	**Gender (M/F)**
Chief Executive Officer & President	[redacted]	[redacted]	M

Home Address Line 1
[redacted]

Address Line 2

N/A

City	**State**	**Zip Code**	**County**
[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 _____	[ ] **Partner**

Effective Date (MM/DD/YYYY):

Ownership Percentage_____%

If the above noted individual is a managing employee, please select all that apply and give the effective date:

Title	**Effective Date (MM/DD/YYYY**		**Effective Date (MM/DD/YYYY**
Chief Executive Officer & President			
[X] **Director/Officer**	12/21/2021	[ ] **Managing Employee (W-2)**	N/A
[ ] 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:

[X] **Authorized Official**	**[ ] Delegated Official**

Effective Date (MM/DD/YYYY): 12/21/2021

Section 1(b): Individuals with Ownership Interest and/or Agents/Managing Control

The following individuals must be reported on this form:

- **All individual owners with 5% or more direct/indirect ownership**
- **All officers and directors of the disclosing Offeror**
- **All managing employees of the disclosing Offeror**
- **All authorized and delegated officials**

If there is more than one individual with ownership/control interest that should be reported, copy and complete this page for each individual.

Last Name	**First Name**	**MI**	**Suffix**
Ewing	Chandler	A	

Title	**Social Security Number (required)**	**Date of Birth (MM/DD/YYYY)**	**Gender (M/F)**
Chief Financial Officer & Director	[redacted]	[redacted]	M

Home Address Line 1
[redacted]

Address Line 2
N/A

City	**State**	**Zip Code**	**County**
[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 _____	**[ ] Partner**

Effective Date (MM/DD/YYYY):

Ownership Percentage_____%

If the above noted individual is a managing employee, please select all that apply and give the effective date:

Title	**Effective Date (MM/DD/YYYY)**		**Effective Date (MM/DD/YYYY)**
Chief Financial Officer & Director			
[X] **Director/Officer**	12/21/2021	[ ] **Managing Employee (W-2)**	N/A
[ ] 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:

[X] **Authorized Official**	[ ] **Delegated Official**

Effective Date (MM/DD/YYYY): 12/21/2021

Section 1(b): Individuals with Ownership Interest and/or Agents/Managing Control

The following individuals must be reported on this form:

- **All individual owners with 5% or more direct/indirect ownership**
- **All officers and directors of the disclosing Offeror**
- **All managing employees of the disclosing Offeror**
- **All authorized and delegated officials**

If there is more than one individual with ownership/control interest that should be reported, copy and complete this page for each individual.

Last Name	**First Name**	**MI**	**Suffix**
O'Brien	Christine	D	

Title	**Social Security Number (required)**	**Date of Birth (MM/DD/YYYY)**	**Gender (M/F)**
Director	[redacted]	[redacted]	F

Home Address Line 1
[redacted]

Address Line 2
N/A

City	**State**	**Zip Code**	**County**
[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 _____		[ ] **Partner**	
Effective Date (MM/DD/YYYY):			
Ownership Percentage_____%			
If the above noted individual is a managing employee, please select all that apply and give the effective date:			
Title Director	**Effective Date** (MM/DD/YYYY		**Effective Date** (MM/DD/YYYY
[X] **Director/Officer**	02/14/2020	[ ] **Managing Employee (W-2)**	N/A
[ ] **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:			
[X] **Authorized Official**		[ ] **Delegated Official**	
Effective Date (MM/DD/YYYY): 02/14/2020			

Section 1(b): Individuals with Ownership Interest and/or Agents/Managing Control

The following individuals must be reported on this form:

- **All individual owners with 5% or more direct/indirect ownership**
- **All officers and directors of the disclosing Offeror**
- **All managing employees of the disclosing Offeror**
- **All authorized and delegated officials**

If there is more than one individual with ownership/control interest that should be reported, copy and complete this page for each individual.

Last Name	**First Name**	**MI**	**Suffix**
Gill	Peter	M	

Title	**Social Security Number (required)**	**Date of Birth (MM/DD/YYYY)**	**Gender (M/F)**
Treasurer	[redacted]	[redacted]	M

Home Address Line 1 [redacted]

Address Line 2

City	**State**	**Zip Code**	**County**
[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 _____		**[ ] Partner**	
Effective Date (MM/DD/YYYY):			
Ownership Percentage_____%			
If the above noted individual is a managing employee, please select all that apply and give the effective date:			
Title Treasurer	Effective Date (MM/DD/YYYY		**Effective Date (MM/DD/YYYY**
[X] Director/Officer	08-15-2018	[ ] **Managing Employee (W-2)**	N/A

[ ] 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:			
[X] **Authorized Official**		[ ] **Delegated Official**	
Effective Date (MM/DD/YYYY): 08-15-2018			

Section 1(b): Individuals with Ownership Interest and/or Agents/Managing Control

The following individuals must be reported on this form:

- **All individual owners with 5% or more direct/indirect ownership**
- **All officers and directors of the disclosing Offeror**
- **All managing employees of the disclosing Offeror**
- **All authorized and delegated officials**

If there is more than one individual with ownership/control interest that should be reported, copy and complete this page for each individual.

Last Name	**First Name**	**MI**	**Suffix**
Lang	Heather	A	

Title	**Social Security Number (required)**	**Date of Birth (MM/DD/YYYY)**	**Gender (M/F)**
Assistant Secretary	[redacted]	[redacted]	F

Home Address Line 1 [redacted]

Address Line 2
N/A

City	**State**	**Zip Code**	**County**
[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 _____	[ ] **Partner**
Effective Date (MM/DD/YYYY):	
Ownership Percentage_____%	

If the above noted individual is a managing employee, please select all that apply and give the effective date:			
Title Assistant Secretary	**Effective Date (MM/DD/YYYY**		**Effective Date (MM/DD/YYYY**
[X] **Director/Officer**	06-14-2015	[**Managing Employee (W-2)**	N/A
[ ] **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:			
[X] **Authorized Official**		[ ] **Delegated Official**	
Effective Date (MM/DD/YYYY): 06-14-2015			

Section 1(b): Individuals with Ownership Interest and/or Agents/Managing Control

The following individuals must be reported on this form:

- **All individual owners with 5% or more direct/indirect ownership**
- **All officers and directors of the disclosing Offeror**
- **All managing employees of the disclosing Offeror**
- **All authorized and delegated officials**

If there is more than one individual with ownership/control interest that should be reported, copy and complete this page for each individual.

Last Name	**First Name**	**MI**	**Suffix**
Zuba	Jessica	L	

Title	**Social Security Number (required)**	**Date of Birth (MM/DD/YYYY)**	**Gender (M/F)**
Assistant Secretary	[redacted]	[redacted]	F

Home Address Line 1

[redacted]

Address Line 2

[redacted]

City	**State**	**Zip Code**	**County**
[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 _____	[ ] **Partner**

Effective Date (MM/DD/YYYY):

Ownership Percentage_____%

If the above noted individual is a managing employee, please select all that apply and give the effective date:

Title	**Effective Date (MM/DD/YYYY**		**Effective Date (MM/DD/YYYY**
Assistant Secretary			
[X] **Director/Officer**	12-19-2017	[ ] **Managing Employee (W-2)**	N/A
[ ] **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:

[X] **Authorized Official**	[ ] **Delegated Official**

Effective Date (MM/DD/YYYY): 12-19-2017

Section 1(b): Individuals with Ownership Interest and/or Agents/Managing Control

The following individuals must be reported on this form:

- **All individual owners with 5% or more direct/indirect ownership**
- **All officers and directors of the disclosing Offeror**
- **All managing employees of the disclosing Offeror**
- **All authorized and delegated officials**

If there is more than one individual with ownership/control interest that should be reported, copy and complete this page for each individual.

Last Name	**First Name**	**MI**	**Suffix**
Cottington	Nyle	B	

Title	**Social Security Number (required)**	**Date of Birth (MM/DD/YYYY)**	**Gender (M/F)**
Vice President	[redacted]	[redacted]	M

Home Address Line 1

[redacted]

Address Line 2

City	**State**	**Zip Code**	**County**
[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 _____	[ ] **Partner**

Effective Date (MM/DD/YYYY):

Ownership Percentage_____%

If the above noted individual is a managing employee, please select all that apply and give the effective date:

Title **Vice President**	**Effective Date (MM/DD/YYYY**		**Effective Date (MM/DD/YYYY**
[X] **Director/Officer**	06/30/2015	[ ] **Managing Employee (W-2)**	N/A
[ ] **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:

[X] **Authorized Official**	[ ] **Delegated Official**

Effective Date (MM/DD/YYYY): 06/30/2015

[REST OF PAGE INTENTIONALLY LEFT BLANK]

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

Section 2: Disclosure of Subcontractor Information

Disclosure of Subcontractor Information				
Include information about subcontractors of the Offeror in which the Offeror or owner of the Offeror has a more than 5% ownership interest and/or a management control interest. Use a new form for each subcontractor and/or ownership interest. Use a copy of this page for each subcontractor subject to disclosure.				
This response applies to: [ ] The Offeror [ ] An Owner of the Offeror **UnitedHealthcare of Mississippi, Inc. and UnitedHealthcare, Inc. do not have more than 5% ownership interest and/or management control interest in any of the subcontractors identified to perform services under any contract resulting from this RFQ.**				
If this applies to an owner of the offeror, name that owner (as already disclosed in Section 1, above):				
The person or entity named as an: [ ] Ownership Interest [ ] Management Control Interest				
If there is an ownership interest, what is the ownership percentage?_____%				
If there is a management control interest, describe that interest:				
Effective Date of Ownership and/or Management Control:				
Legal Business Name of Subcontractor as Reported to the Internal Revenue Service:				
Doing Business As Name (if applicable):	Tax Identification Number (required):			
Primary Business Address				
Line 1 (Street Name and Number):				
Address Line 2 (Suite, Room, etc.):				
City:	State:	Zip Code:	County:	
Mailing Address (P.O. Box):	City:	State:	Zip Code:	County:
Additional Business Location(s): Duplicate this page to provide all locations if necessary.				
Address Line 1:				
Address Line 2:				
City:	State:	Zip Code:	County:	
Business Location				
Address Line 1:				
Address Line 2:				
City:	State:	Zip Code:	County:	
Business Location				
Address Line 1:				
Address Line 2:				
City:	State:	Zip Code:	County:	

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

Section 3: Other Disclosing Entities

Ownership Interests in the Division's Fiscal Agent, Another Managed Care Entity, or other Disclosing Entity under 42 C.F.R § 104(b)

Do any of the entities or individuals named in Sections 1.a or 1.b have an ownership and/or management control interest in the Division's Fiscal Agent? [**X**] Yes [] No

Do any of the entities or individuals named in Sections 1.a or 1.b have an ownership and/or management control interest in Another Managed Care Entity? [**X**] Yes [ ] No

Do any of the entities or individuals named in Section 1.a or 1.b have an ownership and/or management control interest in any other Disclosing Entity under 42 C.F.R § 104(b)? [**X**] Yes [ ] No

If yes to any question above, provide additional information below:

Name of entity/individual named in Section 1.a or 1.b	Name of Entity in which the entity/individual has an interest	Describe the entity/individual's interest (Ownership or Management)	If the entity/individual is an owner, give the ownership percentage.
UnitedHealthcare, Inc.	Arizona Physicians IPA, Inc.	Ownership	100%
UnitedHealthcare, Inc.	Capital City Medical Group, L.L.C	Ownership	100%
UnitedHealthcare, Inc.	Harken Health Insurance Company	Ownership	100%
UnitedHealthcare, Inc.	Neighborhood Health Partnership, Inc.	Ownership	100%
UnitedHealthcare, Inc.	New Orleans Regional Physician Hospital Organization, L.L.C.	Ownership	100%
UnitedHealthcare, Inc.	Sierra Health Services, Inc.	Ownership	100%
UnitedHealthcare, Inc.	Southwest Michigan Health Network Inc.	Ownership	100%
UnitedHealthcare, Inc.	UnitedHealthcare of Mississippi, Inc.	Ownership	100%
UnitedHealthcare, Inc.	UnitedHealthcare Insurance Company of the River Valley	Ownership	100%
UnitedHealthcare, Inc.	UnitedHealthcare of Alabama, Inc.	Ownership	100%
UnitedHealthcare, Inc.	UnitedHealthcare of Arizona, Inc.	Ownership	100%
UnitedHealthcare, Inc.	UnitedHealthcare of Arkansas, Inc.	Ownership	100%
UnitedHealthcare, Inc.	UnitedHealthcare of Colorado, Inc.	Ownership	100%
UnitedHealthcare, Inc.	UnitedHealthcare of Florida, Inc.	Ownership	100%
UnitedHealthcare, Inc.	UnitedHealthcare of Georgia, Inc.	Ownership	100%

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.
UnitedHealthcare, Inc.	UnitedHealthcare of Illinois, Inc.	Ownership	100%
UnitedHealthcare, Inc.	UnitedHealthcare of Kentucky, Ltd.	Ownership	5.828%
UnitedHealthcare, Inc.	UnitedHealthcare of Louisiana, Inc.	Ownership	100%
UnitedHealthcare, Inc.	UnitedHealthcare of North Carolina, Inc.	Ownership	100%
UnitedHealthcare, Inc.	UnitedHealthcare of South Carolina, Inc.	Ownership	100%
UnitedHealthcare, Inc.	UnitedHealthcare of Texas, Inc.	Ownership	100%
UnitedHealthcare, Inc.	UnitedHealthcare of the Mid-Atlantic, Inc.	Ownership	100%
UnitedHealthcare, Inc.	UnitedHealthcare of the Midlands, Inc.	Ownership	100%
UnitedHealthcare, Inc.	UnitedHealthcare of the Midwest, Inc.	Ownership	100%
UnitedHealthcare, Inc.	UnitedHealthcare of Utah, Inc.	Ownership	100%
UnitedHealthcare, Inc.	UnitedHealthcare of Wisconsin, Inc.	Ownership	100%
UnitedHealthcare, Inc.	UnitedHealthcare Plan of the River Valley, Inc.	Ownership	100%

4.3.2.2 When and to Whom Information Will Be Disclosed

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:

4. Upon the Contractor submitting a qualification in accordance with the State's procurement process;
5. Annually, including upon the execution, renewal, and extension of the contract with the State; and,
6. 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.

UnitedHealthcare of Mississippi, Inc.
Name of Offeror

J. Michael Parnell
Printed name of person attesting for Offeror

Chief Executive Officer
Title of person attesting for Offeror


Signature of person attesting for Offeror

03/03/2022
Date

[END OF RESPONSE]

4.3.2.3 Information Related to Business Transactions

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:

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

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

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

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

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

The Offeror does not have:

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

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

UnitedHealthcare of Mississippi, Inc.
Name of Offeror

J. Michael Parnell
Printed name of person attesting for Offeror

Chief Executive Officer
Title of person attesting for Offeror

Signature of person attesting for Offeror

03/03/2022
Date

CONFIDENTIAL INFORMATION

Business Transactions with Subcontractors	
Disclose The ownership of any subcontractor with whom the Contractor has had business transactions totaling more than twenty-five thousand dollars and zero cents ($25,000.00) during the twelve (12)-month period ending on the date of the request. Use additional pages as necessary.	
Name of Subcontractor: Dental Benefit Providers, Inc.	**TIN/SSN (as applicable):** 41-2014834
Address of Subcontractor: 10175 Little Patuxent Parkway Columbia, MD 21044	
Date of Transaction: January 2022	**Amount of Transaction:** [redacted]
Name of Subcontractor: MARCH® Vision Care Group, Incorporated	**TIN/SSN (as applicable):** 95-4874334
Address of Subcontractor: 6601 Center Drive West, Suite 200 Los Angeles, CA 90045	
Date of Transaction: January 2022	**Amount of Transaction:** [redacted]
Name of Subcontractor: United Behavioral Health, Inc. (operating under the brand name of "Optum")	**TIN/SSN (as applicable):** 94-2649097
Address of Subcontractor: 425 Market Street 14th Floor San Francisco, CA 94105	
Date of Transaction: January 2022	**Amount of Transaction:** [redacted]
Name of Subcontractor: OptumHealth Care Solutions, LLC (Optum)	**TIN/SSN (as applicable):** 41-1591944
Address of Subcontractor: 11000 Optum Circle Eden Prairie, MN 55344	
Date of Transaction: January 2022	**Amount of Transaction:** [redacted]

CONFIDENTIAL INFORMATION

Name of Subcontractor: OptumRx, Inc.	**TIN/SSN (as applicable):** 33-0441200
Address of Subcontractor: 1600 McConnor Parkway Schaumburg, IL 60173-6801	
Date of Transaction: January 2022	**Amount of Transaction:** [redacted]
Name of Subcontractor: OptumInsight, Inc.	**TIN/SSN (as applicable):** 41-1858498
Address of Subcontractor: 11000 Optum Circle Eden Prairie, MN 55344	
Date of Transaction: January 2022	**Amount of Transaction:** [redacted]
Name of Subcontractor: CareCore National, LLC dba eviCore healthcare (“eviCore”)	**TIN/SSN (as applicable):** 14-1831391
Address of Subcontractor: 400 Buckwalter Place Blvd. Bluffton, SC 29910	
Date of Transaction: January 2022	**Amount of Transaction:** [redacted]
Name of Subcontractor: Medical Transportation Management (MTM)	**TIN/SSN (as applicable):** 43-1719762
Address of Subcontractor: 16 Hawk Ridge Circle Lake St. Louis, MO 63367	
Date of Transaction: January 2022	**Amount of Transaction:** [redacted]

CONFIDENTIAL INFORMATION

Significant Business Transactions	
Significant business transaction means any business transaction or series of transactions that, during any one fiscal year, exceed the lesser of $25,000 and 5 percent of a provider's total operating expenses.	
Name of Entity with Whom the Transaction Took Place: Dental Benefit Providers, Inc.	
TIN/SSN (as applicable): 41-2014834	**The entity is a:** **[ ] Subcontractor** **[X] Wholly-Owned Subsidiary**
Address of Subcontractor: 10175 Little Patuxent Parkway Columbia, MD 21044	
Date of Transaction: January 2022	**Amount of Transaction:** [redacted]
Name of Entity with Whom the Transaction Took Place: MARCH® Vision Care Group, Incorporated	
TIN/SSN (as applicable): 95-4874334	**The entity is a:** **[ ] Subcontractor** **[X] Wholly-Owned Subsidiary**
Address of Subcontractor: 6601 Center Drive West, Suite 200 Los Angeles, CA 90045	
Date of Transaction: January 2022	**Amount of Transaction:** [redacted]
Name of Entity with Whom the Transaction Took Place: United Behavioral Health, Inc. (operating under the brand name of "Optum")	
TIN/SSN (as applicable): 94-2649097	**The entity is a:** **[ ] Subcontractor** **[X] Wholly-Owned Subsidiary**
Address of Subcontractor: 425 Market Street 14th Floor San Francisco, CA 94105	
Date of Transaction: January 2022	**Amount of Transaction:** [redacted]

CONFIDENTIAL INFORMATION

Name of Entity with Whom the Transaction Took Place: OptumHealth Care Solutions, LLC (Optum)	
TIN/SSN (as applicable): 41-1591944	**The entity is a:** **[ ] Subcontractor** **[X] Wholly-Owned Subsidiary**
Address of Subcontractor: 11000 Optum Circle Eden Prairie, MN 55344	
Date of Transaction: January 2022	**Amount of Transaction:** [redacted]
Name of Entity with Whom the Transaction Took Place: OptumRx, Inc.	
TIN/SSN (as applicable): 33-0441200	**The entity is a:** **[ ] Subcontractor** **[X] Wholly-Owned Subsidiary**
Address of Subcontractor: 1600 McConnor Parkway Schaumburg, IL 60173-6801	
Date of Transaction: January 2022	**Amount of Transaction:** [redacted]
Name of Entity with Whom the Transaction Took Place: OptumInsight, Inc.	
TIN/SSN (as applicable):): 41-1858498	**The entity is a:** **[ ] Subcontractor** **[X] Wholly-Owned Subsidiary**
Address of Subcontractor: 11000 Optum Circle Eden Prairie, MN 55344	
Date of Transaction: January 2022	**Amount of Transaction:** [redacted]
Name of Entity with Whom the Transaction Took Place: CareCore National, LLC dba eviCore healthcare (“eviCore”)	
TIN/SSN (as applicable): 14-1831391	**The entity is a:** **[X] Subcontractor** **[ ] Wholly-Owned Subsidiary**
Address of Subcontractor: 400 Buckwalter Place Blvd. Bluffton, SC 29910	
Date of Transaction: January 2022	**Amount of Transaction:** [redacted]

CONFIDENTIAL INFORMATION

Name of Entity with Whom the Transaction Took Place: Medical Transportation Management (MTM)	
TIN/SSN (as applicable): 43-1719762	**The entity is a:** **[X] Subcontractor** **[ ] Wholly-Owned Subsidiary**
Address of Subcontractor: 16 Hawk Ridge Circle Lake St. Louis, MO 63367	
Date of Transaction: January 2022	**Amount of Transaction:** [redacted]

4.3.2.4 Change of Ownership

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.

UnitedHealthcare of Mississippi, Inc.
Name of Offeror

J. Michael Parnell
Printed name of person attesting for Offeror

Chief Executive Officer
Title of person attesting for Offeror

Signature of person attesting for Offeror

03/03/2022
Date

[END OF RESPONSE]

4.3.2.5 Disclosure of Identity of Any Person Convicted of a Criminal Offense

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.

UnitedHealthcare of Mississippi, Inc.
Name of Offeror

J. Michael Parnell
Printed name of person attesting for Offeror

Chief Executive Officer
Title of person attesting for Offeror

Signature of person attesting for Offeror

03/03/2022
Date

Management Qualification: 4.3.2.5 Disclosure of Identity of Any Person Convicted of a Criminal Offense (Marked) – Pass/Fail

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

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

United Healthcare Community Plan

SECTION 4.3.2.6

Audited Financial Statements, Lines of Credit, and Pro Forma Financial Template

Att. 4.3.2.6-1
UnitedHealthcare of Mississippi, Inc. 2018 Audited Financial Statement

UnitedHealthcare of Mississippi, Inc.

Statutory Basis Financial Statements as of and
for the Years Ended December 31, 2018 and 2017,
Supplemental Schedules as of and for the
Year Ended December 31, 2018,
Independent Auditors' Report and Qualification Letter

UNITEDHEALTHCARE OF MISSISSIPPI, INC.

TABLE OF CONTENTS

Deloitte & Touche LLP
50 South 6th Street
Suite 2800
Minneapolis, MN 55402-1538
USA

Tel: +1 612 397 4000
Fax: +1 612 397 4450
www.deloitte.com

INDEPENDENT AUDITORS' REPORT

To the Audit Committee of
UnitedHealthcare of Mississippi, Inc.
795 Woodlands Parkway, Suite 301
Ridgeland, MS 39157

We have audited the accompanying statutory basis financial statements of UnitedHealthcare of Mississippi, Inc. (the "Company"), which comprise the statutory basis statements of admitted assets, liabilities, and capital and surplus as of December 31, 2018 and 2017, and the related statutory basis statements of operations, changes in capital and surplus, and cash flows for the years then ended, and the related notes to the statutory basis financial statements.

Management's Responsibility for the Statutory Basis Financial Statements

Management is responsible for the preparation and fair presentation of these statutory basis financial statements in accordance with the accounting practices prescribed or permitted by the Mississippi Insurance Department. Management is also responsible for the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

Auditors' Responsibility

Our responsibility is to express an opinion on these statutory basis financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the statutory basis financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the statutory basis financial statements. The procedures selected depend on the auditor's judgment including the assessment of the risks of material misstatement of the statutory basis financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the Company's preparation and fair presentation of the statutory basis financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Company's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the statutory basis financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, the statutory basis financial statements referred to above present fairly, in all material respects, the admitted assets, liabilities, and capital and surplus of UnitedHealthcare of Mississippi, Inc. as of December 31, 2018 and 2017, and the results of its operations and its cash flows for the years then ended in accordance with the accounting practices prescribed or permitted by the Mississippi Insurance Department described in Note 1 to the statutory basis financial statements.

Basis of Accounting

We draw attention to Note 1 of the statutory basis financial statements, which describes the basis of accounting. As described in Note 1 to the statutory basis financial statements, the statutory basis financial statements are prepared by UnitedHealthcare of Mississippi, Inc. using accounting practices prescribed or permitted by the Mississippi Insurance Department, which is a basis of accounting other than accounting principles generally accepted in the United States of America, to meet the requirements of the Mississippi Insurance Department. Our opinion is not modified with respect to this matter.

Report on Supplemental Schedules

Our 2018 audit was conducted for the purpose of forming an opinion on the 2018 statutory basis financial statements as a whole. The supplemental schedule of investment risks interrogatories and the supplemental summary investment schedule, as of and for the year ended December 31, 2018 are presented for purposes of additional analysis and are not a required part of the 2018 statutory basis financial statements. These schedules are the responsibility of the Company's management and were derived from and relate directly to the underlying accounting and other records used to prepare the statutory basis financial statements. Such schedules have been subjected to the auditing procedures applied in our audit of the 2018 statutory basis financial statements and certain additional procedures, including comparing and reconciling such schedules directly to the underlying accounting and other records used to prepare the statutory basis financial statements or to the statutory basis financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States of America. In our opinion, such schedules are fairly stated in all material respects in relation to the 2018 statutory basis financial statements as a whole.

Restriction on Use

Our report is intended solely for the information and use of the Audit Committee and the management of UnitedHealthcare of Mississippi, Inc. and for filing with state insurance departments to whose jurisdiction the Company is subject and is not intended to be and should not be used by anyone other than these specified parties.

Deloitte & Touche LLP

April 25, 2019

UNITEDHEALTHCARE OF MISSISSIPPI, INC.

STATUTORY BASIS STATEMENTS OF ADMITTED ASSETS, LIABILITIES, AND CAPITAL AND SURPLUS AS OF DECEMBER 31, 2018 AND 2017

	2018	2017
ADMITTED ASSETS		
CASH AND INVESTED ASSETS:		
Bonds	$ 149,765,510	$ 143,405,272
Cash of $153,685 and $62,170, cash equivalents of $68,745,768 and $87,137,827, and short-term investments of $2,673 and $5,005,278 in 2018 and 2017, respectively	68,902,126	92,205,275
Subtotal cash and invested assets	218,667,636	235,610,547
OTHER ASSETS:		
Investment income due and accrued	1,130,259	984,506
Premiums and considerations	53,925,680	35,758,337
Amounts recoverable from reinsurers	225,715	5,914,394
Amounts receivable relating to uninsured plans	739,899	10,081
Net deferred tax asset	1,159,535	6,757,136
Health care receivables	1,165,206	1,137,370
State income tax recoverable	-	405,755
Other assets	-	11,687
Subtotal other assets	58,346,294	50,979,266
TOTAL ADMITTED ASSETS	$ 277,013,930	$ 286,589,813
LIABILITIES AND CAPITAL AND SURPLUS		
LIABILITIES:		
Claims unpaid	$ 79,509,238	$ 83,011,073
Accrued medical incentive pool and bonus amounts	502,604	98,893
Unpaid claims adjustment expenses	769,995	958,982
Aggregate health policy reserves	22,122	28,472,835
Aggregate health claim reserves	1,623,150	2,085,092
Premiums received in advance	609,000	8,963,599
General expenses due or accrued	21,920,742	11,822,571
Current federal income taxes payable	3,405,803	1,943,967
Ceded reinsurance premiums payable	-	5,459,410
Amounts withheld or retained for the account of others	7,171	8,158
Amounts due to parent, subsidiaries, and affiliates, net	3,796,013	2,989,501
Liability for amounts held under uninsured plans	86,367	143,367
Other liabilities	10,000	-
Total liabilities	112,262,205	145,957,448
CAPITAL AND SURPLUS:		
Section 9010 ACA subsequent fee year assessment	-	24,958,691
Common capital stock, $0.01 par value — 2,000 shares authorized; 2000 shares issued and outstanding	20	20
Gross paid-in and contributed surplus	165,327,293	165,327,293
Unassigned deficit	(575,588)	(49,653,639)
Total capital and surplus	164,751,725	140,632,365
TOTAL LIABILITIES AND CAPITAL AND SURPLUS	$ 277,013,930	$ 286,589,813

See notes to statutory basis financial statements.

UNITEDHEALTHCARE OF MISSISSIPPI, INC.

STATUTORY BASIS STATEMENTS OF OPERATIONS
FOR THE YEARS ENDED DECEMBER 31, 2018 AND 2017

	2018	2017
REVENUES:		
Net premium income	$ 1,144,574,860	$ 1,103,339,557
Change in unearned premium reserves and reserve for rate credits	26,272	2,216,119
Total revenues	1,144,601,132	1,105,555,676
UNDERWRITING DEDUCTIONS:		
Hospital and medical:		
Hospital/medical benefits	725,171,293	746,930,935
Other professional services	73,857,370	88,353,084
Prescription drugs	189,075,107	212,318,606
Incentive pool, withhold adjustments, and bonus amounts	498,197	(939,161)
Net reinsurance recoveries	(943,575)	(64,998,601)
Total hospital and medical	987,658,392	981,664,863
Claims adjustment expenses	42,748,017	45,328,911
General administrative expenses	106,834,975	84,076,764
(Decrease) increase in reserves for accident and health contracts	(28,006,000)	28,006,000
Total underwriting deductions	1,109,235,384	1,139,076,538
NET UNDERWRITING GAIN (LOSS)	35,365,748	(33,520,862)
NET INVESTMENT GAINS:		
Net investment income earned	4,299,487	2,400,989
Net realized capital (losses) gains less capital gains tax of $5,993 and $4,318 in 2018 and 2017, respectively	(11,710)	3,428
Total net investment gains	4,287,777	2,404,417
NET LOSS FROM PREMIUM BALANCES CHARGED OFF	(70,875)	(1,198,610)
OTHER LOSSES	(10,000)	(243,250)
NET INCOME (LOSS) BEFORE FEDERAL INCOME TAXES	39,572,650	(32,558,305)
FEDERAL INCOME TAXES INCURRED (BENEFIT)	6,945,808	(1,790,790)
NET INCOME (LOSS)	$ 32,626,842	$ (30,767,515)

See notes to statutory basis financial statements.

UNITEDHEALTHCARE OF MISSISSIPPI, INC.

STATUTORY BASIS STATEMENTS OF CHANGES IN CAPITAL AND SURPLUS
FOR THE YEARS ENDED DECEMBER 31, 2018 AND 2017

	Section 9010 ACA Subsequent Fee Year Assessment	Common Capital Stock		Gross Paid-In and Contributed Surplus	Unassigned Deficit	Total Capital and Surplus
		Shares	Amount			
BALANCE — January 1, 2017	$ -	2,000	$ 20	$ 100,327,293	$ (2,972,176)	$ 97,355,137
Net loss	-	-	-	-	(30,767,515)	(30,767,515)
Change in net deferred income taxes	-	-	-	-	3,157,141	3,157,141
Change in nonadmitted assets	-	-	-	-	5,887,602	5,887,602
Section 9010 ACA subsequent fee year assessment	24,958,691	-	-	-	(24,958,691)	-
Capital infusions	-	-	-	65,000,000	-	65,000,000
BALANCE — December 31, 2017	24,958,691	2,000	20	165,327,293	(49,653,639)	140,632,365
Net income	-	-	-	-	32,626,842	32,626,842
Change in net unrealized capital gains less capital gains tax of $1	-	-	-	-	2	2
Change in net deferred income taxes	-	-	-	-	(5,597,600)	(5,597,600)
Change in nonadmitted assets	-	-	-	-	(2,909,884)	(2,909,884)
Section 9010 ACA subsequent fee year assessment	(24,958,691)	-	-	-	24,958,691	-
BALANCE — December 31, 2018	$ -	2,000	$ 20	$ 165,327,293	$ (575,588)	$ 164,751,725

See notes to statutory basis financial statements.

UNITEDHEALTHCARE OF MISSISSIPPI, INC.

STATUTORY BASIS STATEMENTS OF CASH FLOWS
FOR THE YEARS ENDED DECEMBER 31, 2018 AND 2017

	2018	2017
CASH FLOWS FROM OPERATIONS:		
Premiums collected, net of reinsurance	$ 1,112,402,863	$ 1,093,324,312
Net investment income	5,024,895	2,638,060
Benefit and loss related payments	(988,695,927)	(989,460,258)
Operating expenses paid	(140,114,933)	(126,742,660)
Federal income taxes (paid) recovered, net	(5,489,964)	3,305,994
Net cash used in operations	(16,873,066)	(16,934,552)
CASH FLOWS FROM INVESTMENTS:		
Proceeds from bonds sold, matured, or repaid	24,586,424	10,445,562
Cost of bonds acquired	(31,821,751)	(92,074,538)
Net losses on cash equivalents	(1,268)	-
Miscellaneous applications	-	(779,058)
Net cash used in investments	(7,236,595)	(82,408,034)
CASH FLOWS FROM FINANCING AND MISCELLANEOUS ACTIVITIES:		
Cash provided through net transfers from affiliates	806,512	58,378,390
Cash infusions	-	65,000,000
Other cash applied	-	(1,586,406)
Net cash provided by financing and miscellaneous activities	806,512	121,791,984
RECONCILIATION OF CASH, CASH EQUIVALENTS, AND SHORT-TERM INVESTMENTS:		
NET CHANGE IN CASH, CASH EQUIVALENTS, AND SHORT-TERM INVESTMENTS	(23,303,149)	22,449,398
CASH, CASH EQUIVALENTS, AND SHORT-TERM INVESTMENTS — Beginning of year	92,205,275	69,755,877
CASH, CASH EQUIVALENTS, AND SHORT-TERM INVESTMENTS — End of year	$ 68,902,126	$ 92,205,275

See notes to statutory basis financial statements.

1. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES AND GOING CONCERN

Organization and Operation

UnitedHealthcare of Mississippi, Inc. (the "Company"), licensed as a health maintenance organization ("HMO"), offers its enrollees a variety of managed care programs and products through contractual arrangements with health care providers. The Company is a wholly owned subsidiary of UnitedHealthcare, Inc. ("UHC"). UHC is a wholly owned subsidiary of United HealthCare Services, Inc. ("UHS"), a management corporation that provides services to the Company under the terms of a management agreement (the "Agreement"). UHS is a wholly owned subsidiary of UnitedHealth Group Incorporated ("UnitedHealth Group"). UnitedHealth Group is a publicly held company trading on the New York Stock Exchange.

The Company was incorporated on August 6, 1990, as an HMO and operations commenced in January 1993. The Company is certified as an HMO by the Mississippi Insurance Department (the "Department"). The Company has entered into contracts with physicians, hospitals, and other health care provider organizations to deliver health care services for all enrollees. The Company is licensed in the State of Mississippi.

The Company offers comprehensive commercial products to employer groups. Each contract outlines the coverage provided and renewal provisions. In 2016, the Company also participated in the Affordable

Care Act ("ACA") individual exchange market in Mississippi. Effective January 1, 2017, the Company exited the ACA individual exchange market in Mississippi (see Note 4).

The Company has a contract with the State of Mississippi, Division of Medicaid ("Mississippi DOM"), to provide health care services to Medicaid eligible beneficiaries in Mississippi. The program, referred to as the Mississippi Coordinated Access Network ("Mississippi CAN"), targets high-risk Medicaid beneficiaries. The current contract is effective through June 30, 2020, and includes an option for two (2) one-year extensions thereafter.

The Company also has a contract with the Mississippi DOM, to provide health care services to eligible beneficiaries under the Children's Health Insurance Program ("CHIP") in Mississippi. The current contract is effective through June 30, 2019.

A. Accounting Practices

The statutory basis financial statements of the Company are presented on the basis of accounting practices prescribed or permitted by the Department.

The Department recognizes only statutory accounting practices, prescribed or permitted by the State of Mississippi, for determining and reporting the financial condition and results of operations of an HMO, for determining its solvency under Mississippi Insurance Law. The state prescribes the use of the National Association of Insurance Commissioners' ("NAIC") Accounting Practices and Procedures manual ("NAIC SAP") in effect for the accounting periods covered in the statutory basis financial statements.

No significant differences exist between the practices prescribed or permitted by the State of Mississippi and the NAIC SAP which materially affect the statutory basis net income (loss) and capital and surplus, as illustrated in the table below:

Net Income (Loss)	SSAP #	AFS Line	2018	2017
(1) Company state basis	XXX	XXX	$ 32,626,842	$ (30,767,515)
(2) State prescribed practices that are an increase/(decrease) from NAIC SAP: Not applicable			-	-
(3) State permitted practices that are an increase/(decrease) from NAIC SAP: Not applicable			-	-
(4) NAIC SAP (1 - 2 - 3 = 4)	XXX	XXX	$ 32,626,842	$ (30,767,515)
Capital and Surplus				
(5) Company state basis	XXX	XXX	$ 164,751,725	$ 140,632,365
(6) State prescribed practices that are an increase/(decrease) from NAIC SAP: Not applicable			-	-
(7) State permitted practices that are an increase/(decrease) from NAIC SAP: Not applicable			-	-
(8) NAIC SAP (5 - 6 - 7 = 8)	XXX	XXX	$ 164,751,725	$ 140,632,365

B. Use of Estimates in the Preparation of the Statutory Basis Financial Statements

The preparation of these statutory basis financial statements in conformity with the NAIC Annual Statement Instructions and the NAIC SAP include certain amounts that are based on the Company's estimates and judgments. These estimates require the Company to apply complex assumptions and judgments, often because the Company must make estimates about the effects of matters that are inherently uncertain and will change in subsequent periods. The most significant estimates relate to hospital and medical benefits, claims unpaid, aggregate health policy reserves (including premium deficiency reserves) and aggregate health claim reserves, and risk adjustment estimates. The Company adjusts these estimates each period as more current information becomes available. The impact of any changes in estimates is included in the determination of net income (loss) in the period in which the estimate is adjusted.

C. Accounting Policy

Basis of Presentation — The Company prepares its statutory basis financial statements on the basis of accounting practices prescribed or permitted by the Department. These statutory practices differ from accounting principles generally accepted in the United States of America ("GAAP").

Accounting policy disclosures that are required by the NAIC Annual Statement instructions are as follows:

(1–2) Bonds and short-term investments are stated at book/adjusted carrying value if they meet NAIC designation of one or two and stated at the lower of book/adjusted carrying value or fair value if they meet an NAIC designation of three or higher. The Company does not have any mandatory convertible securities or Securities Valuation Office of the NAIC ("SVO") identified funds (i.e.: exchange traded funds or bond mutual funds) in its bond portfolio.

Amortization of bond premium or accretion of discount is calculated using the constant-yield interest method. Bonds and short-term investments are valued and reported using market prices published by the SVO in accordance with the NAIC Valuation of Securities manual prepared by the SVO or an external pricing service;

(3–4) The Company holds no common or preferred stock;

(5) The Company holds no mortgage loans on real estate;

(6) U.S. government and agency securities and corporate debt securities include loan-backed securities (mortgage-backed securities and asset-backed securities), which are valued using the retrospective adjustment methodology. Prepayment assumptions for the determination of the book/adjusted carrying value, commonly referred to as amortized cost, of loan-backed securities are based on a three-month constant prepayment rate history obtained from external data source vendors. The Company's investment policy limits investments in nonagency residential mortgage-backed securities, including home equity and sub-prime mortgages, to 10% of total cash and invested assets. Total combined investments in mortgage-backed securities and asset-backed securities cannot exceed more than 30% of total cash and invested assets;

(7) The Company holds no investments in subsidiaries, controlled, or affiliated entities;

(8) The Company has no investment interests with respect to joint ventures, partnerships, or limited liability companies;

(9) The Company holds no derivatives;

(10) Premium deficiency reserves (inclusive of conversion reserves) and the related expenses are recognized when it is probable that expected future health care expenses, claims adjustment expenses ("CAE"), direct administration costs, and an allocation of indirect administration costs under a group of existing contracts will exceed anticipated future premiums and reinsurance recoveries considered over the remaining lives of the contracts, and are recorded as aggregate health policy reserves in the statutory basis statements of admitted assets, liabilities, and capital and surplus. Indirect administration costs arise from activities that are not specifically identifiable to a specific group of existing contracts, and therefore, those costs are fully allocated among the various contract groupings. The allocation of indirect administration costs to each contract grouping is made proportionately to the expected margins remaining in the premiums after future health care expenses, CAE, and direct administration costs are considered. The methods for making such estimates and for establishing the resulting reserves are periodically reviewed and updated, and any adjustments are reflected as a (decrease) increase in reserves for life and accident and health contracts in the statutory basis statements of operations in the period in which the change in estimate is identified. The Company anticipates investment income as a factor in the premium deficiency calculation (see Note 30);

(11) CAE are those costs expected to be incurred in connection with the adjustment and recording of accident and health claims. Pursuant to the terms of the Agreement (see Note 10), the Company pays a management fee to its affiliate, UHS, in exchange for administrative and management services. A detailed review of the administrative expenses of the Company and UHS is performed to determine the allocation between CAE and general administrative expenses ("GAE") to be reported in the statutory basis statements of operations. It is the responsibility of UHS to pay CAE in the event the Company ceases operations. The Company has recorded an estimate of unpaid CAE associated with incurred but unpaid claims, which is included in unpaid CAE in the statutory basis statements of admitted assets, liabilities, and capital and surplus. Management believes the amount of the liability for unpaid CAE as of December 31, 2018 is adequate to cover

the Company's cost for the adjustment and recording of unpaid claims; however, actual expenses may differ from those established estimates. Adjustments to the estimates for unpaid CAE are reflected in operating results in the period in which the change in estimate is identified;

(12) The Company does not carry any fixed assets on the statutory basis financial statements;

(13) Health care receivables consist of pharmacy rebates receivable estimated based on the most currently available data from the Company's claims processing systems and from data provided by the Company's affiliated pharmaceutical benefit manager, OptumRx, Inc. ("OptumRx"). Health care receivables also include receivables for claim overpayments to providers, hospitals and other health care organizations. Health care receivables are considered nonadmitted assets under the NAIC SAP if they do not meet admissibility requirements. Accordingly, the Company has excluded receivables that do not meet the admissibility criteria from the statutory basis statements of admitted assets, liabilities, and capital and surplus (see Note 28).

The Company has also deemed the following to be significant accounting policies and/or differences between statutory practices and GAAP:

ASSETS

Cash and Invested Assets

- Bonds include U.S. government and agency securities, state and agency municipal securities, city and county municipal securities, and corporate debt securities, with a maturity of greater than one year at the time of purchase;

- Certain debt investments categorized as available-for-sale or held-to-maturity under GAAP are presented at the lower of book/adjusted carrying value or fair value in accordance with the NAIC designations in the statutory basis financial statements, whereas under GAAP, these investments are shown at fair value or book/adjusted carrying value, respectively;

- Cash, cash equivalents, and short-term investments in the statutory basis financial statements represent cash balances and investments with original maturities of one year or less from the time of acquisition, whereas under GAAP, the corresponding caption of cash, cash equivalents, and short-term investments includes cash balances and investments that will mature in one year or less from the balance sheet date;

- Cash represents cash held by the Company in operating accounts. Claims and other payments are made from the operating accounts daily;

- Cash equivalents include money-market funds. Cash equivalents have original maturity dates of three months or less from the date of acquisition. Cash equivalents, excluding money-market funds, are reported at cost or book/adjusted carrying value depending on the nature of the underlying security, which approximates fair value. Money-market funds are reported at fair value or net asset value ("NAV") as a practical expedient;

- Short-term investments include corporate debt securities. Short-term investments have a maturity of greater than three months but less than one year at the time of purchase. Short-term investments also consist of the Company's share of an investment pool sponsored and administered by UHS. The investment pool consists principally of investments with original maturities of less than one year, with the average life of the individual investments being less than 60 days. The Company's share of the pool represents an undivided ownership interest in the pool and is immediately convertible to

cash at no cost or penalty. The participants within the pool have an individual fund number to track those investments owned by the Company. In addition, the Company is listed as a participant in the executed custodial agreement between UHS and the custodian whereby the Company's share in the investment pool is segregated and separately maintained. The pool is primarily invested in government obligations, commercial paper, certificates of deposit, and short-term agency notes and is recorded at cost or book/adjusted carrying value depending on the composition of the underlying securities. Interest income from the pool accrues daily to participating members based upon ownership percentage;

- Realized capital gains and losses on sales of investments are calculated based upon specific identification of the investments sold. These gains and losses are reported as net realized capital (losses) gains less capital gains tax in the statutory basis statements of operations;

- The Company continually monitors the difference between amortized cost and estimated fair value of its investments. If any of the Company's investments experience a decline in value that the Company has determined is other-than-temporary, or if the Company has determined it will sell a security that is in an impaired status, the Company will record a realized loss in net realized capital (losses) gains less capital gains tax in the statutory basis statements of operations. The new cost basis is not changed for subsequent recoveries in fair value. The prospective adjustment method is utilized for loan-backed securities for periods subsequent to the loss recognition. The Company recognized an other-than-temporary impairment ("OTTI") of $0 and $90 for the years ended December 31, 2018 and 2017, respectively;

- The statutory basis statements of cash flows reconcile cash, cash equivalents, and short-term investments, which includes restricted cash reserves, with original maturities of one year or less from the time of acquisition; whereas under GAAP, pursuant to Accounting Standards Update 2016-18*, Statement of Cash Flows, Restricted Cash,* the statements of cash flows reconcile the corresponding captions of cash, cash equivalents and restricted cash with maturities of three months or less. Short-term investments with a final maturity of one year or less from the balance sheet date are not included in the reconciliation of GAAP cash flows. In addition, there are classification differences within the presentation of the cash flow categories between GAAP and statutory reporting. The statutory basis statements of cash flows are prepared in accordance with the NAIC Annual Statement Instructions.

Other Assets

- **Investment Income Due and Accrued** — Investment income earned and due as of the reporting date, in addition to investment income earned but not paid or collected until subsequent periods, is reported as investment income due and accrued in the statutory basis statements of admitted assets, liabilities, and capital and surplus. The Company evaluates the collectability of the amounts due and accrued and amounts determined to be uncollectible are written off in the period in which the determination is made. In addition, the remaining balance is assessed for admissibility and any balance greater than 90 days past due is considered a nonadmitted asset.

- **Premiums and Considerations** — The Company reports uncollected premium balances from its insured members as premiums and considerations in the statutory basis statements of admitted assets, liabilities, and capital and surplus. Uncollected premium balances that are over 90 days past due, with the exception of amounts due from government insured plans, are considered nonadmitted assets. In addition to those balances, current balances are also considered nonadmitted if the corresponding balance greater than 90 days past due is deemed more than inconsequential. Premiums and

considerations also include risk adjustment receivables as defined in Section 1343 of the ACA. Premium adjustments are based upon the risk scores (health status) of enrollees participating in risk adjustment covered plans, rather than the actual loss experience of the insured. Effective for 2018 benefit plan year, the risk adjustments and distributions are calculated using a high-cost risk pool which adds a reinsurance-like element to this program. A risk adjustment receivable is recorded when the Company estimates its average actuarial risk score for policies included in this program is greater than the average actuarial risk scores in that market and state risk pool. Premium adjustments for the ACA Section 1343 risk adjustment program are accounted for as premium adjustments subject to redetermination (see Note 24).

- **Amounts Receivable Relating to Uninsured Plans** — Effective December 1, 2015, the Company has contracted with the Mississippi DOM to participate in the Mississippi Hospital Access Program ("MHAP"). This program helps to ensure sufficient access to inpatient hospital services for the Medicaid population by including enhanced hospital reimbursement in the capitation rates to be "passed-through" from Mississippi DOM to its hospitals. The Company has no financial or member risk under this pass-through arrangement. The Company records a receivable for any MHAP amount due from Mississippi DOM, which is included in amounts receivable relating to uninsured plans in the statutory basis statements of admitted assets, liabilities, and capital and surplus (see Note 18).

- **Net Deferred Tax Asset** — The NAIC SAP provides for an amount to be recorded for deferred taxes on temporary differences between the financial reporting and tax bases of assets, subject to a valuation allowance and admissibility limitations on deferred tax assets (see Note 9). In addition, under the NAIC SAP, the change in deferred tax assets is recorded directly to unassigned deficit in the statutory basis financial statements, whereas under GAAP, the change in deferred tax assets is recorded as a component of the income tax provision within the income statement and is based on the ultimate recoverability of the deferred tax assets. Based on the admissibility criteria under the NAIC SAP, any deferred tax assets determined to be nonadmitted are charged directly to surplus and excluded from the statutory basis financial statements, whereas under GAAP, such assets are included in the balance sheet.

- **State Income Tax Recoverable** — State income tax recoverable represents amounts that are expected to be recovered as a result of an overpayment of estimated tax carrybacks, or items for which the reporting entity has authority to recover under a state regulation or statute.

LIABILITIES

- **Claims Unpaid and Aggregate Health Claim Reserves** — Claims unpaid and aggregate health claim reserves include claims processed but not yet paid, estimates for claims received but not yet processed, estimates for the costs of health care services enrollees have received but for which claims have not yet been submitted, and payments and liabilities for physician, hospital, and other medical costs disputes.

  The estimates for incurred but not yet reported claims are developed using an actuarial process that is consistently applied, centrally controlled, and automated. The actuarial models consider factors such as historical submission and payment data, cost trends, customer and product mix, seasonality, utilization of health care services, contracted service rates, and other relevant factors. The Company estimates such liabilities for physician, hospital, and other medical cost disputes based upon an analysis of potential outcomes, assuming a combination of litigation and settlement strategies. These estimates may change as actuarial methods change or as underlying facts upon which estimates are

based change. The Company did not change actuarial methods during 2018 and 2017. Management believes the amount of claims unpaid and aggregate health claim reserves is a best estimate of the Company's liability for unpaid claims and aggregate health claim reserves as of December 31, 2018; however, actual payments may differ from those established estimates.

The reserves ceded to reinsurers for claims unpaid and aggregate health claim reserves have been reported as reductions of the related reserves rather than as assets, which would be required under GAAP.

The Company contracts with hospitals, physicians, and other providers of health care under capitated or discounted fee for service arrangements, including a hospital per diem to provide medical care services to enrollees. Some of these contracts are with related parties (see Note 10). Capitated providers are at risk for the cost of medical care services provided to the Company's enrollees; however, the Company is ultimately responsible for the provision of services to its enrollees should the capitated provider be unable to provide the contracted services.

- **Accrued Medical Incentive Pool and Bonus Amounts** — The Company has agreements with certain independent physicians and physician network organizations that provide for the establishment of a fund into which the Company places monthly premiums payable for members assigned to the physician. The Company manages the disbursement of funds from this account as well as reviews the utilization of nonprimary care medical services of members assigned to the physicians. Any surpluses in the fund are shared by the Company and the physician based upon predetermined risk-sharing percentage and the liability is included in accrued medical incentive pool and bonus amounts in the statutory basis statements of admitted assets, liabilities, and capital and surplus. The Company has incentive and bonus arrangements with providers that are based on quality, utilization, and/or various health outcome measures. The estimated amount due to providers that meet the established metrics is included in accrued medical incentive pool and bonus amounts in the statutory basis statements of admitted assets, liabilities, and capital and surplus.

- **Aggregate Health Policy Reserves** — The Company establishes a liability, net of ceded reinsurance, for estimated accrued retrospective and redetermination premiums due from the Company based on the actuarial method and assumptions for each respective contract. Aggregate health policy reserves also includes:

  a) risk adjustment payables as defined in Section 1343 of the ACA. Premium adjustments are based upon the risk scores (health status) of enrollees participating in risk adjustment covered plans, rather than the actual loss experience of the insured. Effective for 2018 benefit plan year, the risk adjustments and distributions are calculated using a high-cost risk pool which adds a reinsurance-like element to this program. A risk adjustment payable is recorded when the Company estimates its average actuarial risk score for policies included in this program is less than the average actuarial risk scores in that market and state risk pool (see Note 24);

  b) unearned premiums are established for the portion of premiums received during the current period that are partially unearned at the end of the period and are included in aggregate health policy reserves in the statutory basis statements of admitted assets, liabilities, and capital and surplus; and

  c) the estimated amount for premium deficiency reserves (see Note 30).

- **Premiums Received in Advance** — Premiums received in full for the policies processed during the current period, but prior to the commencement of the service period, are recorded as premiums received in advance in the statutory basis statements of admitted assets, liabilities, and capital and surplus.

- **General Expenses Due or Accrued** — General expenses that are due as of the reporting date in addition to general expenses that have been incurred but are not due until a subsequent period are reported as general expenses due or accrued in the statutory basis statements of admitted assets, liabilities, and capital and surplus. General expenses due or accrued also include the amounts for unpaid assessments, premium taxes, state income taxes and the unpaid portion of the contributions required under the ACA risk adjustment and reinsurance programs (see Note 24).

- **Current Federal Income Taxes Payable** — The Company is included in the consolidated federal income tax return with its ultimate parent, UnitedHealth Group under which taxes approximate the amount that would have been computed on a separate company basis, with the exception of net operating losses and capital losses. For these losses, the Company receives a benefit at the federal rate in the current year for current taxable losses incurred in that year to the extent losses can be utilized in the consolidated federal income tax return of UnitedHealth Group. A liability for federal income taxes payable is recognized when its allocated intercompany estimated payments are less than its actual calculated obligation based on the Company's stand-alone federal income tax return (see Note 9).

- **Amounts Due to Parent, Subsidiaries, and Affiliates, Net** — In the normal course of business, the Company has various transactions with related parties (see Note 10). The Company reports any unsettled amounts owed as amounts due to parent, subsidiaries, and affiliates, net, in the statutory basis statements of admitted assets, liabilities, and capital and surplus.

- **Liability for Amounts Held Under Uninsured Plans** — Liability for amounts held under uninsured plans includes the cost reimbursement for the cost-sharing reduction components of the ACA. The Company is fully reimbursed by the federal government for costs incurred related to these provisions. The Company receives advances that are applied to eligible claims. If the Company incurs costs that are less than these subsidies, a corresponding liability is recorded for amounts held under uninsured plans in the statutory basis statements of admitted assets, liabilities, and capital and surplus.

  Liability for amounts held under uninsured plans also include the pass-through payments to the hospitals that are unpaid under the MHAP program (see Amounts Receivable Relating to Uninsured Plans in Note 1). The Company has no financial or member risk under this pass-through arrangement. The Company records the unpaid pass-through payments in liability for amounts held under uninsured plans in the statutory basis statements of admitted assets, liabilities, and capital and surplus (see Note 18).

CAPITAL AND SURPLUS AND MINIMUM STATUTORY REQUIREMENTS

- **Nonadmitted Assets** — Certain assets, including certain aged premium receivables, certain health care receivables and prepaid expenses, are considered nonadmitted assets under the NAIC SAP and are excluded from the statutory basis statements of admitted assets, liabilities, and capital and surplus and charged directly to unassigned deficit. Under GAAP, such assets are included in the balance sheet.

- **Restricted Cash Reserves** — The Company held regulatory deposits in the amount of $614,771 and $622,527 as of December 31, 2018 and 2017, respectively, in compliance with the state requirements for qualification purposes as a domestic insurer. These

restricted cash reserves consist principally of government obligations and are stated at book/adjusted carrying value, which approximates fair value. These restricted deposits are included in bonds in the statutory basis statements of admitted assets, liabilities, and capital and surplus. Interest earned on these deposits accrues to the Company.

- **Minimum Capital and Surplus** — Under the laws of the State of Mississippi, the Department requires the Company to maintain a minimum capital and surplus equal to the greater of $1,000,000, 2% of the first $150,000,000 of annual premium revenue and 1% of annual premium revenue over $150,000,000, or an amount equal to three months of uncovered health care expenditures. The minimum capital and surplus requirement is $12,946,011 and $12,555,557 for December 31, 2018 and 2017, respectively, which was based on premium revenue as that produced the highest minimum requirement. The Company is in compliance with the required amount.

  Risk-based capital ("RBC") is a regulatory tool for measuring the minimum amount of capital appropriate for a managed care organization to support its overall business operations in consideration of its size and risk profile. The Department requires the Company to maintain minimum capital and surplus equal to the greater of the state statute as outlined above, or the company action level as calculated by the RBC formula, or the level needed to avoid action pursuant to the trend test in the RBC formula. The Company is in compliance with the required amount.

- **Section 9010 ACA Subsequent Fee Year Assessment** — The Company is subject to the Section 9010 ACA subsequent fee year assessment. Under the NAIC SAP, an amount equal to the estimated subsequent year fee must be apportioned out of unassigned deficit and reported as Section 9010 ACA subsequent fee year assessment, in the statutory basis statements of admitted assets, liabilities, and capital and surplus, whereas under GAAP, no such special surplus designation is required. In accordance with the 2019 Health Insurer Fee ("HIF") moratorium, no HIF will be payable in 2019, therefore no amounts were apportioned out of unassigned deficit in the 2018 statutory basis statements of admitted assets, liabilities, and capital and surplus.

STATEMENTS OF OPERATIONS

- **Net Premium Income and Change in Unearned Premium Reserves and Reserve for Rate Credits** — Revenues consist of net premium income that is recognized in the period in which enrollees are entitled to receive health care services. Net premium income is shown net of reinsurance premiums paid and reinsurance premiums incurred but not paid in the statutory basis statements of operations. The corresponding change in unearned premium from year to year is reflected as a change in unearned premium reserves and reserve for rate credits in the statutory basis statements of operations. Under GAAP, the change in unearned premium from year to year is reported through premium income.

  Comprehensive commercial health plans with medical loss ratios on fully insured products, as calculated under the definitions in the ACA (see Note 14) and implementing regulations, that fall below certain targets are required to rebate ratable portions of premiums annually. The Company classifies its estimated rebates as change in unearned premium reserves and reserve for rate credits in the statutory basis statements of operations.

  CHIP is subject to minimum loss ratio ("MLR") requirements, similar to those of the Health Reform Legislation, under the terms of the contract. Plans with medical loss ratios that fall below certain targets are required to rebate ratable portions of premiums annually. The Company classifies its estimated rebates as change in unearned premium reserves and reserve for rate credits in the statutory basis statements of operations.

Pursuant to Section 1343 of the ACA, the Company records premium adjustments for changes to the risk adjustment balances which are reflected in net premium income, in the statutory basis statements of operations.

Net premium income also includes amounts paid by state and federal governments on a per member basis in exchange for the provision and administration of medical benefits under the Mississippi CAN and CHIP. Premiums are contractual and are recognized in the coverage period in which members are entitled to receive services, except in the case of maternity payments. Maternity income is billed on contractual rates and recognized as income as each birth case is identified by the Company. Included in net premium income are capitated payments, home nursing risk-sharing payments, high-dollar risk pool payments, and maternity payments. The majority of net premium income recorded is based on capitated rates, which are monthly premiums paid for each member enrolled. Home nursing risk-sharing income is payable based upon the number of members that qualify for such reimbursement.

- **Total Hospital and Medical Expenses** — Total hospital and medical expenses include claims paid, claims processed but not yet paid, estimates for claims received but not yet processed, estimates for the costs of health care services enrollees have received but for which claims have not yet been submitted, and payments and liabilities for physician, hospital, and other medical costs disputes.

  Total hospital and medical expenses also include amounts incurred for incentive pool, withhold adjustments, and bonus amounts that are based on the underlying contractual provisions with the respective providers. In addition, adjustments to claims unpaid estimates and aggregate health claim reserves are reflected in the period once the change in estimate is identified and included in total hospital and medical expenses in the statutory basis statements of operations.

- **General Administrative Expenses** — Pursuant to the terms of the Agreement (see Note 10), the Company pays a management fee to UHS in exchange for administrative and management services. Costs for items not included within the scope of the Agreement are directly expensed as incurred. State income taxes are also a component of GAE. A detailed review of the administrative expenses of the Company and UHS is performed to determine the allocation between CAE and GAE to be reported in the statutory basis statements of operations.

  The Company is subject to an annual fee under Section 9010 of the ACA. A health insurance entity's annual fee becomes payable once the entity provides health insurance for any U.S. health risk during the calendar year, which is nondeductible for tax purposes. Under the NAIC SAP, the entire amount of the estimated annual fee expense is recognized on January 1 of the fee year in GAE in the statutory basis statements of operations, whereas under GAAP, a deferred asset is created on January 1 of the fee year which is amortized to expense on a straight-line basis throughout the year.

- **Net Investment Income Earned** — Net investment income earned includes investment income collected during the period, as well as the change in investment income due and accrued on the Company's holdings. Amortization of premium or discount on bonds and certain external investment management costs are also included in net investment income earned (see Note 7).

- **Federal Income Taxes Incurred (Benefit)** — The provision for federal income taxes incurred (benefit) is calculated based on applying the statutory federal income tax rate of 21% in 2018 and 35% in 2017 to net income (loss) before federal income taxes and net realized capital (losses) gains subject to certain adjustments (see Note 9).

- **Comprehensive Income** — Comprehensive income and its components are not separately presented in the statutory basis financial statements, whereas under GAAP, it is a requirement to present comprehensive income and its components in the financial statements.

REINSURANCE

- **Reinsurance Ceded** — In the normal course of business, the Company seeks to limit its exposure to loss on any single insured and to recover a portion of benefits paid by ceding premium to other insurance enterprises or reinsurers under excess coverage contracts or specific transfer of risk agreements. The Company remains primarily liable as the direct insurer on the risks reinsured. Reinsurance premiums paid and reinsurance premiums incurred but not paid are deducted from net premium income in the statutory basis statements of operations. Any amounts due to the Company pursuant to this agreement are recorded as amounts recoverable from reinsurers in the statutory basis statements of admitted assets, liabilities, and capital and surplus (see Note 23).

- **Amounts Recoverable from Reinsurers** — The Company records amounts recoverable from reinsurers for claims paid pursuant to the reinsurance agreement with Unimerica Insurance Company ("Unimerica") in the statutory basis statements of admitted assets, liabilities, and capital and surplus and as net reinsurance recoveries in the statutory basis statements of operations.

- **Section 1341 ACA Transitional Reinsurance** — The Company has established receivables of $23,686 and $824,564 as of December 31, 2018 and 2017, respectively, which is included in amounts recoverable from reinsurers in the statutory basis statements of admitted assets, liabilities, and capital and surplus, for the transitional reinsurance program. This program was designed to protect issuers in the individual market from an expected increase in large claims due to the elimination of preexisting condition limitations (see Note 24).

- **Ceded Reinsurance Premiums Payable** — The ceded reinsurance premiums payable balance represents amounts due to the reinsurers for specified coverage which will be paid based on the contract terms.

OTHER

- **Vulnerability Due to Certain Concentrations** — The Company is subject to substantial federal and state government regulation, including licensing and other requirements relating to the offering of the Company's existing products in new markets and offerings of new products, both of which may restrict the Company's ability to expand its business.

  The Company has no commercial customers that individually exceed 10% of total direct premiums written and uncollected premiums, including receivables for contracts subject to redetermination, for the years ended December 31, 2018 and 2017.

  Direct premiums written and uncollected premiums, from the Mississippi DOM as a percentage of total direct premiums written and total uncollected premiums, including receivables for contracts subject to redetermination, are 98.2% and 99.3% as of December 31, 2018 and 98.3% and 99.1% as of December 31, 2017, respectively.

Recently Issued Accounting Standards — The Company reviewed all recently issued guidance in 2018 and 2017 that has been adopted for 2018 or subsequent years' implementation and has determined that none of the items would have a significant impact to the statutory basis financial statements.

D. Going Concern

The Company has the ability and will continue to operate for a period of time sufficient to carry out its commitments, obligations and business objectives.

2. ACCOUNTING CHANGES AND CORRECTION OF ERRORS

No changes in accounting principles or correction of errors have been recorded during the years ended December 31, 2018 and 2017.

3. BUSINESS COMBINATIONS AND GOODWILL

A–D. The Company was not party to a business combination during the years ended December 31, 2018 and 2017, and does not carry goodwill in its statutory basis statements of admitted assets, liabilities, and capital and surplus.

4. DISCONTINUED OPERATIONS

The Company did not discontinue any operations during 2018 or 2017; however, effective January 1, 2017, the Company did make the decision to exit the ACA individual exchange market. The 2016 ACA individual exchange revenue represented approximately 6.4% of total direct premiums written as of December 31, 2016.

A. Discontinued Operation Disposed of or Classified as Held for Sale

(1–4) The Company did not have any discontinued operations disposed of or classified as held for sale during 2018 and 2017.

B. Change in Plan of Sale of Discontinued Operation — Not applicable.

C. Nature of any Significant Continuing Involvement with Discontinued Operations after Disposal — Not applicable.

D. Equity Interest Retained in the Discontinued Operation after Disposal — Not applicable.

5. INVESTMENTS AND OTHER INVESTED ASSETS

For purposes of calculating gross realized gains and losses on sales of investments, the amortized cost of each investment sold is used. The gross realized gains and losses on sales of long-term investments were $4,961 and $9,406, respectively, for 2018 and $7,836 and $0, respectively, for 2017. There were no gross realized gains and losses on sales of short-term investments for 2018 and 2017. The net realized (loss) gain is included in net realized capital (losses) gains less capital gains tax in the statutory basis statements of operations. Total proceeds on the sale of long-term investments were $2,005,740 and $481,352 and for short-term investments were $0 and $1,001,925,652 in 2018 and 2017, respectively.

As of December 31, 2018 and 2017, the book/adjusted carrying value, fair value, and gross unrecognized unrealized gains and losses of the Company's investments, excluding cash and cash equivalents of $68,899,453 and $87,199,997, respectively, are as follows:

	2018				
	Book/Adjusted Carrying Value	Gross Unrecognized Unrealized Gains	Gross Unrecognized Unrealized Losses < 1 Year	Gross Unrecognized Unrealized Losses > 1 Year	Fair Value
U.S. government and agency securities	$ 24,356,311	$ 27,431	$ 76,348	$ 371,292	$ 23,936,102
State and agency municipal securities	16,966,159	79,458	4,128	43,765	16,997,724
City and county municipal securities	14,603,873	71,912	29,625	48,465	14,597,695
Corporate debt securities	93,841,840	122,002	308,700	877,077	92,778,065
Total bonds and short-term investments	$ 149,768,183	$ 300,803	$ 418,801	$ 1,340,599	$ 148,309,586

	2018				
	Book/Adjusted Carrying Value	Gross Unrecognized Unrealized Gains	Gross Unrecognized Unrealized Losses < 1 Year	Gross Unrecognized Unrealized Losses > 1 Year	Fair Value
Less than one year	$ 18,093,833	$ 1,248	$ 12,761	$ 54,959	$ 18,027,361
One to five years	88,965,645	118,523	258,054	858,916	87,967,198
Five to ten years	19,818,584	132,083	79,463	62,209	19,808,995
Over ten years	22,890,121	48,949	68,523	364,515	22,506,032
Total bonds and short-term investments	$ 149,768,183	$ 300,803	$ 418,801	$ 1,340,599	$ 148,309,586

	2017				
	Book/Adjusted Carrying Value	Gross Unrecognized Unrealized Gains	Gross Unrecognized Unrealized Losses < 1 Year	Gross Unrecognized Unrealized Losses > 1 Year	Fair Value
U.S. government and agency securities	$ 23,795,384	$ 37,842	$ 98,721	$ 33,529	$ 23,700,976
State and agency municipal securities	16,886,112	114,866	32,918	5,487	16,962,573
City and county municipal securities	13,068,261	82,764	44,701	7,055	13,099,269
Corporate debt securities	94,660,793	98,437	337,639	52,118	94,369,473
Total bonds and short-term investments	$ 148,410,550	$ 333,909	$ 513,979	$ 98,189	$ 148,132,291

Included in U.S. government and agency securities and corporate debt securities in the tables above are mortgage-related loan-backed securities, which do not have a single maturity date. For the years to maturity table above, these securities have been presented in the maturity group based on the securities' final maturity date and at a book/adjusted carrying value of $24,028,167 and fair value of $23,573,255.

The following table illustrates the fair value and gross unrecognized unrealized losses, aggregated by investment category and length of time that the individual securities have been in a continuous unrecognized unrealized loss position as of December 31, 2018 and 2017:

	2018					
	< 1 Year		> 1 Year		Total	
	Fair Value	Gross Unrecognized Unrealized Losses	Fair Value	Gross Unrecognized Unrealized Losses	Fair Value	Gross Unrecognized Unrealized Losses
U.S. government and agency securities	$ 5,324,340	$ 76,348	$ 16,095,813	$ 371,292	$ 21,420,153	$ 447,640
State and agency municipal securities	5,123,886	4,128	5,412,314	43,765	10,536,200	47,893
City and county municipal securities	4,487,591	29,625	3,583,708	48,465	8,071,299	78,090
Corporate debt securities	25,777,185	308,700	53,000,185	877,077	78,777,370	1,185,777
Total bonds and short-term investments	$ 40,713,002	$ 418,801	$ 78,092,020	$ 1,340,599	$ 118,805,022	$ 1,759,400

	2017					
	< 1 Year		> 1 Year		Total	
	Fair Value	Gross Unrecognized Unrealized Losses	Fair Value	Gross Unrecognized Unrealized Losses	Fair Value	Gross Unrecognized Unrealized Losses
U.S. government and agency securities	$ 16,715,419	$ 98,721	$ 1,758,213	$ 33,529	$ 18,473,632	$ 132,250
State and agency municipal securities	7,916,478	32,918	988,069	5,487	8,904,547	38,405
City and county municipal securities	5,498,564	44,701	335,064	7,055	5,833,628	51,756
Corporate debt securities	65,182,617	337,639	7,619,287	52,118	72,801,904	389,757
Total bonds and short-term investments	$ 95,313,078	$ 513,979	$ 10,700,633	$ 98,189	$ 106,013,711	$ 612,168

The unrecognized unrealized losses on investments in U.S. government and agency securities, state and agency municipal securities, city and county municipal securities, and corporate debt securities at December 31, 2018 and 2017, were mainly caused by interest rate increases and not by unfavorable changes in the credit ratings associated with these securities. The Company evaluates impairment at each reporting period for each of the securities whereby the fair value of the investment is less than its book/adjusted carrying value. The contractual cash flows of the U.S. government and agency securities are guaranteed either by the U.S. government or an agency of the U.S. government. It is expected that the securities would not be settled at a price less than the cost of the investment, and the Company does not intend to sell the investment until the unrealized loss is fully recovered. The Company evaluated the credit ratings of the municipal, local agency and corporate debt securities, noting whether a significant deterioration since purchase or other factors that may indicate an OTTI, such as the length of time and extent to which fair value has been less than cost, the financial condition, and near-term prospects of the issuer as well as specific events or circumstances that may influence the operations of the issuer and the Company's intent to sell the investment. Additionally, the Company evaluated its intent and ability to retain loan-backed securities for a period of time sufficient to recover the amortized cost. As a result of these reviews, the Company recorded an OTTI of $0 and $90 as of December 31, 2018 and 2017, respectively, which are included in net realized capital (losses) gains less capital gains tax in the statutory basis statements of operations.

A–C. The Company has no mortgage loans, real estate loans, restructured debt, or reverse mortgages. The Company also has no real estate property occupied by the Company, real estate property held for the production of income, or real estate property held for sale.

D. Loan-Backed Securities

(1) U.S. government and agency securities and corporate debt securities include loan-backed securities (mortgage-backed securities and asset-backed securities), which are valued using the retrospective adjustment methodology. Prepayment assumptions for the

determination of the book/adjusted carrying value, commonly referred to as amortized cost, of loan-backed securities are based on a three-month constant prepayment rate history obtained from external data source vendors.

(2) The Company did not recognize any OTTIs on loan-backed securities as of December 31, 2018 and 2017.

(3) The Company did not have any loan-backed securities with OTTIs to report by CUSIP as of December 31, 2018 or 2017.

(4) The following table illustrates the fair value, gross unrecognized unrealized losses, and length of time that the loan-backed securities have been in a continuous unrecognized unrealized loss position as of December 31, 2018 and 2017:

	2018
The aggregate amount of unrealized losses:	
1. Less than 12 months	$ 108,512
2. 12 months or longer	475,601
The aggregate related fair value of securities with unrealized losses:	
1. Less than 12 months	9,214,137
2. 12 months or longer	22,944,479

	2017
The aggregate amount of unrealized losses:	
1. Less than 12 months	$ 131,796
2. 12 months or longer	21,975
The aggregate related fair value of securities with unrealized losses:	
1. Less than 12 months	26,802,410
2. 12 months or longer	2,287,873

(5) The Company believes that it will collect all principal and interest due on all investments that have an amortized cost in excess of fair value. The unrecognized unrealized losses as of December 31, 2018 and 2017 were primarily caused by interest rate increases and not by unfavorable changes in the credit ratings associated with these securities.

E. Dollar Repurchase Agreements and/or Securities Lending Transactions — Not applicable.

F. Repurchase Agreements Transactions Accounted for as Secured Borrowing — Not applicable.

G. Reverse Repurchase Agreements Transactions Accounted for as Secured Borrowing — Not applicable.

H. Repurchase Agreements Transactions Accounted for as a Sale — Not applicable.

I. Reverse Repurchase Agreements Transactions Accounted for as a Sale — Not applicable.

J. Real Estate — Not applicable.

K. Low-Income Housing Tax Credits — Not applicable.

L. Restricted Assets —

(1) Restricted assets, including pledged securities as of December 31, 2018 and 2017, are presented below:

Restricted Asset Category	1 Total Gross (Admitted & Nonadmitted) Restricted From Current Year	2 Total Gross (Admitted & Nonadmitted) Restricted From Prior Year	3 Increase/ (Decrease) (1 Minus 2)	4 Total Current Year Nonadmitted Restricted	5 Total Current Year Admitted Restricted (1 Minus 4)	6 Gross (Admitted & Nonadmitted) Restricted to Total Assets (a)	7 Admitted Restricted to Total Admitted Assets (b)
a. Subject to contractual obligation for which liability is not shown	$ -	$ -	$ -	$ -	$ -	- %	- %
b. Collateral held under security lending agreements	-	-	-	-	-	-	-
c. Subject to repurchase agreements	-	-	-	-	-	-	-
d. Subject to reverse repurchase agreements	-	-	-	-	-	-	-
e. Subject to dollar repurchase agreements	-	-	-	-	-	-	-
f. Subject to dollar reverse repurchase agreements	-	-	-	-	-	-	-
g. Placed under option contracts	-	-	-	-	-	-	-
h. Letter stock or securities restricted as to sale — excluding FHLB capital stock	-	-	-	-	-	-	-
i. FHLB capital stock	-	-	-	-	-	-	-
j. On deposit with states	614,771	622,527	(7,756)	-	614,771	-	-
k. On deposit with other regulatory bodies	-	-	-	-	-	-	-
l. Pledged as collateral to FHLB (including assets backing funding agreements)	-	-	-	-	-	-	-
m. Pledged as collateral not captured in other categories	-	-	-	-	-	-	-
n. Other restricted assets	-	-	-	-	-	-	-
o. Total restricted assets	$ 614,771	$ 622,527	$ (7,756)	$ -	$ 614,771	- %	- %

(a) Column 1 divided by Asset Page, Column 1, Line 28
(b) Column 5 divided by Asset Page, Column 3, Line 28

(2–4) The Company has no assets pledged as collateral not captured in other categories and no other restricted assets as of December 31, 2018 or 2017.

M. Working Capital Finance Investments — Not applicable.

N. Offsetting and Netting of Assets and Liabilities

The Company does not have any offsetting or netting of assets and liabilities as it relates to derivatives, repurchase and reverse repurchase agreements, and securities borrowing and securities lending activities.

O. Structured Notes

The Company does not have any structured notes.

P. 5GI Securities

The Company does not have any investments with an NAIC designation of 5GI as of December 31, 2018 and 2017.

Q. Short Sales — Not applicable.

R. Prepayment Penalty and Acceleration Fees — Not applicable.

6. JOINT VENTURES, PARTNERSHIPS, AND LIMITED LIABILITY COMPANIES

A–B. The Company has no investments in joint ventures, partnerships, or limited liability companies that exceed 10% of admitted assets and did not recognize any impairment write-down for its investments in joint ventures, partnerships, and limited liability companies during the statement periods.

7. INVESTMENT INCOME

A. The Company excludes all investment income due and accrued amounts that are over 90 days past due from the statutory basis statements of admitted assets, liabilities, and capital and surplus.

B. There were no investment income amounts excluded from the statutory basis financial statements.

8. DERIVATIVE INSTRUMENTS

A–H. The Company has no derivative instruments.

9. INCOME TAXES

The Tax Cuts and Jobs Act ("Tax Reform") enacted by the U.S. federal government in December 2017 changed the existing United States tax law including reducing the U.S. corporate income tax rate from 35% in 2017 to 21% beginning in 2018. The Company accounted for the impacts of Tax Reform and as of December 31, 2017, remeasured its deferred tax assets/(liabilities) at the 21% enacted tax rate.

A. Deferred Tax Asset/Liability

(1) The components of the net deferred tax asset at December 31, 2018 and 2017, are as follows:

	2018			2017			Change		
	1 Ordinary	2 Capital	3 (Col 1 + 2) Total	4 Ordinary	5 Capital	6 (Col 4 + 5) Total	7 (Col 1 - 4) Ordinary	8 (Col 2 - 5) Capital	9 (Col 7 + 8) Total
(a) Gross deferred tax assets	$ 1,312,528	$ 254	$ 1,312,782	$ 6,820,374	$ 76	$ 6,820,450	$ (5,507,846)	$ 178	$ (5,507,668)
(b) Statutory valuation allowance adjustments	-	254	254	-	76	76	-	178	178
(c) Adjusted gross deferred tax assets (1a - 1b)	1,312,528	-	1,312,528	6,820,374	-	6,820,374	(5,507,846)	-	(5,507,846)
(d) Deferred tax assets nonadmitted	-	-	-	-	-	-	-	-	-
(e) Subtotal net admitted deferred tax asset (1c - 1d)	1,312,528	-	1,312,528	6,820,374	-	6,820,374	(5,507,846)	-	(5,507,846)
(f) Deferred tax liabilities	152,992	1	152,993	63,238	-	63,238	89,754	1	89,755
(g) Net admitted deferred tax asset/(net deferred tax liability) (1e - 1f)	$ 1,159,536	$ (1)	$ 1,159,535	$ 6,757,136	$ -	$ 6,757,136	$ (5,597,600)	$ (1)	$ (5,597,601)

(2) The components of the adjusted gross deferred tax assets admissibility calculation under Statement of Statutory Accounting Principles ("SSAP") No. 101, *Income Taxes — A Replacement of SSAP No. 10R and SSAP No. 10,* are as follows:

	2018			2017			Change		
	1	2	3	4	5	6	7	8	9
Admission Calculation Components SSAP No. 101	**Ordinary**	**Capital**	**(Col 1 + 2) Total**	**Ordinary**	**Capital**	**(Col 4 + 5) Total**	**(Col 1 - 4) Ordinary**	**(Col 2 - 5) Capital**	**(Col 7 + 8) Total**
(a) Federal income taxes paid in prior years recoverable through loss carrybacks	$ 1,312,528	$ -	$ 1,312,528	$ 504,008	$ -	$ 504,008	$ 808,520	$ -	$ 808,520
(b) Adjusted gross deferred tax assets expected to be realized (excluding the amount of deferred tax assets from 2(a) above) after application of the threshold limitation. (The lesser of 2(b)1 and 2(b)2 below)	-	-	-	6,316,366	-	6,316,366	(6,316,366)	-	(6,316,366)
1. Adjusted gross deferred tax assets expected to be realized following the balance sheet date	-	-	-	6,316,366	-	6,316,366	(6,316,366)	-	(6,316,366)
2. Adjusted gross deferred tax assets allowed per limitation threshold	XXX	XXX	24,538,829	XXX	XXX	20,081,284	XXX	XXX	4,457,545
(c) Adjusted gross deferred tax assets (excluding the amount of deferred tax assets from 2(a) and 2(b) above) offset by gross deferred tax liabilities	-	-	-	-	-	-	-	-	-
(d) Deferred tax assets admitted as the result of application of SSAP No. 101 Total (2(a) + 2(b) + 2(c))	$ 1,312,528	$ -	$ 1,312,528	$ 6,820,374	$ -	$ 6,820,374	$ (5,507,846)	$ -	$ (5,507,846)

(3) The ratio percentage and adjusted capital and surplus used to determine the recovery period and threshold limitations for the admissibility calculation are presented below:

	2018	**2017**
(a) Ratio percentage used to determine recovery period and threshold limitation amount	400 %	341 %
(b) Amount of adjusted capital and surplus used to determine recovery period and threshold limitation in 2(b)(2) above	$ 163,592,190	$ 133,875,229

(4) The impact to the gross deferred tax assets balances as a result of tax-planning strategies as of December 31, 2018 and 2017, is presented below:

	2018		2017		Change	
	1	2	3	4	5	6
Impact of Tax-Planning Strategies	**Ordinary**	**Capital**	**Ordinary**	**Capital**	**(Col 1 - 3) Ordinary**	**(Col 2 - 4) Capital**
(a) Determination of adjusted gross deferred tax assets and net admitted deferred tax assets by tax character as a percentage.						
1. Adjusted gross DTAs amount from Note 9A1(c)	$ 1,312,528	$ -	$ 6,820,374	$ -	$ (5,507,846)	$ -
2. Percentage of adjusted gross DTAs by tax character attributable to the impact of tax-planning strategies	- %	- %	- %	- %	- %	- %
3. Net admitted adjusted gross DTAs amount from Note 9A1(e)	$ 1,312,528	$ -	$ 6,820,374	$ -	$ (5,507,846)	$ -
4. Percentage of net admitted adjusted gross DTAs by tax character admitted because of the impact of tax-planning strategies	- %	- %	- %	- %	- %	- %
(b) Does the Company's tax-planning strategies include the use of reinsurance?			Yes		No X	

B. Unrecognized Deferred Tax Liabilities

(1–4) There are no unrecognized deferred tax liabilities for the years ended December 31, 2018 and 2017.

C. Significant Components of Income Taxes

(1) The current federal income taxes incurred (benefit) for the years ended December 31, 2018 and 2017 are as follows:

	1 2018	2 2017	3 (Col 1 - 2) Change
1. Current income tax			
(a) Federal	$ 6,945,808	$ (1,790,790)	$ 8,736,598
(b) Foreign	-	-	-
(c) Subtotal	6,945,808	(1,790,790)	8,736,598
(d) Federal income tax on net capital gains	5,993	4,318	1,675
(e) Utilization of capital loss carryforwards	-	-	-
(f) Other	-	-	-
(g) Total federal and foreign income taxes incurred (benefit)	$ 6,951,801	$ (1,786,472)	$ 8,738,273

(2–4) The tax effects of temporary differences that give rise to significant portions of the deferred tax assets and liabilities as of December 31, 2018 and 2017, are as follows:

	1 2018	2 2017	3 (Col 1 - 2) Change
2 Deferred tax assets:			
(a) Ordinary:			
(1) Discounting of unpaid losses	$ 265,806	$ 130,645	$ 135,161
(2) Unearned premium reserve	26,507	378,504	(351,997)
(3) Policyholder reserves	-	5,881,260	(5,881,260)
(4) Investments	-	-	-
(5) Deferred acquisition costs	-	-	-
(6) Policyholder dividends accrual	-	-	-
(7) Fixed assets	-	-	-
(8) Compensation and benefits accrual	-	-	-
(9) Pension accrual	-	-	-
(10) Receivables—nonadmitted	1,019,695	408,510	611,185
(11) Net operating loss carryforward	-	-	-
(12) Tax credit carryforward	-	-	-
(13) Other (including items <5% of total ordinary tax assets)	520	21,455	(20,935)
(99) Subtotal	1,312,528	6,820,374	(5,507,846)
(b) Statutory valuation allowance adjustment	-	-	-
(c) Nonadmitted	-	-	-
(d) Admitted ordinary deferred tax assets (2a99 - 2b - 2c)	1,312,528	6,820,374	(5,507,846)
(e) Capital:			
(1) Investments	254	76	178
(2) Net capital loss carryforward	-	-	-
(3) Real estate	-	-	-
(4) Other (including items <5% of total capital tax assets)	-	-	-
(99) Subtotal	254	76	178
(f) Statutory valuation allowance adjustment	254	76	178
(g) Nonadmitted	-	-	-
(h) Admitted capital deferred tax assets (2e99 - 2f - 2g)	-	-	-
(i) Admitted deferred tax assets (2d + 2h)	1,312,528	6,820,374	(5,507,846)
3 Deferred tax liabilities:			
(a) Ordinary:			
(1) Investments	20,240	6,059	14,181
(2) Fixed assets	-	-	-
(3) Deferred and uncollected premium	-	-	-
(4) Policyholder reserves	-	-	-
(5) Other (including items <5% of total ordinary tax liabilities)	132,752	57,179	75,573
(99) Subtotal	152,992	63,238	89,754
(b) Capital:			
(1) Investments	-	-	-
(2) Real estate	-	-	-
(3) Other (including items <5% of total capital tax liabilities	1	-	1
(99) Subtotal	1	-	1
(c) Deferred tax liabilities (3a99 + 3b99)	152,993	63,238	89,755
4 Net deferred tax assets/liabilities (2i - 3c)	$ 1,159,535	$ 6,757,136	$ (5,597,601)

The other ordinary deferred tax asset of $21,455 for 2017 consists of bad debt of $20,919 and general expenses due and accrued of $536. The other ordinary deferred tax liability of $132,752 for 2018 consists of discounting of unpaid losses of $128,847 and premium acquisition expense

of $3,905. The other ordinary deferred tax liability of $57,179 for 2017 consists of premium acquisition expense. The other capital deferred tax liability of $1 for 2018 consists of unrealized gain.

The Company's measurement of the income tax effects on Tax Reform for the year ended December 31, 2017 was reasonably estimated. The Company has completed the accounting for the income tax effects of Tax Reform by the end of the measurement period in 2018.

The Company assessed the potential realization of the gross deferred tax asset and established a valuation allowance of $254 and $76 to reduce the gross deferred tax asset to $1,312,528 and $6,820,374 as of December 31, 2018 and 2017, respectively, which represents the amount of the asset estimated to be recoverable via carryback of losses and reduction of future taxes. The change in the valuation allowance is attributable to the change in timing of deductibility of expenses, the change in federal income tax rates, and/or expectations for future taxable income.

D. The provision for federal income taxes incurred (benefit) is different from that which would be obtained by applying the statutory federal income tax rate of 21% in 2018 and 35% in 2017 to net income (loss) before federal income taxes incurred (benefit), plus capital gains tax. A summarization of the significant items causing this difference as of December 31, 2018 and 2017 is as follows:

	2018		2017	
	Amount	Effective Tax Rate	Amount	Effective Tax Rate
Tax provision at the federal statutory rate	$ 8,311,512	21 %	$ (11,393,895)	35 %
Tax-exempt interest	(84,440)	-	(114,464)	-
Health insurer fee	4,933,226	13	-	-
Tax effect of nonadmitted assets	(611,075)	(2)	2,060,661	(6)
Change in statutory valuation allowance	178	-	(723)	-
Change in tax law	-	-	4,504,808	(14)
Total statutory income taxes	$ 12,549,401	32 %	$ (4,943,613)	15 %
Federal income taxes incurred (benefit)	$ 6,945,808	18 %	$ (1,790,790)	5 %
Capital gains tax	5,993	-	4,318	-
Change in net deferred income tax	5,597,600	14	(3,157,141)	10
Total statutory income taxes	$ 12,549,401	32 %	$ (4,943,613)	15 %

E. At December 31, 2018, the Company had no net operating loss carryforwards.

Current federal income taxes payable of $3,405,803 and $1,943,967 as of December 31, 2018 and 2017, respectively, are included in the statutory basis statements of admitted assets, liabilities, and capital and surplus. Federal income taxes paid, net of refunds and (recovered), net of payments were $5,489,964 and ($3,305,994) in 2018 and 2017, respectively.

Federal income taxes incurred (benefit) of $6,951,803 and $0 for 2018 and 2017, respectively, are available for recoupment in the event of future net losses.

The Company has not admitted any aggregate amounts of deposits that are included within Section 6603 ("Deposits made to suspend running of interest on potential underpayments, etc.") of the Internal Revenue Service ("IRS") Code.

F. The Company is included in the consolidated federal income tax return with its ultimate parent, UnitedHealth Group. The entities included within the consolidated return are included in NAIC Statutory Statement Schedule Y — Information Concerning Activities of Insurer Members of A Holding Company Group. Federal income taxes are paid to or refunded by UnitedHealth Group pursuant to the terms of a tax-sharing agreement, approved by the Board of Directors, under which taxes approximate the amount that would have been computed on a separate company basis, with the exception of net operating losses and capital losses. For these losses, the Company receives a benefit at the federal rate in the current year for current taxable losses incurred in that year to the extent losses can be utilized in the consolidated federal income tax return of UnitedHealth Group. UnitedHealth Group currently files income tax returns in the U.S. federal jurisdiction, various states, and foreign jurisdictions. The IRS has completed exams on UnitedHealth Group's consolidated income tax returns for fiscal years 2016 and prior. UnitedHealth Group's 2017 and 2018 tax returns are under review by the IRS under its Compliance Assurance Program. With the exception of a few states, UnitedHealth Group is no longer subject to income tax examinations prior to 2012 in major state and foreign jurisdictions. The Company does not believe any adjustments that may result from these examinations will be material to the Company.

G. Tax Contingencies — Not applicable.

H. Repatriation Transition Tax — Not applicable.

I. Alternative Minimum Tax Credit — Not applicable.

10. INFORMATION CONCERNING PARENT, SUBSIDIARIES, AND AFFILIATES

A–O. Material Related Party Transactions

Management believes that its transactions with affiliates are fair and reasonable; however, operations of the Company may not be indicative of those that would have occurred if it had operated as an independent company.

Pursuant to the terms of the Agreement, UHS will provide management services to the Company under a fee structure, which is based on a percentage of premium charges representing UHS' expenses for services or use of assets provided to the Company. In addition, UHS provides or arranges for services on behalf of the Company using a pass-through of charges incurred by UHS on a per member per month ("PMPM") basis (where the charges incurred by UHS is on a PMPM basis) or using another allocation methodology consistent with the Agreement. These services may include, but are not limited to, integrated personal health management solutions, such as disease management, treatment decision support, and wellness services, including a 24-hour call-in service, access to a network of transplant providers, and discount program services. The amount and types of services provided pursuant to the pass-through provision of the Agreement can change year over year as UHS becomes the contracting entity for services provided to the Company's members. Total administrative services, capitation expenses, and access fees under this arrangement totaled $70,510,074 and $73,066,335 in 2018 and 2017, respectively, and are included in total hospital and medical expenses, GAE and CAE in the statutory basis statements of operations. Direct expenses not covered under the Agreement, such as broker commissions, Department of Insurance exam fees, ACA assessments, and premium taxes, are paid by UHS on behalf of the Company. UHS is reimbursed by the Company for these direct expenses.

The following table identifies the amounts for the administrative services, access fees, and cost of care services provided by related parties for the years ended December 31, 2018 and 2017, which meet the disclosure requirements pursuant to SSAP No. 25, *Affiliates and Other Related Parties* ("SSAP No. 25"), regardless of the effective date of the contract:

	2018	2017
UHS	$ 70,510,074	$ 73,066,335
OptumRx	20,093,939	7,387,461
United Behavioral Health	8,418,931	10,214,005
Dental Benefit Providers, Inc.	4,506,096	2,617,196
Spectera, Inc.	2,034,217	16,192,414
OptumInsight, Inc.	1,857,676	1,479,355

OptumRx provides administrative services related to pharmacy management and pharmacy claims processing for its enrollees, pharmacy incentive services and specialty drug pharmacy services.

United Behavioral Health provides mental health and substance abuse treatment services.

Dental Benefit Providers, Inc. manages a network of dental providers to provide dental services, claims processing and other administrative functions.

Spectera, Inc. manages a network of vision providers to provide vision services and or vision products, claims processing and other administrative functions.

OptumInsight, Inc. provides claim analytics, recovery of medical expense overpayments, retroactive fraud, waste and abuse, and subrogation and premium audit services. All recoveries are returned to the Company by OptumInsight, Inc. on a monthly basis.

The Company has premium payments that are received and claim payments that are processed by an affiliated UnitedHealth Group entity. Both premiums and claims applicable to the Company are settled at regular intervals throughout the month via the intercompany settlement process and any amounts outstanding are reflected in payable amounts due to parent, subsidiaries, and affiliates, net in the statutory basis statements of admitted assets, liabilities, and capital and surplus.

The Company holds a $75,000,000 subordinated revolving credit agreement with UnitedHealth Group at an interest rate of London InterBank Offered Rate plus a margin of 0.50%. This credit agreement is subordinate to the extent it does not conflict with any credit facility held by either party. The credit agreement is for a one-year term and automatically renews annually, unless terminated by either party. The agreement was renewed effective November 01, 2018. No amounts were outstanding under the line of credit as of December 31, 2018 and 2017.

In addition to the agreements above, UHS maintains a private short-term investment pool in which affiliated companies may participate (see Note 1). At December 31, 2018 and 2017, the Company's portion was $2,673 and $2,620, respectively, and is included in short-term investments in the statutory basis statements of admitted assets, liabilities, and capital and surplus.

The Company has a Tax Sharing Agreement with UnitedHealth Group (see Note 9).

The Company did not receive any capital infusions in 2018. The Company received capital infusions of $65,000,000 in 2017, from its parent (see Note 13).

The Company's reinsurance agreement with an affiliated entity was terminated effective December 31, 2017 (see Note 23).

At December 31, 2018 and 2017, the Company reported $3,796,013 and $2,989,501, respectively, as amounts due to parent, subsidiaries, and affiliates, net which are included in the statutory basis statements of admitted assets, liabilities, and capital and surplus. These balances are generally settled within 90 days from the incurred date. Any balances due to the Company that are not settled within 90 days are considered nonadmitted assets.

The Company has not extended any guarantees or undertakings for the benefit of an affiliate or related party.

The Company does not have any amount deducted from the value of an upstream intermediate entity or ultimate parent owned, either directly or indirectly, via a downstream subsidiary, controlled, or affiliated entity.

The Company does not have any investments in a subsidiary, controlled, or affiliated entity that exceeds 10% of admitted assets.

The Company does not have any investments in impaired subsidiaries, controlled, or affiliated entities.

The Company does not have any investments in foreign insurance subsidiaries.

The Company does not hold any investments in a downstream noninsurance holding company.

The Company does not have any investments in noninsurance subsidiaries, controlled, or affiliated entities.

The Company does not have any investments in insurance subsidiaries, controlled, or affiliated entities.

11. DEBT

A–B. The Company had no outstanding debt with third-parties or outstanding Federal Home Loan Bank agreements during 2018 and 2017.

12. RETIREMENT PLANS, DEFERRED COMPENSATION, POSTEMPLOYMENT BENEFITS AND COMPENSATED ABSENCES AND OTHER POSTRETIREMENT BENEFIT PLANS

A–I. The Company has no defined benefit plans, defined contribution plans, multiemployer plans, consolidated/holding company plans, postemployment benefits, or compensated absences plans and is not impacted by the Medicare Modernization Act on postretirement benefits, since all personnel are employees of UHS, which provides services to the Company under the terms of the Agreement (see Note 10).

13. CAPITAL AND SURPLUS, SHAREHOLDERS' DIVIDEND RESTRICTIONS, AND QUASI-REORGANIZATIONS

(1–2) The Company has 2,000 shares authorized and 2,000 shares issued and outstanding of $0.01 par value common stock. The Company has no preferred stock outstanding. All issued and outstanding shares of common stock are held by the Company's parent, UHC.

(3) Payment of dividends may be restricted by the Department, which generally requires that dividends be paid out of gross paid-in and contributed surplus.

(4) The Company paid no dividends and no infusions were received during 2018. The Company received cash infusions of $25,000,000, $20,000,000 and $20,000,000 on September 29, 2017, August 11, 2017, and June 30, 2017, respectively, from UHC, its parent, which was recorded as an increase to gross paid-in and contributed surplus in the statutory basis statements of admitted assets, liabilities, and capital and surplus.

(5) The amount of ordinary dividends that may be paid out during any given period is subject to certain restrictions as specified by state statute.

(6) There are no restrictions placed on the Company's unassigned deficit.

(7) The Company is not a mutual reciprocal or a similarly organized entity and does not have advances to surplus not repaid.

(8) The Company does not hold any stock, including stock of affiliated companies for special purposes, such as conversion of preferred stock, employee stock options, or stock purchase warrants.

(9) For the year ended December 31, 2017, the amount of the estimated Section 9010 ACA subsequent fee year assessment apportioned out of unassigned deficit was $24,958,691. As discussed in Note 1, in 2018 no amount was required to be apportioned out of unassigned deficit for the Section 9010 ACA subsequent fee year assessment.

(10) The portion of unassigned deficit, excluding the apportionment of estimated Section 9010 ACA subsequent fee year assessment, net income (loss), and infusions, represented (or reduced) by each item below is as follows:

	2018	2017	Change
Unrealized capital gains on investments	$ 3	$ -	$ 3
Net deferred income taxes	1,159,535	6,757,136	(5,597,601)
Nonadmitted assets	(4,857,351)	(1,947,467)	(2,909,884)
Total	$ (3,697,813)	$ 4,809,669	$ (8,507,482)

(11–13) The Company does not have any outstanding surplus notes and has never been a party to a quasi-reorganization.

14. LIABILITIES, CONTINGENCIES AND ASSESSMENTS

A. Contingent Commitments

The Company has no contingent commitments.

B. Assessments

The Company is not aware of any guaranty fund assessments or premium tax offsets, potential or accrued, that could have a material financial effect on the operations of the entity.

C. Gain Contingencies

The Company is not aware of any gain contingencies that should be disclosed in the statutory basis financial statements.

D. Claims Related Extra Contractual Obligation and Bad Faith Losses Stemming from Lawsuits — Not applicable.

E. Joint and Several Liabilities — Not applicable.

F. All Other Contingencies

The Company's business is regulated at the federal, state, and local levels. The laws and rules governing the Company's business and interpretations of those laws and rules are subject to frequent change. Broad latitude is given to the agencies administering those regulations. Further, the Company must obtain and maintain regulatory approvals to market and sell many of its products.

The ACA and the related federal and state regulations will continue to impact how the Company does business and could restrict revenue and enrollment growth in certain products and market segments, restrict premium growth rates for certain products and market segments, increase the Company's medical and administrative costs, expose the Company to an increased risk of liability (including increasing the Company's liability in federal and state courts for coverage determinations and contract interpretation), or put the Company at risk for loss of business. In addition, the Company's statutory basis results of operations, financial condition, and cash flows could be materially adversely affected by such changes. The ACA may create new or expand existing opportunities for business growth, but due to its complexity, the long-term impact of the ACA remains difficult to predict and is not yet fully known.

Because of the nature of its businesses, the Company is frequently made party to a variety of legal actions and regulatory inquiries, including class actions and suits brought by members, care providers, consumer advocacy organizations, customers and regulators, relating to the Company's businesses, including management and administration of health benefit plans and other services.

The Company records liabilities for its estimates of probable costs resulting from these matters where appropriate. Estimates of costs resulting from legal and regulatory matters involving the Company are inherently difficult to predict, particularly where the matters involve: indeterminate claims for monetary damages or may involve fines, penalties or punitive damages; present novel legal theories or represent a shift in regulatory policy; involve a large number of claimants or regulatory bodies; are in the early stages of the proceedings; or could result in a change in business practices. Accordingly, the Company is often unable to estimate the losses or ranges of losses for those matters where there is a reasonable possibility or it is probable that a loss may be incurred. Although the outcomes of any such legal actions cannot be predicted, in the opinion of management, the resolution of any currently pending or threatened actions will not have a material adverse effect on the statutory basis statements of admitted assets, liabilities, and capital and surplus or statutory basis statements of operations of the Company.

The Company routinely evaluates the collectability of all receivable amounts included in the statutory basis statements of admitted assets, liabilities, and capital and surplus. Impairment reserves are established for those amounts where collectability is uncertain. Based on the Company's past experience, exposure related to uncollectible balances and the potential of loss for those balances not currently reserved for is not material to the Company's statutory basis financial condition.

There are no assets that the Company considers to be impaired at December 31, 2018 and 2017, except as disclosed in Note 5 and Note 20.

15. LEASES

A–B. According to the Agreement between the Company and UHS (see Note 10), operating leases for the rental of office facilities and equipment are the responsibility of UHS. Fees associated with the lease agreements are included as a component of the Company's management fee.

16. INFORMATION ABOUT FINANCIAL INSTRUMENTS WITH OFF-BALANCE-SHEET RISK AND FINANCIAL INSTRUMENTS WITH CONCENTRATIONS OF CREDIT RISK

(1–4) The Company does not hold any financial instruments with off-balance-sheet risk or have any concentrations of credit risk.

17. SALE, TRANSFER, AND SERVICING OF FINANCIAL ASSETS AND EXTINGUISHMENTS OF LIABILITIES

A–C. The Company did not participate in any transfer of receivables, financial assets or wash sales.

18. GAIN OR LOSS TO THE REPORTING ENTITY FROM UNINSURED PLANS AND THE UNINSURED PORTION OF PARTIALLY INSURED PLANS

A–B. The Company has no operations from Administrative Services Only Contracts or Administrative Services Contracts in 2018 and 2017.

C. Medicare or Other Similarly Structured Cost Based Reimbursement Contract

The Company receives payments from the Centers for Medicare and Medicaid Services ("CMS") under the ACA Cost Sharing Reduction ("CSR") program designed to reduce copayments, deductibles, and coinsurance for lower-income members. There is no insurance risk to the Company as a result of the CSR program. Overpayments from CMS are reported in liability for amounts held under uninsured plans in the statutory basis statements of admitted assets, liabilities, and capital and surplus. The Company has recorded a liability of $0 and $17,058 for the CSR program as of December 31, 2018 and December 31, 2017, respectively.

Effective December 1, 2015, the Company has contracted with the Mississippi DOM to participate in the MHAP. This program helps to ensure sufficient access to inpatient hospital services for the Medicaid population by including enhanced hospital reimbursement in the capitation rates. Year to date 2018 and 2017 receipts and expenditures related to this program are reported in the table below:

Mississippi Hospital Access Program	Year to Date December 31, 2018	Quarter to Date as of December 31, 2018	to Date to Date December 31, 2017
MHAP capitation	$ 258,257,547	$ 61,985,684	$ 260,324,910
Premium tax payments	7,080,962	1,643,317	7,882,497
MHAP payments to providers	258,911,077	59,771,685	260,208,682

19. DIRECT PREMIUM WRITTEN/PRODUCED BY MANAGING GENERAL AGENTS/THIRD-PARTY ADMINISTRATORS

The Company did not have any direct premiums written or produced by managing general agents or third-party administrators in 2018 and 2017.

20. FAIR VALUE MEASUREMENT

The NAIC SAP defines fair value, establishes a framework for measuring fair value, and outlines the disclosure requirements related to fair value measurements. The fair value hierarchy is as follows:

Level 1 — Quoted (unadjusted) prices for identical assets in active markets.

Level 2 — Other observable inputs, either directly or indirectly, including:

- Quoted prices for similar assets in active markets;
- Quoted prices for identical or similar assets in nonactive markets (few transactions, limited information, noncurrent prices, high variability over time, etc.);
- Inputs other than quoted prices that are observable for the asset (interest rates, yield curves, volatilities, default rates, etc.);
- Inputs that are derived principally from or corroborated by other observable market data.

Level 3 — Unobservable inputs that cannot be corroborated by observable market data.

The estimated fair values of bonds, short-term investments, and cash equivalents are based on quoted market prices, where available. The Company obtains one price for each security primarily from a third-party pricing service ("pricing service"), which generally uses quoted prices or other observable inputs for the determination of fair value. The pricing service normally derives the security prices through recently reported trades for identical or similar securities, making adjustments through the reporting date based upon available observable market information. For securities not actively traded, the pricing service may use quoted market prices of comparable instruments or discounted cash flow analyses, incorporating inputs that are currently observable in the markets for similar securities. Inputs that are often used in the valuation methodologies include, but are not limited to, non-binding broker quotes, benchmark yields, credit spreads, default rates, and prepayment speeds. As the Company is responsible for the determination of fair value, it performs quarterly analyses on the prices received from the pricing service to determine whether the prices are reasonable estimates of fair value. Specifically, the Company compares the prices received from the pricing service to a secondary pricing source, prices reported by its custodian, its investment consultant, and third-party investment advisors. Additionally, the Company compares changes in the reported market values and returns to relevant market indices to test the reasonableness of the reported prices. The Company's internal price verification procedures and review of fair value methodology documentation provided by independent pricing services have not historically resulted in an adjustment in the prices obtained from the pricing service.

In instances in which the inputs used to measure fair value fall into different levels of the fair value hierarchy, the fair value measurement has been determined based on the lowest-level input that is significant to the fair value measurement in its entirety. The Company's assessment of the significance of a particular item to the fair value measurement in its entirety requires judgment, including the consideration of inputs specific to the asset or liability.

A. Fair Value

(1) Fair Value Measurements at Reporting Date

The following table presents information about the Company's financial assets that are measured and reported at fair value at December 31, 2018 in the statutory basis statements of admitted assets, liabilities, and capital and surplus according to the valuation techniques the Company used to determine their fair values. The Company does not have financial assets measured and reported at fair value at December 31, 2017.

	December 31, 2018				
Description for Each Class of Asset or Liability	(Level 1)	(Level 2)	(Level 3)	Net Asset Value (NAV)	Total
a. Assets at fair value:					
Perpetual preferred stock:					
Industrial and misc	$ -	$ -	$ -	$ -	$ -
Parent, subsidiaries, and affiliates	-	-	-	-	-
Total perpetual preferred stocks	-	-	-	-	-
Bonds:					
U.S. governments	-	-	-	-	-
Industrial and misc	-	-	-	-	-
Hybrid securities	-	-	-	-	-
Parent, subsidiaries, and affiliates	-	-	-	-	-
Total bonds	-	-	-	-	-
Common stock:					
Industrial and misc	-	-	-	-	-
Parent, subsidiaries, and affiliates	-	-	-	-	-
Total common stock	-	-	-	-	-
Derivative assets:					
Interest rate contracts	-	-	-	-	-
Foreign exchange contracts	-	-	-	-	-
Credit contracts	-	-	-	-	-
Commodity futures contracts	-	-	-	-	-
Commodity forward contracts	-	-	-	-	-
Total derivatives	-	-	-	-	-
Money-market funds	68,745,768	-	-	-	68,745,768
Separate account assets	-	-	-	-	-
Total assets at fair value/NAV	$ 68,745,768	$ -	$ -	$ -	$ 68,745,768
b. Liabilities at fair value:					
Derivative liabilities	$ -	$ -	$ -	$ -	$ -
Total liabilities at fair value	$ -	$ -	$ -	$ -	$ -

There were no transfers between Levels 1 and 2 during the year ended December 31, 2018.

(2) The Company does not have any financial assets with a fair value hierarchy of Level 3 that were measured and reported at fair value.

(3) Transfers between fair value hierarchy levels, if any, are recorded as of the beginning of the reporting period in which the transfer occurs. There were no transfers between Levels 1, 2 or 3 of any financial assets or liabilities during the year ended December 31, 2018.

(4) The Company has no investments reported with a fair value hierarchy of Level 2 or Level 3 and therefore has no valuation technique to disclose.

(5) The Company has no derivative assets and liabilities to disclose.

B. Fair Value Combination — Not applicable.

C. Aggregate Fair Value Hierarchy

The aggregate fair value by hierarchy of all financial instruments as of December 31, 2018 and 2017 is presented in the table below:

	2018						
Types of Financial Investment	Aggregate Fair Value	Admitted Assets	(Level 1)	(Level 2)	(Level 3)	Net Asset Value (NAV)	Not Practicable (Carrying Value)
U.S. government and agency securities	$ 23,936,102	$ 24,356,311	$ 4,670,423	$ 19,265,679	$ -	$ -	$ -
State and agency municipal securities	16,997,724	16,966,159	-	16,997,724	-	-	-
City and county municipal securities	14,597,695	14,603,873	-	14,597,695	-	-	-
Corporate debt securities	92,778,065	93,841,840	2,673	92,775,392	-	-	-
Cash equivalents	68,745,768	68,745,768	68,745,768	-	-	-	-
Total bonds, short-term investments and cash equivalents	$ 217,055,354	$ 218,513,951	$ 73,418,864	$ 143,636,490	$ -	$ -	$ -

	2017						
Types of Financial Investment	Aggregate Fair Value	Admitted Assets	(Level 1)	(Level 2)	(Level 3)	Net Asset Value (NAV)	Not Practicable (Carrying Value)
U.S. government and agency securities	$ 23,700,976	$ 23,795,384	$ 4,690,271	$ 19,010,705	$ -	$ -	$ -
State and agency municipal securities	16,962,573	16,886,112	-	16,962,573	-	-	-
City and county municipal securities	13,099,269	13,068,261	-	13,099,269	-	-	-
Corporate debt securities	94,369,473	94,660,793	2,620	94,366,853	-	-	-
Total bonds and short-term investments	$ 148,132,291	$ 148,410,550	$ 4,692,891	$ 143,439,400	$ -	$ -	$ -

Included as Level 1 in U.S. government and agency securities in the fair value hierarchy tables above are U.S. Treasury securities of $4,670,423 and $4,690,271 as of December 31, 2018 and December 31, 2017, respectively.

There are no commercial paper investments included in corporate debt securities in the fair value hierarchy tables above as of December 31, 2018 and 2017.

D. Not Practicable to Estimate Fair Value — Not applicable.

E. Investments Measured Using the NAV Practical Expedient — Not applicable.

21. OTHER ITEMS

A. Unusual or Infrequent Items

The Company did not encounter any unusual or infrequent items for the years ended December 31, 2018 and 2017.

B. Troubled Debt Restructuring: Debtors

The Company has no troubled debt restructurings as of December 31, 2018 and 2017.

C. Other Disclosures

The Company does not have any amounts not recorded in the statutory basis financial statements that represent segregated funds held for others. The Company also does not have any exposures related to forward commitments that are not derivative instruments.

D. Business Interruption Insurance Recoveries

The Company has not received any business interruption insurance recoveries during 2018 and 2017.

E. State Transferable and Non-transferable Tax Credits

The Company has no transferable or non-transferable state tax credits.

F. Sub-Prime Mortgage-Related Risk Exposure

(1) The investment policy for the Company limits investments in loan-backed securities, which includes sub-prime issuers. Further, the policy limits investments in private-issuer mortgage securities to 10% of the portfolio, which also includes sub-prime issuers. The exposure to unrealized losses on sub-prime issuers is due to changes in market prices. There are no realized losses due to not receiving anticipated cash flows. The investments covered have an NAIC designation of 1 or 2.

(2) The Company has no direct exposure through investments in sub-prime mortgage loans.

(3) The Company has no direct exposure through other investments.

(4) The Company has no underwriting exposure to sub-prime mortgage risk through mortgage guaranty or financial guaranty insurance coverage.

G. Retained Assets

The Company does not have any retained asset accounts for beneficiaries.

H. Insurance-Linked Securities Contracts

As of December 31, 2018, the Company is not aware of any possible proceeds of insurance-linked securities.

22. EVENTS SUBSEQUENT

Subsequent events have been evaluated through April 25, 2019, which is the date these statutory basis financial statements were available for issuance.

TYPE I — Recognized Subsequent Events

There are no events subsequent to December 31, 2018, that require recognition and disclosure.

TYPE II — Non-Recognized Subsequent Events

The Company is subject to the annual fee under Section 9010 of the ACA. The fee is allocated to individual health insurers based on the ratio of the amount of the entity's net premiums written during the preceding calendar year to the amount of the health insurance for any U.S. health risk that is written during the preceding calendar year. A health insurance entity's portion of the annual fee becomes

payable once the entity provides health insurance for any U.S. health risk for each calendar year beginning on or after January 1, of the year the fee is due. Pursuant to the 2019 HIF moratorium (see Note 1), no HIF will be payable in 2019 and therefore there is no amount apportioned out of unassigned deficit in 2018 representing an estimate of the 2019 HIF.

The table below presents information regarding the annual fee under Section 9010 of the ACA as of December 31, 2018 and 2017:

	Current Year	Prior Year
A. Did the reporting entity write accident and health insurance premium that is subject to Section 9010 of the Federal Affordable Care Act (Yes/No)?	Yes	
B. ACA fee assessment payable for the upcoming year	$ -	$ 24,958,691
C. ACA fee assessment paid	23,491,552	-
D. Premium written subject to ACA 9010 assessment	-	1,171,567,968
E. Total Adjusted Capital before surplus adjustment (Five-Year Historical Line 14)	164,751,725	
F. Total Adjusted Capital after surplus adjustment (Five-Year Historical Line 14 minus 22B above)	164,751,725	
G. Authorized Control Level (Five-Year Historical Line 15)	40,913,781	
H. Would reporting the ACA assessment as of December 31, 2018, have triggered an RBC action level (Yes/No)?	No	

There are no other events subsequent to December 31, 2018 that require disclosure.

23. REINSURANCE

Reinsurance Agreements — In the normal course of business, the Company seeks to reduce potential losses that may arise from catastrophic events that cause unfavorable underwriting results by reinsuring certain levels of such risk with affiliated and other nonaffiliated reinsurers. The Company remains primarily liable as the direct insurer on all risks reinsured.

The Company had a reinsurance agreement with an affiliated entity, Unimerica, to cede obligations relating to mental health and substance abuse treatments and services. The agreement was approved by the Department. Reinsurance (premium refund) premiums, which are calculated on a PMPM basis, of ($87,369) and $65,020,259 as of December 31, 2018 and 2017, respectively, were included/netted against net premium income in the statutory basis statement of operations. Reinsurance recoveries of $943,575 and $63,051,971 as of December 31, 2018 and 2017, respectively, are included in net reinsurance recoveries in the statutory basis statement of operations. There were $202,029 and $5,089,831 of amounts recoverable from reinsurers related to this agreement as of December 31, 2018 and 2017, respectively. Reinsurance contracts do not relieve the Company from its obligations to policyholders. Failure of reinsurers to honor their obligations could result in losses to the Company. The reinsurance agreement was terminated effective December 31, 2017.

Pursuant to Section 1341 of the ACA, through 2017, the Company was subject to the reinsurance provisions for compliant individual policies (see Note 24).

The effect of both internal and external reinsurance agreements outlined above on net premium income and hospital and medical expenses is presented below:

	2018	2017
Premiums:		
Direct	$ 1,144,487,491	$ 1,168,359,816
Ceded:		
Affiliate	(87,369)	65,020,259
Nonaffiliate	-	-
Net premium income	$ 1,144,574,860	$ 1,103,339,557
Hospital and medical expenses:		
Direct	$ 988,601,967	$ 1,046,663,464
Ceded:		
Affiliate	943,575	63,051,971
Nonaffiliate	-	1,946,630
Net hospital and medical expenses	$ 987,658,392	$ 981,664,863

The Company recognized reinsurance recoveries related to internal and external reinsurance agreements of $943,575 and $64,998,601 in 2018 and 2017, respectively, which are recorded as net reinsurance recoveries in the statutory basis statements of operations. In addition, reinsurance recoverables related to internal and external reinsurance agreements of $225,715 and $5,914,394 for paid losses are recorded as amounts recoverable from reinsurers and $95,706 and $3,163,993 for unpaid losses are recorded as a reduction to claims unpaid in 2018 and 2017, respectively, in the statutory basis statements of admitted assets, liabilities, and capital and surplus.

A. Ceded Reinsurance Report

Section 1 — General Interrogatories

(1) Are any of the reinsurers, listed in Schedule S as non-affiliated, owned in excess of 10% or controlled, either directly or indirectly, by the Company or by any representative, officer, trustee, or director of the Company?

Yes ( ) No (X)

(2) Have any policies issued by the Company been reinsured with a company chartered in a country other than the United States (excluding U.S. branches of such companies) that is owned in excess of 10% or controlled directly or indirectly by an insured, a beneficiary, a creditor, or any other person not primarily engaged in the insurance business?

Yes ( ) No (X)

Section 2 — Ceded Reinsurance Report — Part A

(1) Does the Company have any reinsurance agreements in effect under which the reinsurer may unilaterally cancel any reinsurance for reasons other than for nonpayment of premium or other similar credit?

Yes ( ) No (X)

(2) Does the reporting entity have any reinsurance agreements in effect that the amount of losses paid or accrued through the statement date may result in a payment to the reinsurer of amounts that, in aggregate and allowing for offset of mutual credits from other reinsurance agreements with the same reinsurer, exceed the total direct premium collected under the reinsured policies?

Yes ( ) No (X)

Section 3 — Ceded Reinsurance Report — Part B

(1) What is the estimated amount of the aggregate reduction in surplus (for agreements other than those under which the reinsurer may unilaterally cancel for reasons other than for nonpayment of premium or other similar credits that are reflected in Section 2 above) of termination of all reinsurance agreements, by either party, as of the date of this statement? Where necessary, the Company may consider the current or anticipated experience of the business reinsured in making this estimate.

The Company estimates there should be no aggregate reduction in surplus for termination of all reinsurance agreements as of December 31, 2018.

(2) Have any new agreements been executed or existing agreements amended, since January 1 of the year of this statement, to include policies or contracts that were in force or which had existing reserves established by the Company as of the effective date of the agreement?

Yes ( ) No (X)

B. **Uncollectible Reinsurance** — During 2018 and 2017, there were no uncollectible reinsurance recoverables.

C. **Commutation of Ceded Reinsurance** — There was no commutation of reinsurance in 2018 or 2017.

D. **Certified Reinsurer Rating Downgraded or Status Subject to Revocation** — Not applicable.

24. RETROSPECTIVELY RATED CONTRACTS AND CONTRACTS SUBJECT TO REDETERMINATION

A. The Company estimates accrued retrospective premium adjustments for its group health insurance business based on mathematical calculations in accordance with contractual terms.

B. Estimated accrued retrospective premiums due from the Company are recorded in aggregate health policy reserves in the statutory basis statements of admitted assets, liabilities, and capital and surplus and as an adjustment to change in unearned premium reserves and reserve for rate credits in the statutory basis statements of operations.

C. Pursuant to the ACA, the Company's commercial business is subject to retrospectively rated features based on the actual medical loss ratios experienced on the commercial lines of business. The formula is calculated pursuant to the ACA guidance. The total amount of direct premiums written for the commercial lines of business subject to the retrospectively rated features was $20,334,681 and $20,195,115, representing 1.8% and 1.7% of total direct premiums written as of December 31, 2018 and 2017, respectively.

CMS has released the final Medicaid and CHIP Managed Care Rule which is subject to each State's administration elections. This rule is the first major update to the Medicaid and CHIP Managed Care regulations in more than a decade. Many items including a minimum loss ratio requirement were implemented for contracts with an effective date starting on or after July 1, 2017 (Medicaid) or July 1, 2018 (CHIP) while other elements of the regulation will be implemented over the following decade. Pursuant to the regulations, for contracts effective on or after July 1, 2017 (Medicaid) or July 1, 2018 (CHIP) premiums associated with the Company's Medicaid and CHIP lines of business are subject to retrospectively rated features based on the actual medical loss

ratios experienced on these products. The calculation is pursuant to the Medicaid and CHIP Managed Care guidance. The total amount of direct premiums written for the Medicaid and CHIP lines of business for which a portion is subject to the retrospectively rated features was $1,081,190,463 and $536,875,906 representing 94.5% and 46.0% of total direct premiums written as of December 31, 2018 and December 31, 2017, respectively.

The Medicaid contract with the State of Mississippi has a redetermination feature for which a portion of total direct premiums written is subject to a risk adjustment model that apportions premiums paid according to a health plan's health severity and certain demographic factors. Changes in risk score assignments can result in changes to the Company's Medicaid revenues and result in a net liability or a net receivable. The total amount of direct premiums written from the Medicaid contract subject to the redetermination feature was $1,035,547,616 and $1,060,885,861, representing 90.5% and 90.8% of the Company's total direct premiums written as of December 31, 2018 and December 31, 2017, respectively.

The Medicaid contract with the State of Mississippi includes experience rebates. The rebate period is over the contract period, which is a June 30 year-end. The Company estimates accrued retrospective premium adjustments for its Medicaid business based on contractual requirements. The total amount of direct premiums written from the Medicaid contract subject to the retrospectively rated feature was $1,035,547,616 and $1,060,885,861, representing 90.5% and 90.8% of total direct premiums written as of December 31, 2018 and December 31, 2017, respectively.

Effective January 1, 2015, the CHIP contract with the State of Mississippi includes medical loss ratio rebates. The rebate period is over the contract period, which is a June 30 year-end. The Company estimates accrued retrospective premium adjustments for its CHIP business based on the medical loss ratio experienced on the CHIP line of business. The formula is based on contractual requirements. The amount of direct premiums written for the CHIP contract was $88,605,194 and $87,278,841, representing 7.7% and 7.5% of total direct premiums written as of December 31, 2018 and December 31, 2017, respectively.

D. The Company does not have Medicare business subject to specific minimum loss ratio requirements as of December 31, 2018 and 2017. The Company is required to maintain a specific minimum loss ratio on the comprehensive commercial line of business. The following table discloses the minimum medical loss ratio rebate liability for the comprehensive commercial line of business which is included in aggregate health policy reserves in the statutory basis statements of admitted assets, liabilities, and capital and surplus for the years ended December 31, 2018 and 2017:

	1 Individual	2 Small Group Employer	3 Large Group Employer	4 Other Categories with Rebates	5 Total
Prior reporting year					
(1) Medical loss ratio rebates incurred	$ -	$ -	$ -	$ -	$ -
(2) Medical loss ratio rebates paid	-	-	-	-	-
(3) Medical loss rebates unpaid	-	-	-	-	-
(4) Plus reinsurance assumed amounts	XXX	XXX	XXX	XXX	-
(5) Less reinsurance ceded amounts	XXX	XXX	XXX	XXX	-
(6) Rebates unpaid net of reinsurance	XXX	XXX	XXX	XXX	-
Current reporting year-to-date					
(7) Medical loss ratio rebates incurred	-	-	135,976	-	135,976
(8) Medical loss ratio rebates paid	-	-	135,976	-	135,976
(9) Medical loss rebates unpaid	-	-	-	-	-
(10) Plus reinsurance assumed amounts	XXX	XXX	XXX	XXX	-
(11) Less reinsurance ceded amounts	XXX	XXX	XXX	XXX	-
(12) Rebates unpaid net of reinsurance	XXX	XXX	XXX	XXX	-

Pursuant to the Medicaid and CHIP Managed Care Rule and state contractual minimum loss ratio requirements, the Company is required to maintain specific minimum loss ratios on its CHIP and Mississippi CAN populations. The Company's actual medical loss ratios for its CHIP and Mississippi CAN populations were in excess of the minimum requirements and, as a result, no minimum loss ratio liability was required as of December 31, 2018 and December 31, 2017, respectively.

E. Risk-Sharing Provisions of the Affordable Care Act

(1) The Company has accident and health insurance premiums in 2018 and 2017 subject to the risk- sharing provisions of the ACA.

The ACA imposed fees and premium stabilization provisions on health insurance issuers offering comprehensive commercial health insurance. The three premium stabilization programs are commonly referred to as the 3Rs — risk adjustment, reinsurance, and risk corridors.

Risk Adjustment — The permanent risk adjustment program, designed to mitigate the potential impact of adverse selection and provide stability for health insurance issuers, applies to all non-grandfathered plans not subject to transitional relief in the individual and small group markets both inside and outside of the insurance exchanges. Effective for 2018 benefit plan year, the risk adjustments and distributions are calculated using a high-cost risk pool which adds a reinsurance-like element to this program. The operation of the high-cost risk pools exclude a percentage of costs above a threshold level determined by federal regulations. The program operates two national high-cost risk pools, one for individuals and one for small groups. Premium adjustments pursuant to the risk adjustment program are accounted for as premium subject to redetermination and user fees are accounted for as assessments.

Reinsurance — The transitional reinsurance program was designed to protect issuers in the individual market from an expected increase in large claims due to the elimination of preexisting condition limitations. The transitional reinsurance program was effective from 2014 through 2016 and applied to all issuers of major medical commercial products and third-party administrators. Contributions attributable to enrollees in the ACA compliant individual plans, including program administrative costs, were accounted for as ceded premium and payments received were accounted for as ceded benefit recoveries. The portion of the individual contributions earmarked for the U.S. Treasury was accounted for as an assessment. Contributions made for enrollees in fully insured plans other than the ACA compliant individual plans, including program administrative costs and payments to the U.S. Treasury, were treated as assessments.

Risk Corridors — The temporary risk corridors program, designed to provide some aggregate protection against variability for issuers in the individual and small group markets during the period 2014 through 2016, applied to Qualified Health Plans in the individual and small group markets both inside and outside of the insurance exchanges. Premium adjustments pursuant to the risk corridors program were accounted for as premium adjustments for retrospectively rated contracts.

(2) The following table presents the current year impact of risk-sharing provisions of the ACA on assets, liabilities and operations:

		December 31, 2018
a.	**Permanent ACA Risk Adjustment Program**	
	Assets	
1.	Premium adjustments receivable due to ACA Risk Adjustment (including high risk pool premium)	$ 247,904
	Liabilities	
2.	Risk adjustment user fees payable for ACA Risk Adjustment	1,568
3.	Premium adjustments payable due to ACA Risk Adjustment (including high risk pool premium)	-
	Operations (Revenue & Expense)	
4.	Reported as revenue in premium for accident and health contracts (written/collected) due to ACA Risk Adjustment	477,087
5.	Reported in expenses as ACA risk adjustment user fees (incurred/paid)	1,584
b.	**Transitional ACA Reinsurance Program**	
	Assets	
1.	Amounts recoverable for claims paid due to ACA Reinsurance	$ 23,686
2.	Amounts recoverable for claims unpaid due to ACA Reinsurance (Contra Liability)	-
3.	Amounts receivable relating to uninsured plans for contributions for ACA Reinsurance	-
	Liabilities	
4.	Liabilities for contributions payable due to ACA Reinsurance - not reported as ceded premium	-
5.	Ceded reinsurance premiums payable due to ACA Reinsurance	-
6.	Liability for amounts held under uninsured plans contributions for ACA Reinsurance	-
	Operations (Revenue & Expense)	
7.	Ceded reinsurance premiums due to ACA Reinsurance	-
8.	Reinsurance recoveries (income statement) due to ACA reinsurance payments or expected payments	-
9.	ACA Reinsurance contributions - not reported as ceded premium	-
c.	**Temporary ACA Risk Corridors Program**	
	Assets	
1.	Accrued retrospective premium due to ACA Risk Corridors	$ -
	Liabilities	
2.	Reserve for rate credits or policy experience rating refunds due to ACA Risk Corridors	-
	Operations (Revenue & Expense)	
3.	Effect of ACA Risk Corridors on net premium income (paid/received)	-
4.	Effect of ACA Risk Corridors on change in reserves for rate credits	-

(3) The following table is a rollforward of the prior year ACA risk-sharing provisions for asset and liability balances, along with reasons for adjustments to prior year balances:

	Accrued During the Prior Year on Business Written before December 31 of the Prior Year		Received or Paid as of the Current Year on Business Written before December 31 of the Prior Year		Differences		Adjustments			Unsettled Balances as of the Reporting Date	
					Prior Year Accrued Less Payments (Col 1 - 3)	Prior Year Accrued Less Payments (Col 2 - 4)	To Prior Year Balances	To Prior Year Balances		Cumulative Balance from Prior Years (Col 1 - 3 + 7)	Cumulative Balance from Prior Years (Col 2 - 4 + 8)
	1 Receivable	2 (Payable)	3 Receivable	4 (Payable)	5 Receivable	6 (Payable)	7 Receivable	8 (Payable)	Ref	9 Receivable	10 (Payable)
a. Permanent ACA Risk Adjustment Program											
1. Premium Adjustment Receivable (including high risk pool premium)	$ 8,192	$ -	$ 64,249	$ -	$ (56,057)	$ -	$ 56,057	$ -	A	$ -	$ -
2. Premium Adjustment (Payable) (including high risk pool premium)	-	(418,441)	-	(245,315)	-	(173,126)	-	173,126	B	-	-
3. Subtotal ACA Permanent Risk Adjustment Program	8,192	(418,441)	64,249	(245,315)	(56,057)	(173,126)	56,057	173,126		-	-
b. Transitional ACA Reinsurance Program											
1. Amounts recoverable for claims paid	824,564	-	800,878	-	23,686	-	-	-	C	23,686	-
2. Amounts recoverable for claims unpaid (contra liability)	-	-	-	-	-	-	-	-	D	-	-
3. Amounts receivable relating to uninsured plans	-	-	-	-	-	-	-	-	E	-	-
4. Liabilities for contributions payable due to ACA Reinsurance — not reported as ceded premium	-	-	-	-	-	-	-	-	F	-	-
5. Ceded reinsurance premiums payable	-	-	-	-	-	-	-	-	G	-	-
6. Liability for amounts held under uninsured plans	-	-	-	-	-	-	-	-	H	-	-
7. Subtotal ACA Transitional Reinsurance Program	824,564	-	800,878	-	23,686	-	-	-		23,686	-
c. Temporary ACA Risk Corridors Program											
1. Accrued retrospective premium	-	-	-	-	-	-	-	-	I	-	-
2. Reserve for rate credits or policy experience rating refunds	-	-	-	-	-	-	-	-	J	-	-
3. Subtotal ACA Risk Corridors Program	-	-	-	-	-	-	-	-		-	-
d. Total for ACA Risk-Sharing Provisions	$ 832,756	$ (418,441)	$ 865,127	$ (245,315)	$ (32,371)	$ (173,126)	$ 56,057	$ 173,126		$ 23,686	$ -

Explanation of Adjustments

A. The risk adjustment receivable as of December 31, 2018 was adjusted based on the final CMS Summary Report on Permanent Risk Adjustment Transfers for the 2017 Benefit Year. The risk adjustment receivable as of December 31, 2017 utilized paid claims through October 31, 2017. The adjustment to the prior year receivable balance reflects the true up to final results for the 2017 Benefit Year.
B. The risk adjustment payable as of December 31, 2018 was adjusted based on the final CMS Summary Report on Permanent Risk Adjustment Transfers for the 2017 Benefit Year. The risk adjustment payable as of December 31, 2017 utilized paid claims through October 31, 2017. The adjustment to the prior year payable balance reflects the true up to final results for the 2017 Benefit Year.
C. N/A
D. N/A
E. N/A
F. N/A
G. N/A
H. N/A
I. N/A
J. N/A

(4) The Company does not have any risk corridor receivables or payables to present in the table below:

Risk Corridors Program Year	Accrued during the Prior Year on Business Written before December 31 of the Prior Year 1 Receivable	Accrued during the Prior Year on Business Written before December 31 of the Prior Year 2 (Payable)	Received or Paid as of the Current Year on Business Written before December 31 of the Prior Year 3 Receivable	Received or Paid as of the Current Year on Business Written before December 31 of the Prior Year 4 (Payable)	Differences Prior Year Accrued Less Payments (Col 1 – 3) 5 Receivable	Differences Prior Year Accrued Less Payments (Col 2 – 4) 6 (Payable)	Adjustments To Prior Year Balances 7 Receivable	Adjustments To Prior Year Balances 8 (Payable)	Ref	Unsettled Balances as of the of the Reporting Date Cumulative Balance from Prior Years (Col 1 – 3 + 7) 9 Receivable	Unsettled Balances as of the of the Reporting Date Cumulative Balance from Prior Years (Col 2 – 4 + 8) 10 (Payable)
a. 2014											
1. Accrued retrospective premium	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	A	$ -	$ -
2. Reserve for rate credits or policy experience rating refunds	-	-	-	-	-	-	-	-	B	-	-
b. 2015											
1. Accrued retrospective premium	-	-	-	-	-	-	-	-	C	-	-
2. Reserve for rate credits or policy experience rating refunds	-	-	-	-	-	-	-	-	D	-	-
c. 2016											
1. Accrued retrospective premium	-	-	-	-	-	-	-	-	E	-	-
2. Reserve for rate credits or policy experience rating refunds	-	-	-	-	-	-	-	-	F	-	-
d. Total for Risk Corridors	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -		$ -	$ -

Explanation of Adjustments

A. N/A
B. N/A
C. N/A
D. N/A
E. N/A
F. N/A

(5) The following table discloses ACA risk corridor receivable balances by risk corridor program year:

Risk Corridors Program Year	1 Estimated Amount to be Filed or Final Amount Filed with CMS	2 Non-Accrued Amounts for Impairment or Other Reasons	3 Amounts Received from CMS	4 Asset Balance (Gross of Non-admissions) (1 - 2 - 3)	5 Non-admitted Amount	6 Net Admitted Asset (4 - 5)
a. 2014	$ -	$ -	$ -	$ -	$ -	$ -
b. 2015	809,174	809,174	-	-	-	-
c. 2016	3,906,593	3,906,593	-	-	-	-
d. Total (a + b + c)	$ 4,715,767	$ 4,715,767	$ -	$ -	$ -	$ -

25. CHANGE IN INCURRED CLAIMS AND CLAIMS ADJUSTMENT EXPENSES

A. Changes in estimates related to the prior year incurred claims are included in total hospital and medical expenses in the current year in the statutory basis statements of operations. The following tables disclose paid claims, incurred claims, and the balance in claims unpaid, accrued medical incentive pool and bonus amounts, aggregate health claim reserves, health care receivables and reinsurance recoverables for the years ended December 31, 2018 and 2017:

	2018		
	Current Year Incurred Claims	Prior Years Incurred Claims	Total
Beginning of year claim reserve	$ -	$ (85,195,058)	$ (85,195,058)
Paid claims — net of health care receivables and reinsurance recoveries collected	923,852,050	64,843,877	988,695,927
End of year claim reserve	70,627,136	11,007,856	81,634,992
Incurred claims excluding the change in health care receivables and reinsurance recoverables as presented below	994,479,186	(9,343,325)	985,135,861
Beginning of year health care receivables and reinsurance recoverables	-	8,759,936	8,759,936
End of year health care receivables and reinsurance recoverables	(3,134,693)	(3,102,712)	(6,237,405)
Total incurred claims	$ 991,344,493	$ (3,686,101)	$ 987,658,392

	2017		
	Current Year Incurred Claims	Prior Years Incurred Claims	Total
Beginning of year claim reserve	$ -	$ (105,268,058)	$ (105,268,058)
Paid claims — net of health care receivables* and reinsurance recoveries collected	922,988,496	66,471,762	989,460,258
End of year claim reserve	75,280,947	9,914,111	85,195,058
Incurred claims excluding the change in health care receivables and reinsurance recoverables as presented below	998,269,443	(28,882,185)	969,387,258
Beginning of year health care receivables* and reinsurance recoverables	-	21,037,541	21,037,541
End of year health care receivables* and reinsurance recoverables	(6,334,283)	(2,425,653)	(8,759,936)
Total incurred claims	$ 991,935,160	$ (10,270,297)	$ 981,664,863

*Health care receivables excludes provider loans and advances not yet expensed of $0 and $431 for 2017 and 2016, respectively.

The liability for claims unpaid, accrued medical incentive pool and bonus amounts, aggregate health claim reserves, net of health care receivables and reinsurance recoverables as of December 31, 2017 was $76,435,122. As of December 31, 2018, $64,843,877 has been paid for

incurred claims attributable to insured events of prior years. Reserves remaining for prior years, net of health care receivables and reinsurance recoverables are now $7,905,144, as a result of re-estimation of unpaid claims. Therefore, there has been $3,686,101 favorable prior year development since December 31, 2017 to December 31, 2018. The primary drivers consist of favorable development as a result of a change in the provision for adverse deviations in experience of $4,799,927 and favorable development of $3,309,380 in provider settlements offset by unfavorable development of $4,360,216 in retroactivity for inpatient, outpatient, physician, and pharmacy claims. At December 31, 2017, the Company recorded $10,270,297 favorable development as a result of a change in the provision for adverse deviations in experience of $6,693,683 and favorable development of $2,646,194 in retroactivity for inpatient, outpatient, physician, and pharmacy claims. Original estimates are increased or decreased, as additional information becomes known regarding individual claims, which could have an impact to the accruals for medical loss ratio rebates and retrospectively rated contracts. As a result of the prior year effects, on a regular basis, the Company adjusts revenue and the corresponding liability and/or receivable related to retrospectively rated policies and the impact of the change is included as a component of change in unearned premium reserves and reserve for rate credits in the statutory basis statements of operations.

The Company incurred CAE of $42,748,017 and $45,328,911 in 2018 and 2017, respectively. These costs are included in the management service fees paid by the Company to UHS as a part of the Agreement (see Note 10). The following table discloses paid CAE, incurred CAE, and the balance in unpaid CAE reserve for 2018 and 2017:

	2018	2017
Total claims adjustment expenses	$ 42,748,017	$ 45,328,911
Less: current year unpaid claims adjustment expenses	(769,995)	(958,982)
Add: prior year unpaid claims adjustment expenses	958,982	1,490,301
Total claims adjustment expenses paid	$ 42,937,004	$ 45,860,230

B. The Company did not make any significant changes in methodologies and assumptions used in the calculation of the liability for claims unpaid and unpaid CAE in 2018.

26. INTERCOMPANY POOLING ARRANGEMENTS

A–G. The Company did not have any intercompany pooling arrangements in 2018 or 2017.

27. STRUCTURED SETTLEMENTS

A–B. The Company did not have structured settlements in 2018 or 2017.

28. HEALTH CARE RECEIVABLES

A. Pharmacy rebates receivable are recorded when reasonably estimated or billed by the affiliated pharmaceutical benefit manager in accordance with pharmaceutical rebate contract provisions. Information used to support rebates billed to the manufacturer is based on utilization information gathered by the pharmaceutical benefit manager and adjusted for significant changes in pharmaceutical contract provisions.

The Company evaluates admissibility of all pharmacy rebates receivable based on the administration of each underlying pharmaceutical benefit management agreement. The Company has nonadmitted and excluded all pharmacy rebates receivable that do not meet the admissibility criteria of SSAP No. 84, *Certain Health Care Receivables and Receivables under Government Insured Plans* (“SSAP No. 84”) from the statutory basis statements of admitted assets, liabilities, and capital and surplus.

For each pharmaceutical management agreement for which a portion of the total pharmacy rebates receivable can be admitted based on the admissibility criteria of SSAP No. 84, the pharmacy rebate transaction history is summarized as follows:

Quarter	Estimated Pharmacy Rebates as Reported on Financial Statements	Pharmacy Rebates as Billed or Otherwise Confirmed	Actual Rebates Received within 90 Days of Billing	Actual Rebates Received within 91 to 180 Days of Billing	Actual Rebates Received More than 180 Days after Billing
12/31/2018	$ 642,511	$ -	$ -	$ -	$ -
9/30/2018	625,829	638,559	318,524	-	-
6/30/2018	662,115	684,661	316,806	295,872	-
3/31/2018	608,686	615,769	159,857	375,853	71,919
12/31/2017	659,446	628,458	221,988	343,820	57,810
9/30/2017	666,645	638,066	190,595	351,396	91,284
6/30/2017	589,141	621,672	136,499	323,833	157,624
3/31/2017	644,693	682,290	61,914	291,103	322,462
12/31/2016	2,498,308	2,419,573	836,925	917,497	610,002
9/30/2016	2,542,309	2,472,972	707,031	1,150,655	575,305
6/30/2016	2,104,681	2,198,919	1,145,862	812,631	127,028
3/31/2016	1,629,349	2,029,278	499,661	1,429,019	77,363

Of the amount reported as health care receivables, $963,262 and $1,046,144 relates to pharmacy rebates receivable and $201,944, and $91,226 related to claims overpayments as of December 31, 2018 and 2017, respectively. This decrease is primarily due to decreased membership along with the change in generic/name brand mix.

B. The Company does not have any risk-sharing receivables.

29. PARTICIPATING POLICIES

The Company did not have any participating contracts in 2018 or 2017.

30. PREMIUM DEFICIENCY RESERVES

The following table summarizes the Company's premium deficiency reserves as of December 31, 2018 and 2017:

	2018
1. Liability carried for premium deficiency reserves	$ -
2. Date of the most recent evaluation of this liability	12/31/2018
3. Was anticipated investment income utilized in this calculation?	Yes [X] No [ ]
	2017
1. Liability carried for premium deficiency reserves	$ 28,006,000
2. Date of the most recent evaluation of this liability	12/31/2017
3. Was anticipated investment income utilized in this calculation?	Yes [X] No [ ]

Premium deficiency reserves are included in aggregate health policy reserves (see Note 1 — *Basis of Presentation*) in the statutory basis statements of admitted assets, liabilities, and capital and surplus.

31. ANTICIPATED SALVAGE AND SUBROGATION

Due to the type of business being written, the Company has no salvage. As of December 31, 2018 and 2017, the Company had no specific accruals established for outstanding subrogation, as it is considered a component of the actuarial calculations used to develop the estimates of claims unpaid and aggregate health claim reserves.

* * * * * *

SUPPLEMENTAL SCHEDULES

EXHIBIT I:
SUPPLEMENTAL INVESTMENT RISKS INTERROGATORIES

SUPPLEMENTAL INVESTMENT RISKS INTERROGATORIES

For The Year Ended December 31, 2018
(To Be Filed by April 1)

Of The UnitedHealthcare of Mississippi, Inc.

ADDRESS (City, State and Zip Code) Minnetonka , MN 55343

NAIC Group Code 0707 NAIC Company Code 95716 Federal Employer's Identification Number (FEIN) 63-1036817

The Investment Risks Interrogatories are to be filed by April 1. They are also to be included with the Audited Statutory Financial Statements.

Answer the following interrogatories by reporting the applicable U.S. dollar amounts and percentages of the reporting entity's total admitted assets held in that category of investments.

1. Reporting entity's total admitted assets as reported on Page 2 of this annual statement. $ 277,013,930

2. Ten largest exposures to a single issuer/borrower/investment.

	1 Issuer	2 Description of Exposure	3 Amount	4 Percentage of Total Admitted Assets
2.01	DEUTSCHE GOV - ICAXX	Bonds	$ 11,998,985	4.3 %
2.02	TUGXX US Equity - TUGXX	Bonds	$ 10,611,485	3.8 %
2.03	FNMA	Bonds	$ 10,268,621	3.7 %
2.04	HSBC - HGIXX	Bonds	$ 10,237,435	3.7 %
2.05	FHLMC	Bonds	$ 8,975,265	3.2 %
2.06	Northern Inst - BGSXX	Bonds	$ 1,888,144	0.7 %
2.07	HOUSTON TX	Bonds	$ 1,804,037	0.7 %
2.08	VIRGINIA ST PUBL - APP	Bonds	$ 1,570,093	0.6 %
2.09	NATIONWIDE BLDG	Bonds	$ 1,503,201	0.5 %
2.10	GENERAL DYNAMICS	Bonds	$ 1,498,267	0.5 %

3. Amounts and percentages of the reporting entity's total admitted assets held in bonds and preferred stocks by NAIC designation.

	Bonds	1	2		Preferred Stocks	3	4
3.01	NAIC-1	$ 138,225,386	49.9 %	3.07	P/RP-1	$ 0	0.0 %
3.02	NAIC-2	$ 11,542,797	4.2 %	3.08	P/RP-2	$ 0	0.0 %
3.03	NAIC-3	$ 0	0.0 %	3.09	P/RP-3	$ 0	0.0 %
3.04	NAIC-4	$ 0	0.0 %	3.10	P/RP-4	$ 0	0.0 %
3.05	NAIC-5	$ 0	0.0 %	3.11	P/RP-5	$ 0	0.0 %
3.06	NAIC-6	$ 0	0.0 %	3.12	P/RP-6	$ 0	0.0 %

4. Assets held in foreign investments:

4.01 Are assets held in foreign investments less than 2.5% of the reporting entity's total admitted assets? Yes [ ] No [X]

If response to 4.01 above is yes, responses are not required for interrogatories 5 - 10.

4.02	Total admitted assets held in foreign investments	$ 14,807,358	5.3 %
4.03	Foreign-currency-denominated investments	$ 0	0.0 %
4.04	Insurance liabilities denominated in that same foreign currency	$ 0	0.0 %

5. Aggregate foreign investment exposure categorized by NAIC sovereign designation:

		1	2
5.01	Countries designated NAIC-1	$ 14,289,482	5.2 %
5.02	Countries designated NAIC-2	$ 517,876	0.2 %
5.03	Countries designated NAIC-3 or below	$ 0	0.0 %

6. Largest foreign investment exposures by country, categorized by the country's NAIC sovereign designation:

		1	2
	Countries designated NAIC - 1:		
6.01	Country 1: UNITED KINGDOM	$ 3,411,756	1.2 %
6.02	Country 2: FRANCE	$ 2,300,061	0.8 %
	Countries designated NAIC - 2:		
6.03	Country 1: MEXICO	$ 517,876	0.2 %
6.04	Country 2:	$ 0	0.0 %
	Countries designated NAIC - 3 or below:		
6.05	Country 1:	$ 0	0.0 %
6.06	Country 2:	$ 0	0.0 %

		1	2
7.	Aggregate unhedged foreign currency exposure	$ 0	0.0 %

8. Aggregate unhedged foreign currency exposure categorized by NAIC sovereign designation:

		1	2
8.01	Countries designated NAIC-1	$ 0	0.0 %
8.02	Countries designated NAIC-2	$ 0	0.0 %
8.03	Countries designated NAIC-3 or below	$ 0	0.0 %

9. Largest unhedged foreign currency exposures by country, categorized by the country's NAIC sovereign designation:

		1	2
	Countries designated NAIC - 1:		
9.01	Country 1:	$ 0	0.0 %
9.02	Country 2:	$ 0	0.0 %
	Countries designated NAIC - 2:		
9.03	Country 1:	$ 0	0.0 %
9.04	Country 2:	$ 0	0.0 %
	Countries designated NAIC - 3 or below:		
9.05	Country 1:	$ 0	0.0 %
9.06	Country 2:	$ 0	0.0 %

10. Ten largest non-sovereign (i.e. non-governmental) foreign issues:

	1 Issuer	2 NAIC Designation	3	4
10.01	Asian Development Bank	1	$ 1,194,063	0.4 %
10.02	European Investment Bank	1	$ 1,096,385	0.4 %
10.03	MACQUARIE GROUP	1	$ 1,005,945	0.4 %
10.04	NATIONWIDE BLDG	1	$ 1,003,201	0.4 %
10.05	EUROPEAN BK RECON & DEV	1	$ 998,667	0.4 %
10.06	Inter Amer'n Development Bank	1	$ 997,923	0.4 %
10.07	STATOIL ASA	1	$ 743,219	0.3 %
10.08	NOVARTIS CAPITAL	1	$ 702,545	0.3 %
10.09	UBS GROUP FUNDIN	1	$ 649,614	0.2 %
10.10	Export Import Bank Korea	1	$ 579,901	0.2 %

11. Amounts and percentages of the reporting entity's total admitted assets held in Canadian investments and unhedged Canadian currency exposure:

11.01 Are assets held in Canadian investments less than 2.5% of the reporting entity's total admitted assets? Yes [ ] No [X]

If response to 11.01 is yes, detail is not required for the remainder of interrogatory 11.

		1	2
11.02	Total admitted assets held in Canadian investments	$ 10,497,367	3.8 %
11.03	Canadian-currency-denominated investments	$ 0	0.0 %
11.04	Canadian-denominated insurance liabilities	$ 0	0.0 %
11.05	Unhedged Canadian currency exposure	$ 0	0.0 %

12. Report aggregate amounts and percentages of the reporting entity's total admitted assets held in investments with contractual sales restrictions:

12.01 Are assets held in investments with contractual sales restrictions less than 2.5% of the reporting entity's total admitted assets? Yes [X] No [ ]

If response to 12.01 is yes, responses are not required for the remainder of Interrogatory 12.

	1	2	3
12.02	Aggregate statement value of investments with contractual sales restrictions	$ 0	0.0 %
	Largest three investments with contractual sales restrictions:		
12.03		$ 0	0.0 %
12.04		$ 0	0.0 %
12.05		$ 0	0.0 %

13. Amounts and percentages of admitted assets held in the ten largest equity interests:

13.01 Are assets held in equity interests less than 2.5% of the reporting entity's total admitted assets? Yes [X] No [ ]

If response to 13.01 above is yes, responses are not required for the remainder of Interrogatory 13.

	1 Issuer	2	3
13.02		$ 0	0.0 %
13.03		$ 0	0.0 %
13.04		$ 0	0.0 %
13.05		$ 0	0.0 %
13.06		$ 0	0.0 %
13.07		$ 0	0.0 %
13.08		$ 0	0.0 %
13.09		$ 0	0.0 %
13.10		$ 0	0.0 %
13.11		$ 0	0.0 %

14. Amounts and percentages of the reporting entity's total admitted assets held in nonaffiliated, privately placed equities:

14.01 Are assets held in nonaffiliated, privately placed equities less than 2.5% of the reporting entity's total admitted assets? ..... Yes [X] No [ ]

If response to 14.01 above is yes, responses are not required for the remainder of Interrogatory 14.

	1	2	3
14.02	Aggregate statement value of investments held in nonaffiliated, privately placed equities	$ 0	0.0 %
	Largest three investments held in nonaffiliated, privately placed equities:		
14.03		$ 0	0.0 %
14.04		$ 0	0.0 %
14.05		$ 0	0.0 %

15. Amounts and percentages of the reporting entity's total admitted assets held in general partnership interests:

15.01 Are assets held in general partnership interests less than 2.5% of the reporting entity's total admitted assets? ..... Yes [X] No [ ]

If response to 15.01 above is yes, responses are not required for the remainder of Interrogatory 15.

	1	2	3
15.02	Aggregate statement value of investments held in general partnership interests	$ 0	0.0 %
	Largest three investments in general partnership interests:		
15.03		$ 0	0.0 %
15.04		$ 0	0.0 %
15.05		$ 0	0.0 %

16. Amounts and percentages of the reporting entity's total admitted assets held in mortgage loans:

16.01 Are mortgage loans reported in Schedule B less than 2.5% of the reporting entity's total admitted assets? ..... Yes [X] No [ ]

If response to 16.01 above is yes, responses are not required for the remainder of Interrogatory 16 and Interrogatory 17.

	1 Type (Residential, Commercial, Agricultural)	2	3
16.02		$ 0	0.0 %
16.03		$ 0	0.0 %
16.04		$ 0	0.0 %
16.05		$ 0	0.0 %
16.06		$ 0	0.0 %
16.07		$ 0	0.0 %
16.08		$ 0	0.0 %
16.09		$ 0	0.0 %
16.10		$ 0	0.0 %
16.11		$ 0	0.0 %

Amount and percentage of the reporting entity's total admitted assets held in the following categories of mortgage loans:

		Loans	
16.12	Construction loans	$ 0	0.0 %
16.13	Mortgage loans over 90 days past due	$ 0	0.0 %
16.14	Mortgage loans in the process of foreclosure	$ 0	0.0 %
16.15	Mortgage loans foreclosed	$ 0	0.0 %
16.16	Restructured mortgage loans	$ 0	0.0 %

17. Aggregate mortgage loans having the following loan-to-value ratios as determined from the most current appraisal as of the annual statement date:

		Residential		Commercial		Agricultural	
	Loan to Value	1	2	3	4	5	6
17.01	above 95%	$ 0	0.0 %	$ 0	0.0 %	$ 0	0.0 %
17.02	91 to 95%	$ 0	0.0 %	$ 0	0.0 %	$ 0	0.0 %
17.03	81 to 90%	$ 0	0.0 %	$ 0	0.0 %	$ 0	0.0 %
17.04	71 to 80%	$ 0	0.0 %	$ 0	0.0 %	$ 0	0.0 %
17.05	below 70%	$ 0	0.0 %	$ 0	0.0 %	$ 0	0.0 %

18. Amounts and percentages of the reporting entity's total admitted assets held in each of the five largest investments in real estate:

18.01 Are assets held in real estate reported less than 2.5% of the reporting entity's total admitted assets? Yes [X] No [ ]

If response to 18.01 above is yes, responses are not required for the remainder of Interrogatory 18.

Largest five investments in any one parcel or group of contiguous parcels of real estate.

	Description 1	2	3
18.02		$ 0	0.0 %
18.03		$ 0	0.0 %
18.04		$ 0	0.0 %
18.05		$ 0	0.0 %
18.06		$ 0	0.0 %

19. Report aggregate amounts and percentages of the reporting entity's total admitted assets held in investments held in mezzanine real estate loans:

19.01 Are assets held in investments held in mezzanine real estate loans less than 2.5% of the reporting entity's total admitted assets? Yes [X] No [ ]

If response to 19.01 is yes, responses are not required for the remainder of Interrogatory 19.

	1	2	3
19.02	Aggregate statement value of investments held in mezzanine real estate loans:	$ 0	0.0 %
	Largest three investments held in mezzanine real estate loans:		
19.03		$ 0	0.0 %
19.04		$ 0	0.0 %
19.05		$ 0	0.0 %

20. Amounts and percentages of the reporting entity's total admitted assets subject to the following types of agreements:

		At Year End		At End of Each Quarter		
				1st Quarter	2nd Quarter	3rd Quarter
		1	2	3	4	5
20.01	Securities lending agreements (do not include assets held as collateral for such transactions)	$ 0	0.0 %	$ 0	$ 0	$ 0
20.02	Repurchase agreements	$ 0	0.0 %	$ 0	$ 0	$ 0
20.03	Reverse repurchase agreements	$ 0	0.0 %	$ 0	$ 0	$ 0
20.04	Dollar repurchase agreements	$ 0	0.0 %	$ 0	$ 0	$ 0
20.05	Dollar reverse repurchase agreements	$ 0	0.0 %	$ 0	$ 0	$ 0

21. Amounts and percentages of the reporting entity's total admitted assets for warrants not attached to other financial instruments, options, caps, and floors:

		Owned		Written	
		1	2	3	4
21.01	Hedging	$ 0	0.0 %	$ 0	0.0 %
21.02	Income generation	$ 0	0.0 %	$ 0	0.0 %
21.03	Other	$ 0	0.0 %	$ 0	0.0 %

22. Amounts and percentages of the reporting entity's total admitted assets of potential exposure for collars, swaps, and forwards:

		At Year End		At End of Each Quarter		
				1st Quarter	2nd Quarter	3rd Quarter
		1	2	3	4	5
22.01	Hedging	$ 0	0.0 %	$ 0	$ 0	$ 0
22.02	Income generation	$ 0	0.0 %	$ 0	$ 0	$ 0
22.03	Replications	$ 0	0.0 %	$ 0	$ 0	$ 0
22.04	Other	$ 0	0.0 %	$ 0	$ 0	$ 0

23. Amounts and percentages of the reporting entity's total admitted assets of potential exposure for futures contracts:

		At Year End		At End of Each Quarter		
				1st Quarter	2nd Quarter	3rd Quarter
		1	2	3	4	5
23.01	Hedging	$ 0	0.0 %	$ 0	$ 0	$ 0
23.02	Income generation	$ 0	0.0 %	$ 0	$ 0	$ 0
23.03	Replications	$ 0	0.0 %	$ 0	$ 0	$ 0
23.04	Other	$ 0	0.0 %	$ 0	$ 0	$ 0

EXHIBIT II:
SUMMARY INVESTMENT SCHEDULE

SUMMARY INVESTMENT SCHEDULE

Investment Categories	Gross Investment Holdings 1 Amount	Gross Investment Holdings 2 Percentage	Admitted Assets as Reported in the Annual Statement 3 Amount	4 Securities Lending Reinvested Collateral Amount	5 Total (Col. 3 + 4) Amount	6 Percentage
1. Bonds:						
1.1 U.S. treasury securities	5,112,424	2.338	5,112,424	0	5,112,424	2.338
1.2 U.S. government agency obligations (excluding mortgage-backed securities):						
1.21 Issued by U.S. government agencies	0	0.000	0	0	0	0.000
1.22 Issued by U.S. government sponsored agencies	1,768,658	0.809	1,768,658	0	1,768,658	0.809
1.3 Non-U.S. government (including Canada, excluding mortgaged-backed securities)	6,277,070	2.871	6,277,070	0	6,277,070	2.871
1.4 Securities issued by states, territories, and possessions and political subdivisions in the U.S. :						
1.41 States, territories and possessions general obligations	1,803,833	0.825	1,803,833	0	1,803,833	0.825
1.42 Political subdivisions of states, territories and possessions and political subdivisions general obligations	3,847,655	1.760	3,847,655	0	3,847,655	1.760
1.43 Revenue and assessment obligations	25,918,544	11.853	25,918,544	0	25,918,544	11.853
1.44 Industrial development and similar obligations	0	0.000	0	0	0	0.000
1.5 Mortgage-backed securities (includes residential and commercial MBS):						
1.51 Pass-through securities:						
1.511 Issued or guaranteed by GNMA	0	0.000	0	0	0	0.000
1.512 Issued or guaranteed by FNMA and FHLMC	15,749,593	7.203	15,749,593	0	15,749,593	7.203
1.513 All other	0	0.000	0	0	0	0.000
1.52 CMOs and REMICs:						
1.521 Issued or guaranteed by GNMA, FNMA, FHLMC or VA	1,725,635	0.789	1,725,635	0	1,725,635	0.789
1.522 Issued by non-U.S. Government issuers and collateralized by mortgage-backed securities issued or guaranteed by agencies shown in Line 1.521	6,552,939	2.997	6,552,939	0	6,552,939	2.997
1.523 All other	0	0.000	0	0	0	0.000
2. Other debt and other fixed income securities (excluding short-term):						
2.1 Unaffiliated domestic securities (includes credit tenant loans and hybrid securities)	61,981,503	28.345	61,981,503	0	61,981,503	28.345
2.2 Unaffiliated non-U.S. securities (including Canada)	19,027,655	8.702	19,027,655	0	19,027,655	8.702
2.3 Affiliated securities	0	0.000	0	0	0	0.000
3. Equity interests:						
3.1 Investments in mutual funds	0	0.000	0	0	0	0.000
3.2 Preferred stocks:						
3.21 Affiliated	0	0.000	0	0	0	0.000
3.22 Unaffiliated	0	0.000	0	0	0	0.000
3.3 Publicly traded equity securities (excluding preferred stocks):						
3.31 Affiliated	0	0.000	0	0	0	0.000
3.32 Unaffiliated	0	0.000	0	0	0	0.000
3.4 Other equity securities:						
3.41 Affiliated	0	0.000	0	0	0	0.000
3.42 Unaffiliated	0	0.000	0	0	0	0.000
3.5 Other equity interests including tangible personal property under lease:						
3.51 Affiliated	0	0.000	0	0	0	0.000
3.52 Unaffiliated	0	0.000	0	0	0	0.000
4. Mortgage loans:						
4.1 Construction and land development	0	0.000	0	0	0	0.000
4.2 Agricultural	0	0.000	0	0	0	0.000
4.3 Single family residential properties	0	0.000	0	0	0	0.000
4.4 Multifamily residential properties	0	0.000	0	0	0	0.000
4.5 Commercial loans	0	0.000	0	0	0	0.000
4.6 Mezzanine real estate loans	0	0.000	0	0	0	0.000
5. Real estate investments:						
5.1 Property occupied by company	0	0.000	0	0	0	0.000
5.2 Property held for production of income (including $ 0 of property acquired in satisfaction of debt)	0	0.000	0	0	0	0.000
5.3 Property held for sale (including $ 0 property acquired in satisfaction of debt)	0	0.000	0	0	0	0.000
6. Contract loans	0	0.000	0	0	0	0.000
7. Derivatives	0	0.000	0	0	0	0.000
8. Receivables for securities	0	0.000	0	0	0	0.000
9. Securities Lending (Line 10, Asset Page reinvested collateral)	0	0.000	0	XXX	XXX	XXX
10. Cash, cash equivalents and short-term investments	68,902,126	31.510	68,902,126	0	68,902,126	31.510
11. Other invested assets	0	0.000	0	0	0	0.000
12. Total invested assets	218,667,636	100.000	218,667,636	0	218,667,636	100.000

OTHER ATTACHMENT

Deloitte.

Deloitte & Touche LLP
50 South 6th Street
Suite 2800
Minneapolis, MN 55402-1538
USA

Tel: +1 612 397 4000
Fax: +1 612 397 4450
www.deloitte.com

To the Audit Committee of
UnitedHealthcare of Mississippi, Inc.
795 Woodlands Parkway, Suite 301
Ridgeland, MS 39157

The Management of
UnitedHealthcare of Mississippi, Inc.
795 Woodlands Parkway, Suite 301
Ridgeland, MS 39157

Dear Members of the Audit Committee and Management:

We have audited, in accordance with auditing standards generally accepted in the United States of America, the statutory basis financial statements of UnitedHealthcare of Mississippi, Inc. (the "Company") for the years ended December 31, 2018, and 2017, and have issued our report thereon dated April 25, 2019. In connection therewith, we advise you as follows:

a. We are independent certified public accountants with respect to the Company and conform to the standards of the accounting profession as contained in the *Code of Professional Conduct* and pronouncements of the American Institute of Certified Public Accountants, the rules and regulations of the Mississippi Insurance Department, and the Rules of Professional Conduct of the Minnesota State Board of Accountancy.

b. The engagement partner and engagement manager, who are certified public accountants, have 29 years and 8 years, respectively, of experience in public accounting and are experienced in auditing insurance enterprises. Members of the engagement team, most of whom have had experience in auditing insurance enterprises and 29% percent of whom are certified public accountants, were assigned to perform tasks commensurate with their training and experience.

c. We understand that the Company intends to file its audited statutory basis financial statements and our report thereon with the Mississippi Insurance Department and other state insurance departments in states in which the Company is licensed and that the insurance commissioners of those states will be relying on that information in monitoring and regulating the statutory basis financial condition of the Company.

   While we understand that an objective of issuing a report on the statutory basis financial statements is to satisfy regulatory requirements, our audit was not planned to satisfy all objectives or responsibilities of insurance regulators. In this context, the Company and insurance commissioners should understand that the objective of an audit of statutory basis financial statements in accordance with auditing standards generally accepted in the United States of America is to form an opinion and issue a report on whether the statutory basis financial statements present fairly, in all material respects, the admitted assets, liabilities, and capital and surplus, results of operations and cash flows in accordance with accounting practices prescribed or permitted by the Mississippi Insurance Department. Consequently, under auditing standards generally accepted in the United States of America, we have the responsibility, within the inherent limitations of the auditing process, to plan and perform our audit to obtain

reasonable assurance regarding whether the statutory basis financial statements are free from material misstatement, whether due to error or fraud, and to exercise due professional care in the conduct of the audit. The Company is not required to have, nor were we engaged to perform, an audit of internal control over financial reporting. Our audit included consideration of internal control relevant to the entity's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of internal control over financial reporting. The concept of selective testing of the data being audited, which involves judgment both as to the number of transactions to be audited and the areas to be tested, has been generally accepted as a valid and sufficient basis for an auditor to express an opinion on financial statements. Audit procedures that are effective for detecting errors, if they exist, may be ineffective for detecting misstatements resulting from fraud. Because of the characteristics of fraud, particularly those involving concealment and falsified documentation (including forgery), a properly planned and performed audit may not detect a material misstatement resulting from fraud. In addition, an audit does not address the possibility that material misstatements may occur in the future. Also, our use of professional judgment and the assessment of materiality for the purpose of our audit mean that matters may exist that would have been assessed differently by insurance commissioners.

It is the responsibility of the management of the Company to adopt sound accounting policies, to maintain an adequate and effective system of accounts, and to establish and maintain internal control that will, among other things, provide reasonable, but not absolute, assurance that assets are safeguarded against loss from unauthorized use or disposition and that transactions are executed in accordance with management's authorization and are recorded properly to permit the preparation of financial statements in conformity with accounting practices prescribed or permitted by the Mississippi Insurance Department.

The Insurance Commissioner should exercise due diligence to obtain whatever other information that may be necessary for the purpose of monitoring and regulating the statutory basis financial position of insurers and should not rely solely on the independent auditors' report.

d. We will retain the working papers (including those kept in a hard copy or electronic medium) prepared in the conduct of our audit until the Mississippi Insurance Department has filed a Report of Examination covering 2018, but no longer than seven years. After notification to the Company, we will make the working papers available for review by the Mississippi Insurance Department or its delegates, at the offices of the insurer, at our offices, at the Mississippi Insurance Department, or at any other reasonable place designated by the Insurance Commissioner. Furthermore, in the conduct of the aforementioned periodic review by the Mississippi Insurance Department, photocopies of pertinent audit working papers may be made (under the control of Deloitte & Touche LLP) and such copies may be retained by the Mississippi Insurance Department. In addition, to the extent requested, we may provide the Mississippi Insurance Department with copies of certain audit working papers (such as unlocked copies of Excel spreadsheets that do not contain password protection or encryption). As such, these audit working papers will be subject to potential modification by Mississippi Insurance Department or by others. We are not responsible for any modifications made to the copies, electronic or otherwise, after they are provided to the Mississippi Insurance Department; and we are likewise not responsible for any effect that any such modifications, whether intentional or not, might have on the process, substance, or outcome of your regulatory examination.

e. The engagement partner has served in this capacity with respect to the Company since 2018, is licensed by the Minnesota State Board of Accountancy, and is a member in good standing of the American Institute of Certified Public Accountants.

f. To the best of our knowledge and belief, we are in compliance with the requirements of section 7 of the *NAIC's Model Rule (Regulation) Requiring Annual Audited Financial Reports* regarding qualifications of independent certified public accountants.

This letter is intended solely for the information and use of the Audit Committee and management of UnitedHealthcare of Mississippi, Inc. and for filing with the Mississippi Insurance Department and other state insurance departments to whose jurisdiction the Company is subject and is not intended to be and should not be used by anyone other than these specified parties.

Deloitte & Touche LLP

April 25, 2019

Att. 4.3.2.6-2
UnitedHealthcare of Mississippi, Inc. 2019 Audited Financial Statement

UnitedHealthcare of Mississippi, Inc.

Statutory Basis Financial Statements as of and
for the Years Ended December 31, 2019 and 2018,
Supplemental Schedules as of and for the
Year Ended December 31, 2019,
Independent Auditors' Report and Qualification Letter

UNITEDHEALTHCARE OF MISSISSIPPI, INC.

TABLE OF CONTENTS

Deloitte.

Deloitte & Touche LLP
50 South 6th Street
Suite 2800
Minneapolis, MN 55402-1538
USA

Tel: +1 612 397 4000
Fax: +1 612 397 4450
www.deloitte.com

INDEPENDENT AUDITORS' REPORT

To the Audit Committee of
UnitedHealthcare of Mississippi, Inc.
795 Woodlands Parkway, Suite 301
Ridgeland, MS 39157

We have audited the accompanying statutory basis financial statements of UnitedHealthcare of Mississippi, Inc. (the "Company"), which comprise the statutory basis statements of admitted assets, liabilities, and capital and surplus as of December 31, 2019 and 2018, and the related statutory basis statements of operations, changes in capital and surplus, and cash flows for the years then ended, and the related notes to the statutory basis financial statements.

Management's Responsibility for the Statutory Basis Financial Statements

Management is responsible for the preparation and fair presentation of these statutory basis financial statements in accordance with the accounting practices prescribed or permitted by the Mississippi Insurance Department. Management is also responsible for the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

Auditors' Responsibility

Our responsibility is to express an opinion on these statutory basis financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the statutory basis financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the statutory basis financial statements. The procedures selected depend on the auditor's judgment including the assessment of the risks of material misstatement of the statutory basis financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the Company's preparation and fair presentation of the statutory basis financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Company's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the statutory basis financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, the statutory basis financial statements referred to above present fairly, in all material respects, the admitted assets, liabilities, and capital and surplus of UnitedHealthcare of Mississippi, Inc. as of December 31, 2019 and 2018, and the results of its operations and its cash flows for the years then ended in accordance with the accounting practices prescribed or permitted by the Mississippi Insurance Department described in Note 1 to the statutory basis financial statements.

Basis of Accounting

We draw attention to Note 1 of the statutory basis financial statements, which describes the basis of accounting. As described in Note 1 to the statutory basis financial statements, the statutory basis financial statements are prepared by UnitedHealthcare of Mississippi, Inc. using accounting practices prescribed or permitted by the Mississippi Insurance Department, which is a basis of accounting other than accounting principles generally accepted in the United States of America, to meet the requirements of the Mississippi Insurance Department. Our opinion is not modified with respect to this matter.

Report on Supplemental Schedules

Our 2019 audit was conducted for the purpose of forming an opinion on the 2019 statutory basis financial statements as a whole. The supplemental schedule of investment risks interrogatories and the supplemental summary investment schedule, as of and for the year ended December 31, 2019 are presented for the purpose of additional analysis and are not a required part of the 2019 statutory basis financial statements. These schedules are the responsibility of the Company's management and were derived from and relate directly to the underlying accounting and other records used to prepare the statutory basis financial statements. Such schedules have been subjected to the auditing procedures applied in our audit of the 2019 statutory basis financial statements and certain additional procedures, including comparing and reconciling such schedules directly to the underlying accounting and other records used to prepare the statutory basis financial statements or to the statutory basis financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States of America. In our opinion, such schedules are fairly stated in all material respects in relation to the 2019 statutory basis financial statements as a whole.

Restriction on Use

Our report is intended solely for the information and use of the Audit Committee and the management of UnitedHealthcare of Mississippi, Inc. and for filing with state insurance departments to whose jurisdiction the Company is subject and is not intended to be and should not be used by anyone other than these specified parties.

Deloitte & Touche LLP

April 21, 2020

UNITEDHEALTHCARE OF MISSISSIPPI, INC.

STATUTORY BASIS STATEMENTS OF ADMITTED ASSETS, LIABILITIES, AND CAPITAL AND SURPLUS AS OF DECEMBER 31, 2019 AND 2018

	2019	2018
ADMITTED ASSETS		
CASH AND INVESTED ASSETS:		
Bonds	$ 152,856,919	$ 149,765,510
Cash of $49,541 and $153,685, cash equivalents of $56,705,676 and $68,745,768, and short-term investments of $0 and $2,673 in 2019 and 2018, respectively	56,755,217	68,902,126
Subtotal cash and invested assets	209,612,136	218,667,636
OTHER ASSETS:		
Investment income due and accrued	959,294	1,130,259
Premiums and considerations	43,310,114	53,925,680
Amounts recoverable from reinsurers	4,514	225,715
Amounts receivable relating to uninsured plans	-	739,899
Net deferred tax asset	915,298	1,159,535
Health care receivables	1,015,170	1,165,206
Subtotal other assets	46,204,390	58,346,294
TOTAL ADMITTED ASSETS	$ 255,816,526	$ 277,013,930
LIABILITIES AND CAPITAL AND SURPLUS		
LIABILITIES:		
Claims unpaid	$ 63,948,758	$ 79,509,238
Accrued medical incentive pool and bonus amounts	1,436,114	502,604
Unpaid claims adjustment expenses	652,988	769,995
Aggregate health policy reserves	39,599	22,122
Aggregate health claim reserves	1,256,730	1,623,150
Premiums received in advance	9,031,531	609,000
General expenses due or accrued	3,656,429	21,920,742
Current federal income taxes payable	707,861	3,405,803
Amounts withheld or retained for the account of others	-	7,171
Remittances and items not allocated	36,854	-
Amounts due to parent, subsidiaries, and affiliates, net	5,390,800	3,796,013
Liability for amounts held under uninsured plans	932,571	86,367
Other liabilities	-	10,000
Total liabilities	87,090,235	112,262,205
CAPITAL AND SURPLUS:		
Section 9010 ACA subsequent fee year assessment	18,820,864	-
Common capital stock, $0.01 par value — 2,000 shares authorized; 2,000 shares issued and outstanding	20	20
Gross paid-in and contributed surplus	145,327,293	165,327,293
Unassigned surplus (deficit)	4,578,114	(575,588)
Total capital and surplus	168,726,291	164,751,725
TOTAL LIABILITIES AND CAPITAL AND SURPLUS	$ 255,816,526	$ 277,013,930

See notes to statutory basis financial statements.

UNITEDHEALTHCARE OF MISSISSIPPI, INC.

STATUTORY BASIS STATEMENTS OF OPERATIONS
FOR THE YEARS ENDED DECEMBER 31, 2019 AND 2018

	2019	2018
REVENUES:		
Net premium income	$ 993,404,401	$ 1,144,574,860
Change in unearned premium reserves and reserve for rate credits	(5,348)	26,272
Total revenues	993,399,053	1,144,601,132
UNDERWRITING DEDUCTIONS:		
Hospital and medical:		
Hospital/medical benefits	597,066,689	725,171,293
Other professional services	63,106,623	73,857,370
Prescription drugs	186,603,946	189,075,107
Incentive pool, withhold adjustments, and bonus amounts	1,297,497	498,197
Net reinsurance incurred (recoveries)	153,641	(943,575)
Total hospital and medical	848,228,396	987,658,392
Claims adjustment expenses	44,809,281	42,748,017
General administrative expenses	78,313,042	106,834,975
Decrease in reserves for accident and health contracts	-	(28,006,000)
Total underwriting deductions	971,350,719	1,109,235,384
NET UNDERWRITING GAIN	22,048,334	35,365,748
NET INVESTMENT GAINS:		
Net investment income earned	5,272,428	4,299,487
Net realized capital gains (losses) less capital gains tax of $51,015 and $5,993 in 2019 and 2018, respectively	157,593	(11,710)
Total net investment gains	5,430,021	4,287,777
NET LOSS FROM PREMIUM BALANCES CHARGED OFF	(9,367)	(70,875)
OTHER LOSSES	(10,300)	(10,000)
NET INCOME BEFORE FEDERAL INCOME TAXES	27,458,688	39,572,650
FEDERAL INCOME TAXES INCURRED	5,980,846	6,945,808
NET INCOME	$ 21,477,842	$ 32,626,842

See notes to statutory basis financial statements.

UNITEDHEALTHCARE OF MISSISSIPPI, INC.

STATUTORY BASIS STATEMENTS OF CHANGES IN CAPITAL AND SURPLUS
FOR THE YEARS ENDED DECEMBER 31, 2019 AND 2018

	Section 9010 ACA Subsequent Fee Year Assessment	Common Capital Stock		Gross Paid-In and Contributed Surplus	Unassigned Surplus (Deficit)	Total Capital and Surplus
		Shares	Amount			
BALANCE — January 1, 2018	$ 24,958,691	2,000	$ 20	$ 165,327,293	$ (49,653,639)	$ 140,632,365
Net income	-	-	-	-	32,626,842	32,626,842
Change in net unrealized capital gains on investments less capital gains tax of $1	-	-	-	-	2	2
Section 9010 ACA subsequent fee year assessment	(24,958,691)	-	-	-	24,958,691	-
Change in nonadmitted assets	-	-	-	-	(2,909,884)	(2,909,884)
Change in net deferred income taxes	-	-	-	-	(5,597,600)	(5,597,600)
BALANCE — December 31, 2018	-	2,000	20	165,327,293	(575,588)	164,751,725
Net income	-	-	-	-	21,477,842	21,477,842
Dividend to parent	-	-	-	(20,000,000)	-	(20,000,000)
Change in net unrealized capital gains on investments less capital gains tax of $101	-	-	-	-	380	380
Section 9010 ACA subsequent fee year assessment	18,820,864	-	-	-	(18,820,864)	-
Change in nonadmitted assets	-	-	-	-	2,740,480	2,740,480
Change in net deferred income taxes	-	-	-	-	(244,136)	(244,136)
BALANCE — December 31, 2019	$ 18,820,864	2,000	$ 20	$ 145,327,293	$ 4,578,114	$ 168,726,291

See notes to statutory basis financial statements.

UNITEDHEALTHCARE OF MISSISSIPPI, INC.

STATUTORY BASIS STATEMENTS OF CASH FLOWS
FOR THE YEARS ENDED DECEMBER 31, 2019 AND 2018

	2019	2018
CASH FLOWS FROM OPERATIONS:		
Premiums collected, net of reinsurance	$ 1,012,455,647	$ 1,112,402,863
Net investment income	5,909,490	5,024,895
Benefit and loss related payments	(860,102,574)	(988,695,927)
Operating expenses paid	(139,966,066)	(140,114,933)
Federal income taxes paid, net	(8,729,803)	(5,489,964)
Net cash provided by (used in) operations	9,566,694	(16,873,066)
CASH FLOWS FROM INVESTMENTS:		
Proceeds from investments:		
Bonds sold or matured	66,570,710	24,586,424
Miscellaneous proceeds (applications)	482	(1,268)
Total investment proceeds	66,571,192	24,585,156
Cost of investments acquired:		
Bonds	(69,916,434)	(31,821,751)
Total cost of investments acquired	(69,916,434)	(31,821,751)
Net cash used in investments	(3,345,242)	(7,236,595)
CASH FLOWS FROM FINANCING AND MISCELLANEOUS ACTIVITIES:		
Cash provided through net transfers from affiliates	1,594,787	806,512
Dividend to parent	(20,000,000)	-
Other cash provided	36,852	-
Net cash (used in) provided by financing and miscellaneous activities	(18,368,361)	806,512
RECONCILIATION OF CASH, CASH EQUIVALENTS, AND SHORT-TERM INVESTMENTS:		
NET CHANGE IN CASH, CASH EQUIVALENTS, AND SHORT-TERM INVESTMENTS	(12,146,909)	(23,303,149)
CASH, CASH EQUIVALENTS, AND SHORT-TERM INVESTMENTS — Beginning of year	68,902,126	92,205,275
CASH AND CASH EQUIVALENTS — End of year	$ 56,755,217	$ 68,902,126

See notes to statutory basis financial statements.

1. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES AND GOING CONCERN

Organization and Operation

UnitedHealthcare of Mississippi, Inc. (the "Company"), licensed as a health maintenance organization ("HMO"), offers its enrollees a variety of managed care programs and products through contractual arrangements with health care providers. The Company is a wholly owned subsidiary of UnitedHealthcare, Inc. ("UHC"). UHC is a wholly owned subsidiary of United HealthCare Services, Inc. ("UHS"), a management corporation that provides services to the Company under the terms of a management agreement (the "Agreement"). UHS is a wholly owned subsidiary of UnitedHealth Group Incorporated ("UnitedHealth Group"). UnitedHealth Group is a publicly held company trading on the New York Stock Exchange.

The Company was incorporated on August 6, 1990, as an HMO and operations commenced in January 1993. The Company is certified as an HMO by the Mississippi Insurance Department (the "Department"). The Company has entered into contracts with physicians, hospitals, and other health care provider organizations to deliver health care services for all enrollees. The Company is licensed in the State of Mississippi.

The Company offers comprehensive commercial products to employer groups. Each contract outlines the coverage provided and renewal provisions.

The Company has a contract with the State of Mississippi, Division of Medicaid ("Mississippi DOM") to provide health care services to Medicaid eligible beneficiaries in Mississippi. The program referred to as the Mississippi Coordinated Access Network ("Mississippi CAN"), targets high-risk Medicaid beneficiaries. The current contract is effective through June 30, 2020, and includes an option for two (2) one-year extensions thereafter.

The Company also has a contract with the Mississippi DOM to provide health care services to eligible beneficiaries under the Children's Health Insurance Program ("CHIP") in Mississippi. The current contract is effective through July 31, 2022 and includes an option for two (2) one-year extensions thereafter.

A. Accounting Practices

The statutory basis financial statements of the Company are presented on the basis of accounting practices prescribed or permitted by the Department.

The Department recognizes only statutory accounting practices, prescribed or permitted by the State of Mississippi, for determining and reporting the financial condition and results of operations of an HMO, for determining its solvency under Mississippi Insurance Law. The state prescribes the use of the National Association of Insurance Commissioners' ("NAIC") Accounting Practices and Procedures manual ("NAIC SAP") in effect for the accounting periods covered in the statutory basis financial statements.

No significant differences exist between the practices prescribed or permitted by the State of Mississippi and the NAIC SAP which materially affect the statutory basis net income and capital and surplus, as illustrated in the table below:

		SSAP #	AFS Line #	December 31, 2019	December 31, 2018
Net Income					
(1)	Company state basis	XXX	XXX	$ 21,477,842	$ 32,626,842
(2)	State prescribed practices that are an increase/(decrease) from NAIC SAP: Not Applicable			-	-
(3)	State permitted practices that are an increase/(decrease) from NAIC SAP: Not Applicable			-	-
(4)	NAIC SAP (1 - 2 - 3 = 4)	XXX	XXX	$ 21,477,842	$ 32,626,842
Capital and Surplus					
(5)	Company state basis	XXX	XXX	$ 168,726,291	$ 164,751,725
(6)	State prescribed practices that are an increase/(decrease) from NAIC SAP: Not Applicable			-	-
(7)	State permitted practices that are an increase/(decrease) from NAIC SAP: Not Applicable			-	-
(8)	NAIC SAP (5 - 6 - 7 = 8)	XXX	XXX	$ 168,726,291	$ 164,751,725

B. Use of Estimates in the Preparation of the Statutory Basis Financial Statements

The preparation of these statutory basis financial statements in conformity with the NAIC Annual Statement Instructions and the NAIC SAP include certain amounts that are based on the Company's estimates and judgments. These estimates require the Company to apply complex assumptions and judgments, often because the Company must make estimates about the effects of matters that are inherently uncertain and will change in subsequent periods. The most significant estimates relate to hospital and medical benefits, claims unpaid, aggregate health policy reserves (including premium deficiency reserves ("PDR")) and aggregate health claim reserves. The Company adjusts these estimates each period as more current information becomes available. The impact of any changes in estimates is included in the determination of net income in the period in which the estimate is adjusted.

C. Accounting Policy

Basis of Presentation — The Company prepares its statutory basis financial statements on the basis of accounting practices prescribed or permitted by the Department. These statutory practices differ from accounting principles generally accepted in the United States of America ("GAAP").

Accounting policy disclosures that are required by the NAIC Annual Statement instructions are as follows:

(1–2) Bonds and short-term investments are stated at book/adjusted carrying value if they meet NAIC designation of one or two and stated at the lower of book/adjusted carrying value or fair value if they meet an NAIC designation of three or higher. The Company does not have

any mandatory convertible securities or Securities Valuation Office of the NAIC ("SVO") identified funds (i.e.: exchange traded funds or bond mutual funds) in its bond portfolio. Amortization of bond premium or accretion of discount is calculated using the constant-yield interest method. Bonds and short-term investments are valued and reported using market prices published by the SVO in accordance with the NAIC Valuation of Securities manual prepared by the SVO or an external pricing service;

(3–4) The Company holds no common or preferred stock;

(5) The Company holds no mortgage loans on real estate;

(6) U.S. government and agency securities and corporate debt securities include loan-backed securities (mortgage-backed securities and asset-backed securities), which are valued using the retrospective adjustment methodology. Prepayment assumptions for the determination of the book/adjusted carrying value, commonly referred to as amortized cost, of loan-backed securities are based on a three-month constant prepayment rate history obtained from external data source vendors. The Company's investment policy limits investments in nonagency residential mortgage-backed securities, including home equity and sub-prime mortgages, to 10% of total cash and invested assets. Total combined investments in mortgage-backed securities and asset-backed securities cannot exceed more than 30% of total cash and invested assets;

(7) The Company holds no investments in subsidiaries, controlled, or affiliated entities;

(8) The Company has no investment interests with respect to joint ventures, partnerships, or limited liability companies;

(9) The Company holds no derivatives;

(10) PDR (inclusive of conversion reserves) and the related expenses are recognized when it is probable that expected future health care expenses, claims adjustment expenses ("CAE"), direct administration costs, and an allocation of indirect administration costs under a group of existing contracts will exceed anticipated future premiums and reinsurance recoveries considered over the remaining lives of the contracts, and are recorded as aggregate health policy reserves in the statutory basis statements of admitted assets, liabilities, and capital and surplus. Indirect administration costs arise from activities that are not specifically identifiable to a specific group of existing contracts, and therefore, those costs are fully allocated among the various contract groupings. The allocation of indirect administration costs to each contract grouping is made proportionately to the expected margins remaining in the premiums after future health care expenses, CAE, and direct administration costs are considered. The data and assumptions underlying such estimates and the resulting reserves are periodically updated, and any adjustments are reflected as a decrease in reserves for accident and health contracts in the statutory basis statements of operations in the period in which the change in estimate is identified. The Company anticipates investment income as a factor in the PDR calculation (see Note 30);

(11) CAE are those costs expected to be incurred in connection with the adjustment and recording of accident and health claims. Pursuant to the terms of the Agreement (see Note 10), the Company pays a management fee to its affiliate, UHS, in exchange for administrative and management services. A detailed review of the administrative expenses of the Company and UHS is performed to determine the allocation between CAE and general administrative expenses ("GAE") to be reported in the statutory basis statements of operations. It is the responsibility of UHS to pay CAE in the event the Company ceases operations. The Company has recorded an estimate of unpaid CAE associated with incurred but unpaid claims, which is included in unpaid CAE in the statutory basis statements of admitted assets, liabilities, and capital and surplus. Management believes

the amount of the liability for unpaid CAE as of December 31, 2019 is adequate to cover the Company's cost for the adjustment and recording of unpaid claims; however, actual expenses may differ from those established estimates. Adjustments to the estimates for unpaid CAE are reflected in operating results in the period in which the change in estimate is identified;

(12) The Company does not carry any fixed assets on the statutory basis financial statements;

(13) Health care receivables consist of pharmacy rebates receivable estimated based on the most currently available data from the Company's claims processing systems and from data provided by the Company's unaffiliated pharmaceutical benefit manager and affiliated pharmaceutical benefit manager, OptumRx, Inc. ("OptumRx"). Health care receivables also include receivables for claim overpayments to providers, hospitals and other health care organizations. Health care receivables are considered nonadmitted assets under the NAIC SAP if they do not meet admissibility requirements. Accordingly, the Company has excluded receivables that do not meet the admissibility criteria from the statutory basis statements of admitted assets, liabilities, and capital and surplus (see Note 28).

The Company has also deemed the following to be significant accounting policies and/or differences between statutory practices and GAAP:

ASSETS

Cash and Invested Assets

- Bonds include U.S. government and agency securities, state and agency municipal securities, city and county municipal securities, and corporate debt securities, with a maturity of greater than one year at the time of purchase;

- Certain debt investments categorized as available-for-sale or held-to-maturity under GAAP are presented at the lower of book/adjusted carrying value or fair value in accordance with the NAIC designations in the statutory basis financial statements, whereas under GAAP, these investments are shown at fair value or book/adjusted carrying value, respectively;

- Cash, cash equivalents, and short-term investments in the statutory basis financial statements represent cash balances and investments with original maturities of one year or less from the time of acquisition, whereas under GAAP, the corresponding caption of cash, cash equivalents, and short-term investments includes cash balances and investments that will mature in one year or less from the balance sheet date;

- Cash represents cash held by the Company in operating accounts. Claims and other payments are made from the operating accounts daily;

- Cash equivalents include money-market funds. Cash equivalents have original maturity dates of three months or less from the date of acquisition. Cash equivalents, excluding money-market funds, are reported at cost or book/adjusted carrying value depending on the nature of the underlying security, which approximates fair value. Money-market funds are reported at fair value or net asset value ("NAV") as a practical expedient;

- Short-term investments include corporate debt securities. Short-term investments have a maturity of greater than three months but less than one year at the time of purchase. Short-term investments also consist of the Company's share of an investment pool sponsored and administered by UHS. The investment pool consists principally of investments with original maturities of less than one year, with the average life of the individual investments

being less than 60 days. The Company's share of the pool represents an undivided ownership interest in the pool and is immediately convertible to cash at no cost or penalty. The participants within the pool have an individual fund number to track those investments owned by the Company. In addition, the Company is listed as a participant in the executed custodial agreement between UHS and the custodian whereby the Company's share in the investment pool is segregated and separately maintained. The pool is primarily invested in government obligations, commercial paper, certificates of deposit, and short-term agency notes and is recorded at cost or book/adjusted carrying value depending on the composition of the underlying securities. Interest income from the pool accrues daily to participating members based upon ownership percentage;

- Realized capital gains and losses on sales of investments are calculated based upon specific identification of the investments sold. These gains and losses are reported as net realized capital gains (losses) less capital gains tax in the statutory basis statements of operations;

- The Company continually monitors the difference between amortized cost and estimated fair value of its investments. If any of the Company's investments experience a decline in value that the Company has determined is other-than-temporary, or if the Company has determined it will sell a security that is in an impaired status, the Company will record a realized loss in net realized capital gains (losses) less capital gains tax in the statutory basis statements of operations. The new cost basis is not changed for subsequent recoveries in fair value. The prospective adjustment method is utilized for loan-backed securities for periods subsequent to the loss recognition. The Company recognized an other-than-temporary impairment ("OTTI") of $833 and $0 for the years ended December 31, 2019 and 2018, respectively;

- The NAIC SAP requires the following captions to be taken into consideration in the reconciliation of the statutory basis statements of cash flows: cash, cash equivalents, and short-term investments, which can include restricted cash reserves, with original maturities of one year or less from the time of acquisition, whereas under GAAP, pursuant to Accounting Standards Update 2016-18, *Statement of Cash Flows, Restricted Cash*, the statements of cash flows reconcile the corresponding captions of cash, cash equivalents and restricted cash with maturities of three months or less. Short-term investments with a final maturity of one year or less from the balance sheet date are not included in the reconciliation of GAAP cash flows. In addition, there are classification differences within the presentation of the cash flow categories between GAAP and NAIC SAP. The statutory basis statements of cash flows are prepared in accordance with the NAIC Annual Statement Instructions.

Other Assets

- **Investment Income Due and Accrued** — Investment income earned and due as of the reporting date, in addition to investment income earned but not paid or collected until subsequent periods, is reported as investment income due and accrued in the statutory basis statements of admitted assets, liabilities, and capital and surplus. The Company evaluates the collectability of the amounts due and accrued and amounts determined to be uncollectible are written off in the period in which the determination is made. In addition, the remaining balance is assessed for admissibility and any balance greater than 90 days past due is considered a nonadmitted asset.

- **Premiums and Considerations** — The Company reports uncollected premium balances from its insured members, groups, and state Medicaid agency as premiums and considerations in the statutory basis statements of admitted assets, liabilities, and capital and surplus. Uncollected premium balances that are over 90 days past due, with the

exception of amounts due from government insured plans, are considered nonadmitted assets. In addition to those balances, current balances are also considered nonadmitted if the corresponding balance greater than 90 days past due is deemed more than inconsequential. Premiums and considerations also include the following:

a) risk adjustment receivables as defined in Section 1343 of the ACA. Premium adjustments are based upon the risk scores (health status) of enrollees participating in risk adjustment covered plans, rather than the actual loss experience of the insured. Effective for 2018 benefit plan year, the risk adjustments and distributions are calculated using a high-cost risk pool which adds a reinsurance-like element to this program. A risk adjustment receivable is recorded when the Company estimates its average actuarial risk score for policies included in this program is greater than the average actuarial risk scores in that market and state risk pool (see Note 24); and

b) the pay for performance program receivables based upon the Company's performance against various quality and operational measures established in the Company's contract with the State which is based on a stated percentage of total direct premiums written. Premium adjustments for the Medicaid performance guarantee program are accounted for as premium adjustments subject to redetermination (see Note 24).

- **Amounts Receivable Relating to Uninsured Plans** — Effective December 1, 2015, the Company has contracted with the Mississippi DOM to participate in the Mississippi Hospital Access Program ("MHAP"). This program helps to ensure sufficient access to inpatient hospital services for the Medicaid population by including enhanced hospital reimbursement in the capitation rates to be "passed-through" from Mississippi DOM to its hospitals. Effective July 1, 2019, the Company has contracted with the Mississippi DOM to participate in the Mississippi Medicaid Access to Physician Services Program ("MAPS"). This program provides enhanced pass-through payments to physicians and other service practitioners who are employed by a qualifying hospital or assigned Mississippi Medicaid payments to a qualifying hospital. The Company has no financial or member risk under these pass-through arrangements. The Company records a receivable for any MHAP and MAPS amount due from Mississippi DOM, which is included in amounts receivable relating to uninsured plans in the statutory basis statements of admitted assets, liabilities, and capital and surplus (see Note 18).

- **Net Deferred Tax Asset** — The NAIC SAP provides for an amount to be recorded for deferred taxes on temporary differences between the financial reporting and tax bases of assets, subject to a valuation allowance and admissibility limitations on deferred tax assets (see Note 9). In addition, under the NAIC SAP, the change in deferred tax assets is recorded directly to unassigned surplus (deficit) in the statutory basis financial statements, whereas under GAAP, the change in deferred tax assets is recorded as a component of the income tax provision within the income statement and is based on the ultimate recoverability of the deferred tax assets. Based on the admissibility criteria under the NAIC SAP, any deferred tax assets determined to be nonadmitted are charged directly to surplus and excluded from the statutory basis financial statements, whereas under GAAP, such assets are included in the balance sheet.

LIABILITIES

- **Claims Unpaid and Aggregate Health Claim Reserves** — Claims unpaid and aggregate health claim reserves include claims processed but not yet paid, estimates for claims received but not yet processed, estimates for the costs of health care services enrollees

have received but for which claims have not yet been submitted, and payments and liabilities for physician, hospital, and other medical costs disputes.

The estimates for incurred but not yet reported claims are developed using an actuarial process that is consistently applied, centrally controlled, and automated. The actuarial models consider factors such as historical submission and payment data, cost trends, customer and product mix, seasonality, utilization of health care services, contracted service rates, and other relevant factors. The Company estimates such liabilities for physician, hospital, and other medical cost disputes based upon an analysis of potential outcomes, assuming a combination of litigation and settlement strategies. These estimates may change as actuarial methods change or as underlying facts upon which estimates are based change. The Company did not change actuarial methods during 2019 and 2018. Management believes the amount of claims unpaid and aggregate health claim reserves is a best estimate of the Company's liability for unpaid claims and aggregate health claim reserves as of December 31, 2019; however, actual payments may differ from those established estimates.

The reserves ceded to reinsurers for claims unpaid and aggregate health claim reserves have been reported as reductions of the related reserves rather than as assets, which would be required under GAAP.

The Company contracts with hospitals, physicians, and other providers of health care under capitated or discounted fee for service arrangements, including a hospital per diem to provide medical care services to enrollees. Some of these contracts are with related parties (see Note 10). Capitated providers are at risk for the cost of medical care services provided to the Company's enrollees; however, the Company is ultimately responsible for the provision of services to its enrollees should the capitated provider be unable to provide the contracted services.

- **Accrued Medical Incentive Pool and Bonus Amounts** — The Company has agreements with certain independent physicians and physician network organizations that provide for the establishment of a fund into which the Company places monthly premiums payable for members assigned to the physician. The Company manages the disbursement of funds from this account as well as reviews the utilization of nonprimary care medical services of members assigned to the physicians. Any surpluses in the fund are shared by the Company and the physician based upon predetermined risk-sharing percentage and the liability is included in accrued medical incentive pool and bonus amounts in the statutory basis statements of admitted assets, liabilities, and capital and surplus. The Company has incentive and bonus arrangements with providers that are based on quality, utilization, and/or various health outcome measures. The estimated amount due to providers that meet the established metrics is included in accrued medical incentive pool and bonus amounts in the statutory basis statements of admitted assets, liabilities, and capital and surplus.

- **Aggregate Health Policy Reserves** — The Company establishes a liability, net of ceded reinsurance, for estimated accrued retrospective and redetermination premiums due from the Company based on the actuarial method and assumptions for each respective contract. Aggregate health policy reserves also includes:

  a) risk adjustment payables as defined in Section 1343 of the ACA. Premium adjustments are based upon the risk scores (health status) of enrollees participating in risk adjustment covered plans, rather than the actual loss experience of the insured. Effective for 2018 benefit plan year, the risk adjustments and distributions are calculated using a high-cost risk pool which adds a reinsurance-like element to this program. A risk adjustment payable is recorded when the Company estimates its

average actuarial risk score for policies included in this program is less than the average actuarial risk scores in that market and state risk pool (see Note 24);

b) unearned premiums are established for the portion of premiums received during the current period that are partially unearned at the end of the period and are included in aggregate health policy reserves in the statutory basis statements of admitted assets, liabilities, and capital and surplus; and

c) the estimated amount for PDR (see Note 30).

- **Premiums Received in Advance** — Premiums received in full for the policies processed during the current period, but prior to the commencement of the service period, are recorded as premiums received in advance in the statutory basis statements of admitted assets, liabilities, and capital and surplus.

- **General Expenses Due or Accrued** — General expenses that are due as of the reporting date in addition to general expenses that have been incurred but are not due until a subsequent period are reported as general expenses due or accrued in the statutory basis statements of admitted assets, liabilities, and capital and surplus. General expenses due or accrued also include the amounts for unpaid assessments, premium taxes, state income taxes and the unpaid portion of the contributions required under the ACA risk adjustment and reinsurance programs (see Note 24).

- **Current Federal Income Taxes Payable** — The Company is included in the consolidated federal income tax return with its ultimate parent, UnitedHealth Group under which taxes approximate the amount that would have been computed on a separate company basis, with the exception of net operating losses and capital losses. For these losses, the Company receives a benefit at the federal rate in the current year for current taxable losses incurred in that year to the extent losses can be utilized in the consolidated federal income tax return of UnitedHealth Group. A liability for federal income taxes payable is recognized when its allocated intercompany estimated payments are less than its actual calculated obligation based on the Company's stand-alone federal income tax return (see Note 9).

- **Remittances and Items Not Allocated** — Remittances and items not allocated generally represent monies received from policyholders for monthly premium billings or providers that have not been specifically identified or applied prior to year-end. The majority is from monies received in the lockbox account on the last day of the year.

- **Amounts Due to Parent, Subsidiaries, and Affiliates, Net** — In the normal course of business, the Company has various transactions with related parties (see Note 10). The Company reports any unsettled amounts owed as amounts due to parent, subsidiaries, and affiliates, net, in the statutory basis statements of admitted assets, liabilities, and capital and surplus.

- **Liability for Amounts Held under Uninsured Plans** — Liability for amounts held under uninsured plans include the pass-through payments to the hospitals that are unpaid under the MHAP and MAPS programs (see Amounts Receivable Relating to Uninsured Plans in Note 1). The Company has no financial or member risk under these pass-through arrangements. The Company records the unpaid pass-through payments in liability for amounts held under uninsured plans in the statutory basis statements of admitted assets, liabilities, and capital and surplus (see Note 18).

CAPITAL AND SURPLUS AND MINIMUM STATUTORY REQUIREMENTS

- **Nonadmitted Assets** — Certain assets, including certain aged premium receivables, certain health care receivables, and prepaid expenses, are considered nonadmitted assets

under the NAIC SAP and are excluded from the statutory basis statements of admitted assets, liabilities, and capital and surplus and charged directly to unassigned surplus (deficit). Under GAAP, such assets are included in the balance sheet.

- **Restricted Cash Reserves** — The Company held regulatory deposits in the amount of $606,921 and $614,771 as of December 31, 2019 and 2018, respectively, in compliance with the state requirements for qualification purposes as a domestic insurer. These restricted cash reserves consist principally of government obligations and are stated at book/adjusted carrying value, which approximates fair value. These restricted deposits are included in bonds in the statutory basis statements of admitted assets, liabilities, and capital and surplus. Interest earned on these deposits accrues to the Company.

- **Minimum Capital and Surplus** — Under the laws of the State of Mississippi, the Department requires the Company to maintain a minimum capital and surplus equal to the greater of $1,000,000; 2% of the first $150,000,000 of annual premium revenue and 1% of annual premium revenue over $150,000,000, or an amount equal to three months of uncovered health care expenditures. The minimum capital and surplus requirement was $11,433,991 and $12,946,011 for December 31, 2019 and 2018, respectively, which was based on premium revenue, as that produced the highest minimum requirement. The Company is in compliance with the required amount.

  Risk-based capital ("RBC") is a regulatory tool for measuring the minimum amount of capital appropriate for a managed care organization to support its overall business operations in consideration of its size and risk profile. The Department requires the Company to maintain minimum capital and surplus equal to the greater of the state statute as outlined above, or the company action level as calculated by the RBC formula, or the level needed to avoid action pursuant to the trend test in the RBC formula. The Company is in compliance with the required amount.

- **Section 9010 ACA Subsequent Fee Year Assessment** — The Company is subject to the Section 9010 ACA subsequent fee year assessment. Under the NAIC SAP, an amount equal to the estimated subsequent year fee must be apportioned out of unassigned surplus (deficit) and reported as Section 9010 ACA subsequent fee year assessment, in the statutory basis statements of admitted assets, liabilities, and capital and surplus, whereas under GAAP, no such special surplus designation is required. In accordance with the 2019 Health Insurer Fee ("HIF") moratorium, no HIF was payable in 2019, therefore no amounts were apportioned out of unassigned surplus (deficit) in the 2018 statutory basis statements of admitted assets, liabilities, and capital and surplus.

STATEMENTS OF OPERATIONS

- **Net Premium Income and Change in Unearned Premium Reserves and Reserve for Rate Credits** — Revenues consist of net premium income that is recognized in the period in which enrollees are entitled to receive health care services. Net premium income is shown net of reinsurance premiums paid and reinsurance premiums incurred but not paid in the statutory basis statements of operations. The corresponding change in unearned premium from year to year is reflected as a change in unearned premium reserves and reserve for rate credits in the statutory basis statements of operations. Under GAAP, the change in unearned premium from year to year is reported through premium income.

  Comprehensive commercial health plans with medical loss ratios on fully insured products, as calculated under the definitions in the ACA (see Note 14) and implementing regulations, that fall below certain targets are required to rebate ratable portions of premiums annually. The Company classifies its estimated rebates as change in unearned premium reserves and reserve for rate credits in the statutory basis statements of operations.

Mississippi CAN and CHIP are subject to minimum loss ratio ("MLR") requirements, similar to those of the Health Reform Legislation, under the terms of the contract. Plans with medical loss ratios that fall below certain targets are required to rebate ratable portions of premiums annually. The Company classifies its estimated rebates as change in unearned premium reserves and reserve for rate credits in the statutory basis statements of operations.

Pursuant to Section 1343 of the ACA, the Company records premium adjustments for changes to the risk adjustment balances which are reflected in net premium income in the statutory basis statements of operations.

Net premium income also includes amounts paid by state and federal governments on a per member basis in exchange for the provision and administration of medical benefits under the Mississippi CAN and CHIP. Premiums are contractual and are recognized in the coverage period in which members are entitled to receive services, except in the case of maternity payments. Maternity income is billed on contractual rates and recognized as income as each birth case is identified by the Company. Included in net premium income are capitated payments, home nursing risk-sharing payments, high-dollar risk pool payments, and maternity payments. The majority of net premium income recorded is based on capitated rates, which are monthly premiums paid for each member enrolled. Home nursing risk-sharing income is payable based upon the number of members that qualify for such reimbursement.

- **Total Hospital and Medical Expenses** — Total hospital and medical expenses include claims paid, claims processed but not yet paid, estimates for claims received but not yet processed, estimates for the costs of health care services enrollees have received but for which claims have not yet been submitted, and payments and liabilities for physician, hospital, and other medical costs disputes.

  Total hospital and medical expenses also include amounts incurred for incentive pool, withhold adjustments, and bonus amounts that are based on the underlying contractual provisions with the respective providers. In addition, adjustments to claims unpaid estimates and aggregate health claim reserves are reflected in the period once the change in estimate is identified and included in total hospital and medical expenses in the statutory basis statements of operations.

- **General Administrative Expenses** — Pursuant to the terms of the Agreement (see Note 10), the Company pays a management fee to UHS in exchange for administrative and management services. Costs for items not included within the scope of the Agreement are directly expensed as incurred. State income taxes are also a component of GAE. A detailed review of the administrative expenses of the Company and UHS is performed to determine the allocation between CAE and GAE to be reported in the statutory basis statements of operations.

  The Company is subject to an annual fee under Section 9010 of the ACA. A health insurance entity's annual fee becomes payable once the entity provides health insurance for any U.S. health risk during the calendar year, which is nondeductible for tax purposes. Under the NAIC SAP, the entire amount of the estimated annual fee expense is recognized on January 1 of the fee year in GAE in the statutory basis statements of operations, whereas under GAAP, a deferred asset is created on January 1 of the fee year which is amortized to expense on a straight-line basis throughout the year.

- **Net Investment Income Earned** — Net investment income earned includes investment income collected during the period, as well as the change in investment income due and accrued on the Company's holdings. Amortization of premium or discount on bonds and

certain external investment management costs are also included in net investment income earned (see Note 7).

- **Federal Income Taxes Incurred** — The provision for federal income taxes incurred is calculated based on applying the statutory federal income tax rate of 21% to net income before federal income taxes and net realized capital gains (losses) subject to certain adjustments (see Note 9).

- **Comprehensive Income** — Comprehensive income and its components are not separately presented in the statutory basis financial statements, whereas under GAAP, it is a requirement to present comprehensive income and its components in the financial statements.

REINSURANCE

- **Reinsurance Ceded** — In the normal course of business, the Company seeks to limit its exposure to loss on any single insured and to recover a portion of benefits paid by ceding premium to other insurance enterprises or reinsurers under excess coverage contracts or specific transfer of risk agreements. The Company remains primarily liable as the direct insurer on the risks reinsured. Reinsurance premiums paid and reinsurance premiums incurred but not paid are deducted from net premium income in the statutory basis statements of operations. Any amounts due to the Company pursuant to this agreement are recorded as amounts recoverable from reinsurers in the statutory basis statements of admitted assets, liabilities, and capital and surplus (see Note 23).

  The Company had a reinsurance agreement with Unimerica Insurance Company ("Unimerica"), an affiliate, to cede obligations relating to mental health and substance abuse treatment and services (see Note 23). This reinsurance agreement was terminated effective December 31, 2017.

- **Amounts Recoverable from Reinsurers** — The Company records amounts recoverable from reinsurers for claims paid pursuant to the reinsurance agreement with Unimerica in the statutory basis statements of admitted assets, liabilities, and capital and surplus and as net reinsurance incurred (recoveries) in the statutory basis statements of operations.

- **Section 1341 ACA Transitional Reinsurance** — The Company has established receivables of $0 and $23,686 as of December 31, 2019 and 2018, respectively, which is included in amounts recoverable from reinsurers in the statutory basis statements of admitted assets, liabilities, and capital and surplus, for the transitional reinsurance program. This program was designed to protect issuers in the individual market from an expected increase in large claims due to the elimination of preexisting condition limitations (see Note 24).

- **Ceded Reinsurance Premiums Payable** — The ceded reinsurance premiums payable balance represents amounts due to the reinsurers for specified coverage which will be paid based on the contract terms.

OTHER

- **Vulnerability Due to Certain Concentrations** — The Company is subject to substantial federal and state government regulation, including licensing and other requirements relating to the offering of the Company's existing products in new markets and offerings of new products, both of which may restrict the Company's ability to expand its business.

The Company has no commercial customers that individually exceed 10% of total direct premiums written and uncollected premiums, including receivables for contracts subject to redetermination, for the years ended December 31, 2019 and 2018.

Direct premiums written and uncollected premiums, from the Mississippi DOM as a percentage of total direct premiums written and total uncollected premiums, including receivables for contracts subject to redetermination, are 98.7% and 99.8% as of December 31, 2019 and 98.2% and 99.3% as of December 31, 2018, respectively.

Recently Issued Accounting Standards — The Company reviewed all recently issued guidance in 2019 and 2018 that have been adopted for 2019 or subsequent years' implementation and has determined that none of the items would have a significant impact to the statutory basis financial statements.

D. Going Concern

The Company has the ability and will continue to operate for a period of time sufficient to carry out its commitments, obligations and business objectives.

2. ACCOUNTING CHANGES AND CORRECTION OF ERRORS

No changes in accounting principles or correction of errors have been recorded during the years ended December 31, 2019 and 2018.

3. BUSINESS COMBINATIONS AND GOODWILL

A–D. The Company was not party to a business combination during the years ended December 31, 2019 and 2018, and does not carry goodwill in its statutory basis statements of admitted assets, liabilities, and capital and surplus.

4. DISCONTINUED OPERATIONS

A. Discontinued Operation Disposed of or Classified as Held for Sale

(1–4) The Company did not have any discontinued operations disposed of or classified as held for sale during 2019 and 2018.

B. Change in Plan of Sale of Discontinued Operation — Not applicable.

C. Nature of any Significant Continuing Involvement with Discontinued Operations after Disposal — Not applicable.

D. Equity Interest Retained in the Discontinued Operation after Disposal — Not applicable.

5. INVESTMENTS AND OTHER INVESTED ASSETS

For purposes of calculating gross realized gains and losses on sales of investments, the amortized cost of each investment sold is used. The gross realized gains and losses on sales of long-term investments were $286,121 and $76,680, respectively, for 2019 and $4,961 and $9,406, respectively, for 2018. There were no gross realized gains and losses on sales on sales of short-term investments in 2019 and 2018. The net realized gain is included in net realized capital gains (losses) less capital gains tax in the statutory basis statements of operations. Total proceeds on the sale of long-term investments were $37,784,552 and $2,005,740 and for short-term investments were $2,688 and $0 in 2019 and 2018, respectively.

As of December 31, 2019 and 2018, the book/adjusted carrying value, fair value, and gross unrecognized unrealized gains and losses of the Company's investments, excluding cash and cash equivalents of $56,755,217 and $68,899,453, respectively, are as follows:

	2019				
	Book/Adjusted Carrying Value	Gross Unrecognized Unrealized Gains	Gross Unrecognized Unrealized Losses < 1 Year	Gross Unrecognized Unrealized Losses > 1 Year	Fair Value
U.S. government and agency securities	$ 20,707,826	$ 288,570	$ -	$ 2,586	$ 20,993,810
State and agency municipal securities	12,883,403	415,968	30,964	-	13,268,407
City and county municipal securities	13,291,608	359,735	41,190	-	13,610,153
Corporate debt securities	105,974,082	2,681,533	78,218	6,714	108,570,683
Total bonds	$ 152,856,919	$ 3,745,806	$ 150,372	$ 9,300	$ 156,443,053

	2019				
	Book/Adjusted Carrying Value	Gross Unrecognized Unrealized Gains	Gross Unrecognized Unrealized Losses < 1 Year	Gross Unrecognized Unrealized Losses > 1 Year	Fair Value
Less than one year	$ 18,130,879	$ 33,204	$ 286	$ 3,229	$ 18,160,568
One to five years	40,908,975	904,588	-	4,353	41,809,210
Five to ten years	28,364,660	1,782,192	16,261	-	30,130,591
Over ten years	65,452,405	1,025,822	133,825	1,718	66,342,684
Total bonds	$ 152,856,919	$ 3,745,806	$ 150,372	$ 9,300	$ 156,443,053

	2018				
	Book/Adjusted Carrying Value	Gross Unrecognized Unrealized Gains	Gross Unrecognized Unrealized Losses < 1 Year	Gross Unrecognized Unrealized Losses > 1 Year	Fair Value
U.S. government and agency securities	$ 24,356,311	$ 27,431	$ 76,348	$ 371,292	$ 23,936,102
State and agency municipal securities	16,966,159	79,458	4,128	43,765	16,997,724
City and county municipal securities	14,603,873	71,912	29,625	48,465	14,597,695
Corporate debt securities	93,841,840	122,002	308,700	877,077	92,778,065
Total bonds and short-term investments	$ 149,768,183	$ 300,803	$ 418,801	$ 1,340,599	$ 148,309,586

Included in U.S. government and agency securities and corporate debt securities in the tables above are mortgage-related loan-backed securities, which do not have a single maturity date. For the years to maturity table above, these securities have been presented in the maturity group based on the securities' final maturity date and at a book/adjusted carrying value of $39,325,222 and fair value of $39,806,508.

The following table illustrates the fair value and gross unrecognized unrealized losses, aggregated by investment category and length of time that the individual securities have been in a continuous unrecognized unrealized loss position as of December 31, 2019 and 2018:

	2019					
	< 1 Year		> 1 Year		Total	
	Fair Value	Gross Unrecognized Unrealized Losses	Fair Value	Gross Unrecognized Unrealized Losses	Fair Value	Gross Unrecognized Unrealized Losses
U.S. government and agency securities	$ -	$ -	$ 2,008,012	$ 2,586	$ 2,008,012	$ 2,586
State and agency municipal securities	3,173,359	30,964	-	-	3,173,359	30,964
City and county municipal securities	2,433,811	41,190	-	-	2,433,811	41,190
Corporate debt securities	15,793,954	78,218	3,948,465	6,714	19,742,419	84,932
Total bonds	$ 21,401,124	$ 150,372	$ 5,956,477	$ 9,300	$ 27,357,601	$ 159,672

	2018					
	< 1 Year		> 1 Year		Total	
	Fair Value	Gross Unrecognized Unrealized Losses	Fair Value	Gross Unrecognized Unrealized Losses	Fair Value	Gross Unrecognized Unrealized Losses
U.S. government and agency securities	$ 5,324,340	$ 76,348	$ 16,095,813	$ 371,292	$ 21,420,153	$ 447,640
State and agency municipal securities	5,123,886	4,128	5,412,314	43,765	10,536,200	47,893
City and county municipal securities	4,487,591	29,625	3,583,708	48,465	8,071,299	78,090
Corporate debt securities	25,777,185	308,700	53,000,185	877,077	78,777,370	1,185,777
Total bonds and short-term investments	$ 40,713,002	$ 418,801	$ 78,092,020	$ 1,340,599	$ 118,805,022	$ 1,759,400

The unrecognized unrealized losses on investments in U.S. government and agency securities, state and agency municipal securities, city and county municipal securities, and corporate debt securities at December 31, 2019 and 2018 were mainly caused by interest rate fluctuations and not by unfavorable changes in the credit ratings associated with these securities. The Company evaluates impairment at each reporting period for each of the securities whereby the fair value of the investment is less than its book/adjusted carrying value. The contractual cash flows of the U.S. government and agency securities are guaranteed either by the U.S. government or an agency of the U.S. government. It is expected that the securities would not be settled at a price less than the cost of the investment, and the Company does not intend to sell the investment until the unrealized loss is fully recovered. The Company evaluated the credit ratings of the municipal, state and local agency and corporate debt securities, noting whether a significant deterioration since purchase or other factors that may indicate an OTTI, such as the length of time and extent to which fair value has been less than cost, the financial condition, and near-term prospects of the issuer as well as specific events or circumstances that may influence the operations of the issuer and the Company's intent to sell the investment. Additionally, the Company evaluated its intent and ability to retain loan-backed securities for a period of time sufficient to recover the amortized cost. As a result of these reviews, the Company recorded an OTTI of $833 and $0 as of December 31, 2019 and 2018, respectively, which are included in net realized capital gains (losses) less capital gains tax in the statutory basis statements of operations.

A–C. The Company has no mortgage loans, real estate loans, restructured debt, or reverse mortgages. The Company also has no real estate property occupied by the Company, real estate property held for the production of income, or real estate property held for sale.

D. Loan-Backed Securities

(1) U.S. government and agency securities and corporate debt securities include loan-backed securities (mortgage-backed securities and asset-backed securities), which are valued using the retrospective adjustment methodology. Prepayment assumptions for the determination of the book/adjusted carrying value, commonly referred to as amortized cost,

of loan-backed securities are based on a three-month constant prepayment rate history obtained from external data source vendors.

(2) As of December 31, 2019, the Company has classified loan-backed securities that have OTTI as intent to sell. For the remaining loan-backed securities, the Company has the intent and ability to retain the investment in the security for a period of time sufficient to recover the amortized cost basis and determined that the present value of cash flows to be collected is equal to or exceeds the amortized cost basis of the security, as of December 31, 2019. The table below illustrates the aggregate OTTIs recognized on loan-backed securities classified on the basis for the OTTI during 2019:

	1 Amortized Cost Basis before Other-than-Temporary Impairment	2 Other-than-Temporary Impairment Recognized in Loss	3 Fair Value 1 - 2
OTTI Recognized 1st Quarter			
a. Intent to sell	$ -	$ -	$ -
b. Inability or lack of intent to retain the investment in the security for a period of time sufficient to recover the amortized cost basis	-	-	-
c. Total 1st Quarter	$ -	$ -	$ -
OTTI Recognized 2nd Quarter			
d. Intent to sell	$ -	$ -	$ -
e. Inability or lack of intent to retain the investment in the security for a period of time sufficient to recover the amortized cost basis	-	-	-
f. Total 2nd Quarter	$ -	$ -	$ -
OTTI Recognized 3rd Quarter			
g. Intent to sell	$ 176,925	$ 833	$ 176,092
h. Inability or lack of intent to retain the investment in the security for a period of time sufficient to recover the amortized cost basis	-	-	-
i. Total 3rd Quarter	$ 176,925	$ 833	$ 176,092
OTTI Recognized 4th Quarter			
j. Intent to sell	$ -	$ -	$ -
k. Inability or lack of intent to retain the investment in the security for a period of time sufficient to recover the amortized cost basis	-	-	-
l. Total 4th Quarter	$ -	$ -	$ -
m. Annual aggregate total		$ 833	

The Company did not recognize any OTTI on loan-backed securities due to an inability or lack of intent to retain the investment in the security for a period of time sufficient to recover the amortized cost basis, or where the present value of cash flows expected to be collected is less than the amortized cost basis of the security, as of December 31, 2019.

The Company did not recognize any OTTI on loan-backed securities as of December 31, 2018.

(3) The table below represents the loan-backed securities with an OTTI for the year ended December 31, 2019, presented by CUSIP:

	2019					
1	2	3	4	5	6	7
CUSIP	Book/Adjusted Carrying Value Amortized Cost before Current Period OTTI	Present Value of Projected Cash Flows	Recognized OTTI	Amortized Cost After OTTI	Fair Value at Time of OTTI	Date of Financial Statement Where Reported
12594MAZ1	$ 176,925	$ 176,092	$ 833	$ 176,092	$ 176,092	9/30/2019
Total	$ 176,925	$ 176,092	$ 833	$ 176,092	$ 176,092	

The Company did not have any loan-backed securities with an OTTI to report by CUSIP as of December 31, 2018.

(4) The following table illustrates the fair value, gross unrecognized unrealized losses, and length of time that the loan-backed securities have been in a continuous unrecognized unrealized loss position as of December 31, 2019 and 2018:

	2019
The aggregate amount of unrealized losses:	
1. Less than 12 months	$ 64,232
2. 12 months or longer	2,353
The aggregate related fair value of securities with unrealized losses:	
1. Less than 12 months	14,238,752
2. 12 months or longer	1,164,748

	2018
The aggregate amount of unrealized losses:	
1. Less than 12 months	$ 108,512
2. 12 months or longer	475,601
The aggregate related fair value of securities with unrealized losses:	
1. Less than 12 months	9,214,137
2. 12 months or longer	22,944,479

(5) The Company believes that it will collect all principal and interest due on all investments that have an amortized cost in excess of fair value. The unrecognized unrealized losses as of December 31, 2019 and 2018 were primarily caused by interest rate increases and not by unfavorable changes in the credit ratings associated with these securities.

E. Dollar Repurchase Agreements and/or Securities Lending Transactions — Not applicable.

F. Repurchase Agreements Transactions Accounted for as Secured Borrowing — Not applicable.

G. Reverse Repurchase Agreements Transactions Accounted for as Secured Borrowing — Not applicable.

H. Repurchase Agreements Transactions Accounted for as a Sale — Not applicable.

I. Reverse Repurchase Agreements Transactions Accounted for as a Sale — Not applicable.

J. Real Estate — Not applicable.

K. Low-Income Housing Tax Credits — Not applicable.

L. Restricted Assets

(1) Restricted assets, including pledged securities as of December 31, 2019 and 2018, are presented below:

	Restricted Asset Category	1 Total Gross (Admitted & Nonadmitted) Restricted from Current Year	2 Total Gross (Admitted & Nonadmitted) Restricted from Prior Year	3 Increase/ (Decrease) (1 Minus 2)	4 Total Current Year Nonadmitted Restricted	5 Total Current Year Admitted Restricted (1 minus 4)	6 Gross (Admitted & Nonadmitted) Restricted to Total Assets (a)	7 Admitted Restricted to Total Admitted Assets (b)
a.	Subject to contractual obligation for which liability is not shown	$ -	$ -	$ -	$ -	$ -	- %	- %
b.	Collateral held under security lending agreements	-	-	-	-	-	-	-
c.	Subject to repurchase agreements	-	-	-	-	-	-	-
d.	Subject to reverse repurchase agreements	-	-	-	-	-	-	-
e.	Subject to dollar repurchase agreements	-	-	-	-	-	-	-
f.	Subject to dollar reverse repurchase agreements	-	-	-	-	-	-	-
g.	Placed under option contracts	-	-	-	-	-	-	-
h.	Letter stock or securities restricted as to sale — excluding FHLB capital stock	-	-	-	-	-	-	-
i.	FHLB capital stock	-	-	-	-	-	-	-
j.	On deposit with states	606,921	614,771	(7,850)	-	606,921	-	-
k.	On deposit with other regulatory bodies	-	-	-	-	-	-	-
l.	Pledged as collateral to FHLB (including assets backing funding agreements)	-	-	-	-	-	-	-
m.	Pledged as collateral not captured in other categories	-	-	-	-	-	-	-
n.	Other restricted assets	-	-	-	-	-	-	-
o.	Total restricted assets	$ 606,921	$ 614,771	$ (7,850)	$ -	$ 606,921	- %	- %

(a) Column 1 divided by Asset Page, Column 1, Line 28
(b) Column 5 divided by Asset Page, Column 3, Line 28

(2–4) The Company has no assets pledged as collateral not captured in other categories and no other restricted assets as of December 31, 2019 or 2018.

M. Working Capital Finance Investments — Not applicable.

N. Offsetting and Netting of Assets and Liabilities

The Company does not have any offsetting or netting of assets and liabilities as it relates to derivatives, repurchase and reverse repurchase agreements, and securities borrowing and securities lending activities.

O. 5GI Securities

The Company does not have any investments with an NAIC designation of 5GI as of December 31, 2019 and 2018.

P. Short Sales — Not applicable.

Q. Prepayment Penalty and Acceleration Fees

The following table illustrates prepayment penalty and acceleration fees as of December 31, 2019:

	General Account
1. Number of CUSIPs	3
2. Aggregate amount of investment income	$ 15,374

6. JOINT VENTURES, PARTNERSHIPS, AND LIMITED LIABILITY COMPANIES

A–B. The Company has no investments in joint ventures, partnerships, or limited liability companies that exceed 10% of admitted assets and did not recognize any impairment write-down for its investments in joint ventures, partnerships, and limited liability companies during the statement periods.

7. INVESTMENT INCOME

A. The Company excludes all investment income due and accrued amounts that are over 90 days past due from the statutory basis statements of admitted assets, liabilities, and capital and surplus.

B. There were no investment income amounts excluded from the statutory basis financial statements.

8. DERIVATIVE INSTRUMENTS

A–B. The Company has no derivative instruments.

9. INCOME TAXES

A. Deferred Tax Asset/Liability

(1) The components of the net deferred tax asset at December 31, 2019 and 2018, are as follows:

	2019			2018			Change		
	1	2	3	4	5	6	7	8	9
	Ordinary	Capital	Col 1+2 Total	Ordinary	Capital	Col 4+5 Total	(Col 1 - 4) Ordinary	(Col 2 - 5) Capital	Col 7+8 Total
(a) Gross deferred tax assets	$ 1,039,992	$ 665	$ 1,040,657	$ 1,312,528	$ 254	$ 1,312,782	$ (272,536)	$ 411	$ (272,125)
(b) Statutory valuation allowance adjustments	-	665	665	-	254	254	-	411	411
(c) Adjusted gross deferred tax assets (1a - 1b)	1,039,992	-	1,039,992	1,312,528	-	1,312,528	(272,536)	-	(272,536)
(d) Deferred tax assets nonadmitted	-	-	-	-	-	-	-	-	-
(e) Subtotal net admitted deferred tax asset (1c - 1d)	1,039,992	-	1,039,992	1,312,528	-	1,312,528	(272,536)	-	(272,536)
(f) Deferred tax liabilities	124,592	102	124,694	152,992	1	152,993	(28,400)	101	(28,299)
(g) Net admitted deferred tax asset/(net deferred tax liability) (1e - 1f)	$ 915,400	$ (102)	$ 915,298	$ 1,159,536	$ (1)	$ 1,159,535	$ (244,136)	$ (101)	$ (244,237)

(2) The components of the adjusted gross deferred tax assets admissibility calculation under Statement of Statutory Accounting Principles ("SSAP") No. 101, Income Taxes — *A Replacement of SSAP No. 10R and SSAP No. 10, are as follows*:

	2019			2018			Change		
	1	2	3	4	5	6	7	8	9
Admission Calculation Components SSAP No. 101	Ordinary	Capital	(Col 1 + 2) Total	Ordinary	Capital	(Col 4 + 5) Total	(Col 1 - 4) Ordinary	(Col 2 - 5) Capital	(Col 7 + 8) Total
(a) Federal income taxes paid in prior years recoverable through loss carrybacks	$ 1,039,992	$ -	$ 1,039,992	$ 1,312,528	$ -	$ 1,312,528	$ (272,536)	$ -	$ (272,536)
(b) Adjusted gross deferred tax assets expected to be realized (excluding the amount of deferred tax assets from 2(a) above) after application of the threshold limitation. (The lesser of 2(b)1 and 2(b)2 below)	-	-	-	-	-	-	-	-	-
1. Adjusted gross deferred tax assets expected to be realized following the balance sheet date	-	-	-	-	-	-	-	-	-
2. Adjusted gross deferred tax assets allowed per limitation threshold	XXX	XXX	25,171,649	XXX	XXX	24,538,829	XXX	XXX	632,820
(c) Adjusted gross deferred tax assets (excluding the amount of deferred tax assets from 2(a) and 2(b) above) offset by gross deferred tax liabilities	-	-	-	-	-	-	-	-	-
(d) Deferred tax assets admitted as the result of application of SSAP No. 101 Total (2(a) + 2(b) + 2(c))	$ 1,039,992	$ -	$ 1,039,992	$ 1,312,528	$ -	$ 1,312,528	$ (272,536)	$ -	$ (272,536)

(3) The ratio percentage and adjusted capital and surplus used to determine the recovery period and threshold limitations for the admissibility calculation are presented below:

	2019	2018
(a) Ratio percentage used to determine recovery period and threshold limitation amount	468 %	400 %
(b) Amount of adjusted capital and surplus used to determine recovery period and threshold limitation in 2(b)(2) above	$ 167,810,933	$ 163,592,190

(4) The impact to the gross deferred tax assets balances as a result of tax-planning strategies as of December 31, 2019 and 2018, is presented below:

	2019		2018		Change	
	1	2	3	4	5	6
Impact of Tax-Planning Strategies	Ordinary	Capital	Ordinary	Capital	(Col 1 - 3) Ordinary	(Col 2 - 4) Capital
(a) Determination of adjusted gross deferred tax assets and net admitted deferred tax assets by tax character as a percentage.						
1. Adjusted gross DTAs amount from Note 9A1(c)	$ 1,039,992	$ -	$ 1,312,528	$ -	$ (272,536)	$ -
2. Percentage of adjusted gross DTAs by tax character attributable to the impact of tax-planning strategies	- %	- %	- %	- %	- %	- %
3. Net admitted adjusted gross DTAs amount from Note 9A1(e)	$ 1,039,992	$ -	$ 1,312,528	$ -	$ (272,536)	$ -
4. Percentage of net admitted adjusted gross DTAs by tax character admitted because of the impact of tax-planning strategies	- %	- %	- %	- %	- %	- %
(b) Does the Company's tax-planning strategies include the use of reinsurance?			Yes		No X	

B. Unrecognized Deferred Tax Liabilities

(1–4) There are no unrecognized deferred tax liabilities for the years ended December 31, 2019 and 2018.

C. Significant Components of Income Taxes

(1) The current federal and foreign income taxes incurred for the years ended December 31, 2019 and 2018 are as follows:

	1	2	3
	2019	2018	(Col 1 - 2) Change
1. Current income tax			
(a) Federal	$ 5,980,846	$ 6,945,808	$ (964,962)
(b) Foreign	-	-	-
(c) Subtotal	5,980,846	6,945,808	(964,962)
(d) Federal income tax on net capital gains	51,015	5,993	45,022
(e) Utilization of capital loss carryforwards	-	-	-
(f) Other	-	-	-
(g) Total federal and foreign income taxes incurred	$ 6,031,861	$ 6,951,801	$ (919,940)

(2–4) The tax effects of temporary differences that give rise to significant portions of the deferred tax assets and liabilities as of December 31, 2019 and 2018, are as follows:

	1 2019	2 2018	3 (Col 1 - 2) Change
2 Deferred tax assets:			
(a) Ordinary:			
(1) Discounting of unpaid losses	$ 215,016	$ 265,806	$ (50,790)
(2) Unearned premium reserve	380,478	26,507	353,971
(3) Policyholder reserves	-	-	-
(4) Investments	-	-	-
(5) Deferred acquisition costs	-	-	-
(6) Policyholder dividends accrual	-	-	-
(7) Fixed assets	-	-	-
(8) Compensation and benefits accrual	-	-	-
(9) Pension accrual	-	-	-
(10) Receivables—nonadmitted	444,152	1,019,695	(575,543)
(11) Net operating loss carryforward	-	-	-
(12) Tax credit carryforward	-	-	-
(13) Other (including items <5% of total ordinary tax assets)	346	520	(174)
(99) Subtotal	1,039,992	1,312,528	(272,536)
(b) Statutory valuation allowance adjustment	-	-	-
(c) Nonadmitted	-	-	-
(d) Admitted ordinary deferred tax assets (2a99 - 2b - 2c)	1,039,992	1,312,528	(272,536)
(e) Capital:			
(1) Investments	665	254	411
(2) Net capital loss carryforward	-	-	-
(3) Real estate	-	-	-
(4) Other (including items <5% of total capital tax assets)	-	-	-
(99) Subtotal	665	254	411
(f) Statutory valuation allowance adjustment	665	254	411
(g) Nonadmitted	-	-	-
(h) Admitted capital deferred tax assets (2e99 - 2f - 2g)	-	-	-
(i) Admitted deferred tax assets (2d + 2h)	1,039,992	1,312,528	(272,536)
3 Deferred tax liabilities:			
(a) Ordinary:			
(1) Investments	27,690	20,240	7,450
(2) Fixed assets	-	-	-
(3) Deferred and uncollected premium	-	-	-
(4) Policyholder reserves	-	-	-
(5) Other (including items <5% of total ordinary tax liabilities)	96,902	132,752	(35,850)
(99) Subtotal	124,592	152,992	(28,400)
(b) Capital:			
(1) Investments	-	-	-
(2) Real estate	-	-	-
(3) Other (including items <5% of total capital tax liabilities)	102	1	101
(99) Subtotal	102	1	101
(c) Deferred tax liabilities (3a99 + 3b99)	124,694	152,993	(28,299)
4 Net deferred tax assets/liabilities (2i - 3c)	$ 915,298	$ 1,159,535	$ (244,237)

The other ordinary deferred tax liability of $96,902 for 2019 consists of discounting of unpaid losses. The other ordinary deferred tax liability of $132,752 for 2018 consists of discounting of unpaid losses of $128,847 and premium acquisition expense of $3,905. The other capital deferred tax liability of $102 for 2019 consists of unrealized gain. The other capital deferred tax liability of $1 for 2018 consists of unrealized gain.

The Company assessed the potential realization of the gross deferred tax asset and established a valuation allowance of $665 and $254 to reduce the gross deferred tax asset to $1,039,992 and $1,312,528 as of December 31, 2019 and 2018, respectively, which represents the amount of the asset estimated to be recoverable via carryback of losses and reduction of future taxes. The change in the valuation allowance is attributable to the change in timing of deductibility of expenses and/or expectations for future taxable income.

D. The provision for federal income taxes incurred is different from that which would be obtained by applying the statutory federal income tax rate of 21% to net income before federal income taxes incurred, plus capital gains taxes. A summarization of the significant items causing this difference as of December 31, 2019 and 2018 is as follows:

	2019		2018	
	Amount	Effective Tax Rate	Amount	Effective Tax Rate
Tax provision at the federal statutory rate	$ 5,777,038	21 %	$ 8,311,512	21 %
Tax-exempt interest	(76,953)	-	(84,440)	-
Health insurer fee	-	-	4,933,226	13
Tax effect of nonadmitted assets	575,501	2	(611,075)	(2)
Change in statutory valuation allowance	411	-	178	-
Total statutory income taxes	$ 6,275,997	23 %	$ 12,549,401	32 %
Federal income taxes incurred	$ 5,980,846	22 %	$ 6,945,808	18 %
Capital gains tax	51,015	-	5,993	-
Change in net deferred income tax	244,136	1	5,597,600	14
Total statutory income taxes	$ 6,275,997	23 %	$ 12,549,401	32 %

E. At December 31, 2019, the Company had no net operating loss carryforwards.

Current federal income taxes payable of $707,861 and $3,405,803 as of December 31, 2019 and 2018, respectively, are included in the statutory basis statements of admitted assets, liabilities, and capital and surplus. Federal income taxes paid, net of refunds were $8,729,803 and $5,489,964 in 2019 and 2018, respectively.

Federal income taxes incurred of $6,031,861 and $6,951,803 for 2019 and 2018, respectively, are available for recoupment in the event of future net losses.

The Company has not admitted any aggregate amounts of deposits that are included within Section 6603 (“Deposits made to suspend running of interest on potential underpayments, etc.”) of the Internal Revenue Service (“IRS”) Code.

F. The Company is included in the consolidated federal income tax return with its ultimate parent, UnitedHealth Group. The entities included within the consolidated return are included in NAIC Statutory Statement Schedule Y — Information Concerning Activities of Insurer Members Of A Holding Company Group. Federal income taxes are paid to or refunded by UnitedHealth Group pursuant to the terms of a tax-sharing agreement, approved by the Board of Directors, under which taxes approximate the amount that would have been computed on a separate company basis, with the exception of net operating losses and capital losses. For these losses, the Company receives a benefit at the federal rate in the current year for current taxable losses incurred in that year to the extent losses can be utilized in the consolidated federal income tax return of UnitedHealth Group. UnitedHealth Group currently files income tax returns in the U.S. federal jurisdiction, various states, and foreign jurisdictions. The IRS has completed exams on UnitedHealth Group's consolidated income tax returns for fiscal years 2016 and prior. UnitedHealth Group's 2017, 2018 and 2019 tax returns are under review by the IRS under its Compliance Assurance Program. With the exception of a few states, UnitedHealth Group is no longer subject to income tax examinations prior to the 2013 tax year. In general, the Company is subject to examination in non-U.S. jurisdictions for years 2014 and forward. The Company does not believe any adjustments that may result from these examinations will be material to the Company.

G. Tax Contingencies — Not applicable.

H. Repatriation Transition Tax — Not applicable

I. Alternative Minimum Tax Credit — Not applicable.

10. INFORMATION CONCERNING PARENT, SUBSIDIARIES, AND AFFILIATES

A–O. Material Related Party Transactions

Management believes that the Company's transactions with affiliates are fair and reasonable; however, operations of the Company may not be indicative of those that would have occurred if it had operated as an independent company.

In the ordinary course of business, the Company contracts with several affiliates to provide a wide variety of services to the Company's members. These agreements are filed with and approved by the Department according to Management's understanding of the current requirements and standards. Within the confines of the applicable filed and approved agreements (including subsequent amendments thereto), the amount and types of services provided by these affiliated entities can change year over year.

The administrative services, access fees, and cost of care services provided by affiliates are calculated using one or more of the following methods: (1) a percentage of premiums; (2) use of assets; (3) direct pass-through of charges; (4) per member per month ("PMPM"); (5) per employee per month; (6) per claim; or (7) a combination thereof consistent with the provisions contained in each contract. These amounts are included in GAE, CAE, and hospital and medical expenses in the statutory basis statements of operations. The following table identifies the amounts for the administrative services, access fees, and cost of care services provided by

related parties for the years ended December 31, 2019 and 2018, which meet the disclosure requirements pursuant to SSAP No. 25, *Affiliates and Other Related Parties*, regardless of the effective date of the contract:

	2019	2018
OptumRx	$ 190,257,377	$ 20,093,939
UHS	61,703,075	70,510,074
United Behavioral Health	10,160,225	8,418,931
Dental Benefit Providers, Inc.	5,900,939	4,506,096
OptumInsight, Inc.	1,721,821	1,857,676
Spectera, Inc.	739,621	2,034,217

UHS provides, or arranges for the provision of, management, administrative, and other services deemed necessary or appropriate for UHS to provide management and operational support to the Company. The services can include, but are not limited to, the categories of management and operational services outlined in the Agreement, such as human resources, legal, facilities, general administration, treasury and investment functions, claims adjudication and payment, benefit administration, disease management, health care decision support, provider networks, quality oversight and wellness management. The amount charged to the Company for the management and operational services provided by UHS are calculated pursuant to the Agreement.

OptumRx provides services that may include, but are not limited to, administrative services related to pharmacy management and pharmacy claims processing for enrollees, manufacturer rebate administration, pharmacy incentive services and specialty drug pharmacy services.

United Behavioral Health provides services related to mental health and substance abuse treatment.

Dental Benefit Providers, Inc. manages a network of dental providers to provide services, claims processing and other administrative functions.

OptumInsight, Inc. provides services that may include, but are not limited to, claim analytics and recovery of medical expense overpayments, retroactive fraud, waste and abuse, subrogation and premium audit services. All recoveries are returned to the Company by OptumInsight, Inc. on a monthly basis.

Spectera, Inc. provides administrative services related to vision benefit management and claims processing.

The Company has premium payments that are received and claim payments that are processed and paid by an affiliated UnitedHealth Group entity. Premiums, claims, and direct expenses applicable to the Company are settled at regular intervals throughout the month via the intercompany settlement process and any amounts outstanding are reflected in payable amounts due to parent, subsidiaries, and affiliates, net in the statutory basis statements of admitted assets, liabilities, and capital and surplus.

The Company holds a $75,000,000 subordinated revolving credit agreement with UnitedHealth Group at an interest rate of London InterBank Offered Rate plus a margin of 0.50%. This credit agreement is subordinate to the extent it does not conflict with any credit facility held by either party. The credit agreement is for a one-year term and automatically renews annually, unless terminated by either party. The agreement was renewed effective November 1, 2018. No amounts were outstanding under the line of credit as of December 31, 2019 and 2018, respectively.

In addition to the agreements above, UHS maintains a private short-term investment pool in which affiliated companies may participate (see Note 1). At December 31, 2019 and 2018, the Company's portion was $0 and $2,673, respectively, and is included in short-term investments in the statutory basis statements of admitted assets, liabilities, and capital and surplus.

The Company has a Tax Sharing Agreement with UnitedHealth Group (see Note 9).

The Company paid an extraordinary dividend of $20,000,000 in 2019 to its parent (see Note 13).

At December 31, 2019 and 2018, the Company reported $5,390,800 and $3,796,013, respectively, as amounts due to parent, subsidiaries, and affiliates, net which are included in the statutory basis statements of admitted assets, liabilities, and capital and surplus. These balances are generally settled within 90 days from the incurred date. Any balances due to the Company that are not settled within 90 days are considered nonadmitted assets.

The Company has not extended any guarantees or undertakings for the benefit of an affiliate or related party.

The Company does not have any amount deducted from the value of an upstream intermediate entity or ultimate parent owned, either directly or indirectly, via a downstream subsidiary, controlled, or affiliated entity.

The Company does not have any investments in a subsidiary, controlled, or affiliated entity that exceeds 10% of admitted assets.

The Company does not have any investments in impaired subsidiaries, controlled, or affiliated entities.

The Company does not have any investments in foreign insurance subsidiaries.

The Company does not hold any investments in a downstream noninsurance holding company.

The Company does not have any investments in noninsurance subsidiaries, controlled, or affiliated entities.

The Company does not have any investments in insurance subsidiaries, controlled, or affiliated entities.

11. DEBT

A–B. The Company had no outstanding debt with third-parties or outstanding Federal Home Loan Bank agreements during 2019 and 2018.

12. RETIREMENT PLANS, DEFERRED COMPENSATION, POSTEMPLOYMENT BENEFITS AND COMPENSATED ABSENCES AND OTHER POSTRETIREMENT BENEFIT PLANS

A–I. The Company has no defined benefit plans, defined contribution plans, multiemployer plans, consolidated/holding company plans, postemployment benefits, or compensated absences plans and is not impacted by the Medicare Modernization Act on postretirement benefits, since all personnel are employees of UHS, which provides services to the Company under the terms of the Agreement (see Note 10).

13. CAPITAL AND SURPLUS, SHAREHOLDERS' DIVIDEND RESTRICTIONS, AND QUASI-REORGANIZATIONS

(1–2) The Company has 2,000 shares authorized and 2,000 shares issued and outstanding of $0.01 par value common stock. The Company has no preferred stock outstanding. All issued and outstanding shares of common stock are held by the Company's parent, UHC.

(3) Payment of dividends may be restricted by the Department, which generally requires that dividends be paid out of gross paid-in and contributed surplus.

(4) The Company paid an extraordinary cash dividend of $20,000,000 on December 30, 2019 to UHS, its parent, which was approved by the Mississippi Insurance Commissioner and recorded as a reduction to gross paid-in and contributed surplus in the statutory basis statements of admitted assets, liabilities, and capital and surplus.

The Company paid no dividends in 2018 and did not receive any capital infusions during 2019 or 2018.

(5) The amount of ordinary dividends that may be paid out during any given period is subject to certain restrictions as specified by state statute.

(6) There are no restrictions placed on the Company's unassigned surplus (deficit).

(7) The Company is not a mutual reciprocal or a similarly organized entity and does not have advances to surplus not repaid.

(8) The Company does not hold any stock, including stock of affiliated companies for special purposes, such as conversion of preferred stock, employee stock options, or stock purchase warrants.

(9) For the year ended December 31, 2019, the amount of the estimated Section 9010 ACA subsequent fee year assessment apportioned out of unassigned surplus (deficit) was $18,820,864. As discussed in Note 1, in 2018 no amount was required to be apportioned out of unassigned surplus (deficit) for the Section 9010 ACA subsequent fee year assessment.

(10) The portion of unassigned surplus (deficit), excluding the apportionment of estimated Section 9010 ACA subsequent fee year assessment, net income, and dividend, represented (or reduced) by each item below is as follows:

	2019	2018	Change
Unrealized capital gains on investments			
Unrealized capital gains on investments	$ 484	$ 3	$ 481
Net deferred income taxes	915,298	1,159,535	(244,237)
Nonadmitted assets	(2,116,871)	(4,857,351)	2,740,480
Total	$ (1,201,089)	$ (3,697,813)	$ 2,496,724

(11–13) The Company does not have any outstanding surplus notes and has never been a party to a quasi-reorganization.

14. LIABILITIES, CONTINGENCIES AND ASSESSMENTS

A. Contingent Commitments

The Company has no contingent commitments.

B. Assessments

The Company is not aware of any guaranty fund assessments or premium tax offsets, potential or accrued, that could have a material financial effect on the operations of the entity.

C. Gain Contingencies

The Company is not aware of any gain contingencies that should be disclosed in the statutory basis financial statements.

D. Claims Related Extra Contractual Obligation and Bad Faith Losses Stemming from Lawsuits — Not applicable.

E. Joint and Several Liabilities — Not applicable.

F. All Other Contingencies

The Company's business is regulated at the federal, state, and local levels. The laws and rules governing the Company's business and interpretations of those laws and rules are subject to frequent change. Broad latitude is given to the agencies administering those regulations. Further, the Company must obtain and maintain regulatory approvals to market and sell many of its products.

The ACA and the related federal and state regulations will continue to impact how the Company does business and could restrict revenue and enrollment growth in certain products and market segments, restrict premium growth rates for certain products and market segments, increase the Company's medical and administrative costs, expose the Company to an increased risk of liability (including increasing the Company's liability in federal and state courts for coverage determinations and contract interpretation), or put the Company at risk for loss of business. In addition, the Company's statutory basis results of operations, financial condition, and cash flows could be materially adversely affected by such changes. The ACA may create new or expand existing opportunities for business growth, but due to its complexity, the long term impact of the ACA remains difficult to predict and is not yet fully known.

The Company has been, or is currently involved, in various governmental investigations, audits and reviews. These include routine, regular and special investigations, audits and reviews by Centers for Medicare and Medicaid Services ("CMS"), state insurance and health and welfare departments and other governmental authorities. The Company cannot reasonably estimate the range of loss, if any, that may result from any material government investigations, audits and reviews in which it is currently involved given the inherent difficulty in predicting regulatory action, fines and penalties, if any, and the various remedies and levels of judicial review available to the Company in the event of an adverse finding.

Because of the nature of its businesses, the Company is frequently made party to a variety of legal actions and regulatory inquiries, including class actions and suits brought by members, care providers, consumer advocacy organizations, customers and regulators, relating to the Company's businesses, including management and administration of health benefit plans and other services.

The Company records liabilities for its estimates of probable costs resulting from these matters where appropriate. Estimates of costs resulting from legal and regulatory matters involving the Company are inherently difficult to predict, particularly where the matters involve: indeterminate claims for monetary damages or may involve fines, penalties or punitive damages; present novel legal theories or represent a shift in regulatory policy; involve a large number of claimants or regulatory bodies; are in the early stages of the proceedings; or could result in a change in business practices. Accordingly, the Company is often unable to estimate the losses or ranges of losses for those matters where there is a reasonable possibility or it is probable that a loss may be incurred. Although the outcomes of any such legal actions cannot be predicted, in the opinion of management, the resolution of any currently pending or threatened actions will not have a material adverse effect on the statutory basis statements of admitted assets, liabilities, and capital and surplus or statutory basis statements of operations of the Company.

The Company routinely evaluates the collectability of all receivable amounts included in the statutory basis statements of admitted assets, liabilities, and capital and surplus. Impairment reserves are established for those amounts where collectability is uncertain. Based on the Company's past experience, exposure related to uncollectible balances and the potential of loss for those balances not currently reserved for is not material to the Company's statutory basis financial condition.

There are no other assets that the Company considers to be impaired at December 31, 2019 and 2018, except as disclosed in Note 5.

15. LEASES

A–B. According to the Agreement between the Company and UHS (see Note 10), operating leases for the rental of office facilities and equipment are the responsibility of UHS. Fees associated with the lease agreements are included as a component of the Company's management fee.

16. INFORMATION ABOUT FINANCIAL INSTRUMENTS WITH OFF-BALANCE-SHEET RISK AND FINANCIAL INSTRUMENTS WITH CONCENTRATIONS OF CREDIT RISK

(1–4) The Company does not hold any financial instruments with off-balance-sheet risk or have any concentrations of credit risk.

17. SALE, TRANSFER, AND SERVICING OF FINANCIAL ASSETS AND EXTINGUISHMENTS OF LIABILITIES

A–C. The Company did not participate in any transfer of receivables, financial assets or wash sales.

18. GAIN OR LOSS TO THE REPORTING ENTITY FROM UNINSURED PLANS AND THE UNINSURED PORTION OF PARTIALLY INSURED PLANS

A–B. The Company has no operations from Administrative Services Only Contracts or Administrative Services Contracts in 2019 and 2018.

C. Medicare or Other Similarly Structured Cost Based Reimbursement Contract

Effective December 1, 2015, the Company has contracted with the Mississippi DOM to participate in the MHAP. This program helps to ensure sufficient access to inpatient hospital services for the Medicaid population by including enhanced hospital reimbursement in the capitation rates. Effective July 1, 2019, the Company has contracted with the Mississippi DOM to participate in the MAPS. This program provides enhanced pass-through payments to physicians and other service practitioners who are employed by a qualifying hospital or assigned Mississippi Medicaid

payments to a qualifying hospital. Year to date 2019 and 2018 receipts and expenditures related to these pass-through programs are reported in the table below:

Mississippi Hospital Access Program/ Mississippi Medicaid Access to Physician Services Program	Year to Date December 31, 2019	Quarter to Date as of December 31, 2019	Prior Year to Date December 31, 2018
MHAP Capitation	$ 235,870,301	$ 55,387,062	$ 258,257,547
MS MAPS Capitation	3,168,713	3,168,713	-
Total Premium Tax Payments	5,999,741	1,326,990	7,080,962
MHAP Payments to Providers	234,284,200	58,432,102	258,911,077
MS MAPS Payments to Providers	3,168,713	3,168,713	-

19. DIRECT PREMIUM WRITTEN/PRODUCED BY MANAGING GENERAL AGENTS/THIRD-PARTY ADMINISTRATORS

The Company did not have any direct premiums written or produced by managing general agents or third-party administrators in 2019 and 2018.

20. FAIR VALUE MEASUREMENT

The NAIC SAP defines fair value, establishes a framework for measuring fair value, and outlines the disclosure requirements related to fair value measurements. The fair value hierarchy is as follows:

Level 1 — Quoted (unadjusted) prices for identical assets in active markets.

Level 2 — Other observable inputs, either directly or indirectly, including:

- Quoted prices for similar assets in active markets;
- Quoted prices for identical or similar assets in nonactive markets (few transactions, limited information, noncurrent prices, high variability over time, etc.);
- Inputs other than quoted prices that are observable for the asset (interest rates, yield curves, volatilities, default rates, etc.);
- Inputs that are derived principally from or corroborated by other observable market data.

Level 3 — Unobservable inputs that cannot be corroborated by observable market data.

The estimated fair values of bonds , cash equivalents, and short-term investments are based on quoted market prices, where available. The Company obtains one price for each security primarily from a third-party pricing service (“pricing service”), which generally uses quoted prices or other observable inputs for the determination of fair value. The pricing service normally derives the security prices through recently reported trades for identical or similar securities, making adjustments through the reporting date based upon available observable market information. For securities not actively traded, the pricing service may use quoted market prices of comparable instruments or discounted cash flow analyses, incorporating inputs that are currently observable in the markets for similar securities. Inputs that are often used in the valuation methodologies include, but are not limited to, non-binding broker quotes, benchmark yields, credit spreads, default rates, and prepayment speeds. As the Company is responsible for the determination of fair value, it performs quarterly analyses on the prices received from the pricing service to determine whether the prices are reasonable estimates of fair value. Specifically, the Company compares the prices received from the pricing service to a secondary pricing source, prices reported by its custodian, its investment consultant, and third-party investment advisors. Additionally, the Company compares changes in the reported market values and returns to relevant market indices to test the reasonableness of the reported prices. The Company’s internal price

verification procedures and review of fair value methodology documentation provided by independent pricing services have not historically resulted in an adjustment in the prices obtained from the pricing service.

In instances in which the inputs used to measure fair value fall into different levels of the fair value hierarchy, the fair value measurement has been determined based on the lowest-level input that is significant to the fair value measurement in its entirety. The Company's assessment of the significance of a particular item to the fair value measurement in its entirety requires judgment, including the consideration of inputs specific to the asset or liability.

A. Fair Value

(1) Fair Value Measurements at Reporting Date

The following tables present information about the Company's financial assets that are measured and reported at fair value at December 31, 2019 and 2018, in the statutory basis statements of admitted assets, liabilities, and capital and surplus according to the valuation techniques the Company used to determine their fair values:

	December 31, 2019				
Description for Each Class of Asset or Liability	(Level 1)	(Level 2)	(Level 3)	Net Asset Value (NAV)	Total
a. Assets at fair value:					
Perpetual preferred stock:					
Industrial and misc	$ -	$ -	$ -	$ -	$ -
Parent, subsidiaries, and affiliates	-	-	-	-	-
Total perpetual preferred stocks	-	-	-	-	-
Bonds:					
U.S. governments	-	-	-	-	-
Industrial and misc	-	-	-	-	-
Hybrid securities	-	-	-	-	-
Parent, subsidiaries, and affiliates	-	-	-	-	-
Total bonds	-	-	-	-	-
Common stock:					
Industrial and misc	-	-	-	-	-
Parent, subsidiaries, and affiliates	-	-	-	-	-
Total common stock	-	-	-	-	-
Derivative assets:					
Interest rate contracts	-	-	-	-	-
Foreign exchange contracts	-	-	-	-	-
Credit contracts	-	-	-	-	-
Commodity futures contracts	-	-	-	-	-
Commodity forward contracts	-	-	-	-	-
Total derivatives	-	-	-	-	-
Money-market funds	56,705,676	-	-	-	56,705,676
Separate account assets	-	-	-	-	-
Total assets at fair value/NAV	$ 56,705,676	$ -	$ -	$ -	$ 56,705,676
b. Liabilities at fair value:					
Derivative liabilities	$ -	$ -	$ -	$ -	$ -
Total liabilities at fair value	$ -	$ -	$ -	$ -	$ -

Description for Each Class of Asset or Liability	December 31, 2018 (Level 1)	(Level 2)	(Level 3)	Net Asset Value (NAV)	Total
a. Assets at fair value:					
Perpetual preferred stock:					
Industrial and misc	$ -	$ -	$ -	$ -	$ -
Parent, subsidiaries, and affiliates	-	-	-	-	-
Total perpetual preferred stocks	-	-	-	-	-
Bonds:					
U.S. governments	-	-	-	-	-
Industrial and misc	-	-	-	-	-
Hybrid securities	-	-	-	-	-
Parent, subsidiaries, and affiliates	-	-	-	-	-
Total bonds	-	-	-	-	-
Common stock:					
Industrial and misc	-	-	-	-	-
Parent, subsidiaries, and affiliates	-	-	-	-	-
Total common stock	-	-	-	-	-
Derivative assets:					
Interest rate contracts	-	-	-	-	-
Foreign exchange contracts	-	-	-	-	-
Credit contracts	-	-	-	-	-
Commodity futures contracts	-	-	-	-	-
Commodity forw ard contracts	-	-	-	-	-
Total derivatives	-	-	-	-	-
Money-market funds	68,745,768	-	-	-	68,745,768
Separate account assets	-	-	-	-	-
Total assets at fair value/NAV	$ 68,745,768	$ -	$ -	$ -	$ 68,745,768
b. Liabilities at fair value:					
Derivative liabilities	$ -	$ -	$ -	$ -	$ -
Total liabilities at fair value	$ -	$ -	$ -	$ -	$ -

There were no transfers between Levels 1 and 2 during the years ended December 31, 2019 and 2018.

(2) The Company does not have any financial assets with a fair value hierarchy of Level 3 that were measured and reported at fair value.

(3) Transfers between fair value hierarchy levels, if any, are recorded as of the beginning of the reporting period in which the transfer occurs. There were no transfers between Levels 1, 2 or 3 of any financial assets or liabilities during the years ended December 31, 2019 or 2018.

(4) The Company has no investments reported with a fair value hierarchy of Level 2 or Level 3 and therefore has no valuation technique to disclose.

(5) The Company has no derivative assets and liabilities to disclose.

B. Fair Value Combination — Not applicable.

C. Aggregate Fair Value Hierarchy

The aggregate fair value by hierarchy of all financial instruments as of December 31, 2019 and 2018 is presented in the table below:

	December 31, 2019						
Type of Financial Instrument	Aggregate Fair Value	Admitted Assets	(Level 1)	(Level 2)	(Level 3)	Net Asset Value (NAV)	Not Practicable (Carrying Value)
U.S. government and agency securities	$ 20,993,810	$ 20,707,826	$ 2,609,155	$ 18,384,655	$ -	$ -	$ -
State and agency municipal securities	13,268,407	12,883,403	-	13,268,407	-	-	-
City and county municipal securities	13,610,153	13,291,608	-	13,610,153	-	-	-
Corporate debt securities	108,570,683	105,974,082	-	108,570,683	-	-	-
Cash equivalents	56,705,676	56,705,676	56,705,676	-	-	-	-
Total bonds and cash equivalents	$ 213,148,729	$ 209,562,595	$ 59,314,831	$ 153,833,898	$ -	$ -	$ -

	December 31, 2018						
Type of Financial Instrument	Aggregate Fair Value	Admitted Assets	(Level 1)	(Level 2)	(Level 3)	Net Asset Value (NAV)	Not Practicable (Carrying Value)
U.S. government and agency securities	$ 23,936,102	$ 24,356,311	$ 4,670,423	$ 19,265,679	$ -	$ -	$ -
State and agency municipal securities	16,997,724	16,966,159	-	16,997,724	-	-	-
City and county municipal securities	14,597,695	14,603,873	-	14,597,695	-	-	-
Corporate debt securities	92,778,065	93,841,840	2,673	92,775,392	-	-	-
Cash equivalents	68,745,768	68,745,768	68,745,768	-	-	-	-
Total bonds, short-term investments and cash equivalents	$ 217,055,354	$ 218,513,951	$ 73,418,864	$ 143,636,490	$ -	$ -	$ -

D. Not Practicable to Estimate Fair Value — Not applicable.

E. Investments Measured Using the NAV Practical Expedient — Not applicable.

21. OTHER ITEMS

A. Unusual or Infrequent Items

The Company did not encounter any unusual or infrequent items for the years ended December 31, 2019 and 2018.

B. Troubled Debt Restructuring: Debtors

The Company has no troubled debt restructurings as of December 31, 2019 and 2018.

C. Other Disclosures

The Company does not have any amounts not recorded in the statutory basis financial statements that represent segregated funds held for others. The Company also does not have any exposures related to forward commitments that are not derivative instruments.

D. Business Interruption Insurance Recoveries

The Company has not received any business interruption insurance recoveries during 2019 and 2018.

E. State Transferable and Non-transferable Tax Credits

The Company has no transferable or non-transferable state tax credits.

F. Sub-Prime Mortgage-Related Risk Exposure

(1) The investment policy for the Company limits investments in loan-backed securities, which includes sub-prime issuers. Further, the policy limits investments in private-issuer mortgage securities to 10% of the portfolio, which also includes sub-prime issuers. The exposure to unrealized losses on sub-prime issuers is due to changes in market prices. There are no realized losses due to not receiving anticipated cash flows. The investments covered have an NAIC designation of 1 or 2.

(2) The Company has no direct exposure through investments in sub-prime mortgage loans.

(3) The Company has no direct exposure through other investments.

(4) The Company has no underwriting exposure to sub-prime mortgage risk through mortgage guaranty or financial guaranty insurance coverage.

G. Retained Assets

The Company does not have any retained asset accounts for beneficiaries.

H. Insurance-Linked Securities Contracts

As of December 31, 2019, the Company is not aware of any possible proceeds of insurance-linked securities.

I. **The Amount That Could Be Realized on Life Insurance Where the Reporting Entity is Owner and Beneficiary or Has Otherwise Obtained Rights to Control the Policy** — Not applicable.

22. EVENTS SUBSEQUENT

Subsequent events have been evaluated through April 21, 2020, which is the date these statutory basis financial statements were available for issuance.

TYPE I — Recognized Subsequent Events

Any material Type I events subsequent to December 31, 2019, have been recognized in the statutory basis financial statements and corresponding disclosures.

TYPE II — Non-Recognized Subsequent Events

The Company is subject to the annual fee under Section 9010 of the ACA. The fee is allocated to individual health insurers based on the ratio of the amount of the entity's net premiums written during the preceding calendar year to the amount of the health insurance for any U.S. health risk that is written during the preceding calendar year. A health insurance entity's portion of the annual fee becomes payable once the entity provides health insurance for any U.S. health risk for each calendar year beginning on or after January 1, of the year the fee is due. The HIF was repealed by Congress, effective January 1, 2021.

As of December 31, 2019, the Company has written health insurance subject to the ACA assessment, expects to conduct health insurance business in 2020, and estimates its portion of the annual health insurance industry fee payable on September 30, 2020 to be $18,820,864. This amount has been apportioned out of unassigned surplus (deficit) and is reflected as Section 9010 ACA Subsequent Fee Year Assessment in the statutory basis financial statements. In accordance with the 2019 HIF moratorium, no amounts were required to be apportioned out of unassigned surplus (deficit) in 2018

(see Note 1). The Company's Authorized Control Level RBC ("ACL RBC") ratio was 471% as of December 31, 2019. Reporting the ACA assessment as a liability as of December 31, 2019, would not have triggered an RBC action level. The Department has not adopted the NAIC's risk based capital ("RBC") model as a part of its minimum capital requirements.

	2019	2018
A. Did the reporting entity write accident and health insurance premium that is subject to Section 9010 of the Federal Affordable Care Act (YES/NO)?	Yes	
B. ACA fee assessment payable for the upcoming year	$ 18,820,864	$ -
C. ACA fee assessment paid	-	23,491,552
D. Premium written subject to ACA 9010 assessment	986,655,634	-
E. Total Adjusted Capital before surplus adjustment (Five-Year Historical Line 14)	168,726,291	
F. Total Adjusted Capital after surplus adjustment (Five-Year Historical Line 14 minus 22B above)	149,905,427	
G. Authorized Control Level (Five-Year Historical Line 15)	35,837,602	
H. Would reporting the ACA assessment as of December 31, 2019, have triggered an RBC action level (YES/NO)?	No	

There are no other material non-recognized Type II events that require disclosure.

23. REINSURANCE

Reinsurance Agreements — In the normal course of business, the Company seeks to reduce potential losses that may arise from catastrophic events that cause unfavorable underwriting results by reinsuring certain levels of such risk with affiliated and other nonaffiliated reinsurers. The Company remains primarily liable as the direct insurer on all risks reinsured.

The Company entered into a reinsurance agreement with an affiliated entity, Unimerica, to cede obligations relating to mental health and substance abuse treatments and services. This reinsurance agreement was terminated effective December 31, 2017. Run-out reinsurance premium refund of $0 and $87,369 as of December 31, 2019 and 2018, respectively, were included in net premium income in the statutory basis statements of operations. Reinsurance incurred (recoveries) of $172,330 and ($943,575) as of December 31, 2019 and 2018, respectively, are included in net reinsurance incurred (recoveries) in the statutory basis statements of operations. There were $4,514 and $202,029 of paid claims receivables as of December 31, 2019 and 2018, respectively, related to this agreement which are included in amounts recoverable from reinsurers in the statutory basis statements of admitted assets, liabilities, and capital and surplus. Reinsurance contracts do not relieve the Company from its obligations to policyholders. Failure of reinsurers to honor their obligations could result in losses to the Company.

Pursuant to Section 1341 of the ACA, through 2017, the Company was subject to the reinsurance provisions for compliant individual policies (see Note 24).

The effect of both internal and external reinsurance agreements outlined above on net premium income and hospital and medical expenses is presented below:

	2019	2018
Premiums:		
Direct	$ 993,404,401	$ 1,144,487,491
Ceded:		
Affiliate	-	(87,369)
Nonaffiliate	-	-
Net premium income	$ 993,404,401	$ 1,144,574,860
Hospital and medical expenses:		
Direct	$ 848,074,754	$ 988,601,967
Ceded:		
Affiliate	(172,330)	943,575
Nonaffiliate	18,688	-
Net hospital and medical expenses	$ 848,228,396	$ 987,658,392

The Company recognized reinsurance incurred (recoveries) related to internal and external reinsurance agreements of $153,641 and ($943,575) in 2019 and 2018, respectively, which are recorded as net reinsurance incurred (recoveries) in the statutory basis statements of operations. In addition, reinsurance recoverables related to internal and external reinsurance agreements of $4,514 and $225,715 for paid losses are recorded as amounts recoverable from reinsurers and $23,289 and $95,706 for unpaid losses are recorded as a reduction to claims unpaid in 2019 and 2018, respectively, in the statutory basis statements of admitted assets, liabilities, and capital and surplus.

A. Ceded Reinsurance Report

Section 1 — General Interrogatories

(1) Are any of the reinsurers, listed in Schedule S as non-affiliated, owned in excess of 10% or controlled, either directly or indirectly, by the Company or by any representative, officer, trustee, or director of the Company?

Yes ( ) No (X)

(2) Have any policies issued by the Company been reinsured with a company chartered in a country other than the United States (excluding U.S. branches of such companies) that is owned in excess of 10% or controlled directly or indirectly by an insured, a beneficiary, a creditor, or any other person not primarily engaged in the insurance business?

Yes ( ) No (X)

Section 2 — Ceded Reinsurance Report — Part A

(1) Does the Company have any reinsurance agreements in effect under which the reinsurer may unilaterally cancel any reinsurance for reasons other than for nonpayment of premium or other similar credit?

Yes ( ) No (X)

(2) Does the reporting entity have any reinsurance agreements in effect that the amount of losses paid or accrued through the statement date may result in a payment to the reinsurer of amounts that, in aggregate and allowing for offset of mutual credits from other

reinsurance agreements with the same reinsurer, exceed the total direct premium collected under the reinsured policies?

Yes ( ) No (X)

Section 3 — Ceded Reinsurance Report — Part B

(1) What is the estimated amount of the aggregate reduction in surplus (for agreements other than those under which the reinsurer may unilaterally cancel for reasons other than for nonpayment of premium or other similar credits that are reflected in Section 2 above) of termination of all reinsurance agreements, by either party, as of the date of this statement? Where necessary, the Company may consider the current or anticipated experience of the business reinsured in making this estimate.

The Company estimates there should be no aggregate reduction in surplus for termination of all reinsurance agreements as of December 31, 2019.

(2) Have any new agreements been executed or existing agreements amended, since January 1 of the year of this statement, to include policies or contracts that were in force or which had existing reserves established by the Company as of the effective date of the agreement?

Yes ( ) No (X)

B. **Uncollectible Reinsurance** — During 2019 and 2018, there were no uncollectible reinsurance recoverables.

C. **Commutation of Ceded Reinsurance** — There was no commutation of reinsurance in 2019 or 2018.

D. **Certified Reinsurer Rating Downgraded or Status Subject to Revocation** — Not applicable.

24. RETROSPECTIVELY RATED CONTRACTS AND CONTRACTS SUBJECT TO REDETERMINATION

A. The Company estimates accrued retrospective premium adjustments for its group health insurance business based on mathematical calculations in accordance with contractual terms.

B. Estimated accrued retrospective premiums from the Company are recorded in aggregate health policy reserves in the statutory basis statements of admitted assets, liabilities, and capital and surplus and as an adjustment to change in unearned premium reserves and reserve for rate credits in the statutory basis statements of operations.

C. Pursuant to the ACA, the Company's commercial business is subject to retrospectively rated features based on the actual medical loss ratios experienced on the commercial lines of business and redetermination features for premium adjustments for changes to each member's health scores based on guidelines determined by the ACA. The total amount of direct premiums written for the commercial lines of business subject to the retrospectively rated and redetermination features was $12,609,370 and $20,334,681, representing 1.3% and 1.8% of total direct premiums written as of December 31, 2019 and 2018, respectively.

CMS has released the final Medicaid and CHIP Managed Care Rule which is subject to each State's administration elections. This rule is the first major update to the Medicaid and CHIP Managed Care regulations in more than a decade. Many items including a minimum loss ratio requirement were implemented for contracts with an effective date starting on or after July 1, 2017 (Medicaid) or July 1, 2018 (CHIP) while other elements of the regulation will be implemented over the following decade. Pursuant to the regulations, for contracts effective on or after July 1, 2017 (Medicaid) or July 1, 2018 (CHIP) premiums associated with the Company's Medicaid and CHIP lines of business are subject to retrospectively rated features based on the actual medical loss

ratios experienced on these products. The calculation is pursuant to the Medicaid and CHIP Managed Care guidance. The total amount of direct premiums written for the Medicaid and CHIP lines of business for which a portion is subject to the retrospectively rated features was $980,795,032 and $1,081,190,463 representing 98.7% and 94.5% of total direct premiums written as of December 31, 2019 and December 31, 2018, respectively.

The Medicaid contract with the State of Mississippi has a redetermination feature for which a portion of total direct premiums written is subject to a risk adjustment model that apportions premiums paid according to a health plan's health severity and certain demographic factors. Changes in risk score assignments can result in changes to the Company's Medicaid revenues and result in a net liability or a net receivable. The total amount of direct premiums written from the Medicaid contract subject to the redetermination feature was $887,448,611 and $1,035,547,616, representing 89.3% and 90.5% of the Company's total direct premiums written as of December 31, 2019 and December 31, 2018, respectively.

The Medicaid contract with the State of Mississippi includes experience rebates. The rebate period is over the contract period, which is a June 30 year-end. The Company estimates accrued retrospective premium adjustments for its Medicaid business based on contractual requirements. The total amount of direct premiums written from the Medicaid contract subject to the retrospectively rated feature was $887,448,611 and $1,035,547,616, representing 89.3% and 90.5% of total direct premiums written as of December 31, 2019 and December 31, 2018, respectively.

Effective January 1, 2015, the CHIP contract with the State of Mississippi includes medical loss ratio rebates. The rebate period is over the contract period, which is a June 30 year-end. The Company estimates accrued retrospective premium adjustments for its CHIP business based on the medical loss ratio experienced on the CHIP line of business. The formula is based on contractual requirements. The amount of direct premiums written for the CHIP contract was $93,346,420 and $88,605,194, representing 9.4% and 7.7% of total direct premiums written as of December 31, 2019 and December 31, 2018, respectively.

D. The Company does not have Medicare business subject to specific minimum loss ratio requirements as of December 31, 2019 and 2018. The Company is required to maintain a specific minimum loss ratio on the comprehensive commercial line of business. The following table discloses the minimum medical loss ratio rebate liability for the comprehensive commercial line of business which is included in aggregate health policy reserves in the statutory basis statements of admitted assets, liabilities, and capital and surplus for the years ended December 31, 2019 and 2018:

	1 Individual	2 Small Group Employer	3 Large Group Employer	4 Other Categories with Rebates	5 Total
Prior reporting year					
(1) Medical loss ratio rebates incurred	$ -	$ -	$ 135,976	$ -	$ 135,976
(2) Medical loss ratio rebates paid	-	-	135,976	-	135,976
(3) Medical loss rebates unpaid	-	-	-	-	-
(4) Plus reinsurance assumed amounts	XXX	XXX	XXX	XXX	-
(5) Less reinsurance ceded amounts	XXX	XXX	XXX	XXX	-
(6) Rebates unpaid net of reinsurance	XXX	XXX	XXX	XXX	-
Current reporting year-to-date					
(7) Medical loss ratio rebates incurred	-	-	-	-	-
(8) Medical loss ratio rebates paid	-	-	-	-	-
(9) Medical loss rebates unpaid	-	-	-	-	-
(10) Plus reinsurance assumed amounts	XXX	XXX	XXX	XXX	-
(11) Less reinsurance ceded amounts	XXX	XXX	XXX	XXX	-
(12) Rebates unpaid net of reinsurance	XXX	XXX	XXX	XXX	-

Pursuant to the Medicaid and CHIP Managed Care Rule and state contractual minimum loss ratio requirements, the Company is required to maintain specific minimum loss ratios on its CHIP and Mississippi CAN populations. The Company's actual medical loss ratios for its CHIP and Mississippi CAN populations were in excess of the minimum requirements and, as a result, no minimum loss ratio liability was required as of December 31, 2019 and December 31, 2018, respectively.

E. Risk-Sharing Provisions of the Affordable Care Act

(1) The Company has accident and health insurance premiums in 2019 and 2018 subject to the risk- sharing provisions of the ACA.

The ACA imposed fees and premium stabilization provisions on health insurance issuers offering comprehensive commercial health insurance. The three premium stabilization programs are commonly referred to as the 3Rs — risk adjustment, reinsurance, and risk corridors.

Risk Adjustment — The permanent risk adjustment program, designed to mitigate the potential impact of adverse selection and provide stability for health insurance issuers, applies to all non-grandfathered plans not subject to transitional relief in the individual and small group markets both inside and outside of the insurance exchanges. Effective for 2018 benefit plan year, the risk adjustments and distributions are calculated using a high-cost risk pool which adds a reinsurance-like element to this program. The operation of the high-cost risk pools exclude a percentage of costs above a threshold level determined by federal regulations. The program operates two national high-cost risk pools, one for individuals and one for small groups. The data used by CMS to determine the risk adjustment amount is subject to risk adjustment data validation audits along with the true-up to the final CMS report, which may result in a material change to arrive at the final risk adjustment amount

from the initial risk adjustment estimate recorded. Premium adjustments pursuant to the risk adjustment program are accounted for as premium subject to redetermination and user fees are accounted for as assessments.

Reinsurance — The transitional reinsurance program was designed to protect issuers in the individual market from an expected increase in large claims due to the elimination of preexisting condition limitations. The transitional reinsurance program was effective from 2014 through 2016 and applied to all issuers of major medical commercial products and third-party administrators. Contributions attributable to enrollees in the ACA compliant individual plans, including program administrative costs, were accounted for as ceded premium and payments received were accounted for as ceded benefit recoveries. The portion of the individual contributions earmarked for the U.S. Treasury was accounted for as an assessment. Contributions made for enrollees in fully insured plans other than the ACA compliant individual plans, including program administrative costs and payments to the U.S. Treasury, were treated as assessments.

Risk Corridors — The temporary risk corridors program, designed to provide some aggregate protection against variability for issuers in the individual and small group markets during the period 2014 through 2016, applied to Qualified Health Plans in the individual and small group markets both inside and outside of the insurance exchanges. Premium adjustments pursuant to the risk corridors program were accounted for as premium adjustments for retrospectively rated contracts.

(2) The following table presents the current year impact of risk-sharing provisions of the ACA on assets, liabilities and operations:

a. Permanent ACA Risk Adjustment Program	**December 31, 2019**
Assets —	
1. Premium adjustments receivable due to ACA Risk Adjustment (including high risk	$ 4,146
Liabilities:	
2. Risk adjustment user fees payable for ACA Risk Adjustment	1,027
3. Premium adjustments payable due to ACA Risk Adjustment (including high risk	12,129
Operations (Revenue & Expense):	
4. Reported as revenue in premium for accident and health contracts (written/collected) due to ACA Risk Adjustment	218,309
5. Reported in expenses as ACA risk adjustment user fees (incurred/paid)	1,027
b. Transitional ACA Reinsurance Program	
Assets —	
1. Amounts recoverable for claims paid due to ACA Reinsurance	-
2. Amounts recoverable for claims unpaid due to ACA Reinsurance (Contra Liability)	-
3. Amounts receivable relating to uninsured plans for contributions for ACA Reinsurance	-
Liabilities:	
4. Liabilities for contributions payable due to ACA Reinsurance — not reported as ceded premium	-
5. Ceded reinsurance premiums payable due to ACA Reinsurance	-
6. Liability for amounts held under uninsured plans contributions for ACA Reinsurance	-
Operations (Revenue & Expense):	
7. Ceded reinsurance premiums due to ACA Reinsurance	-
8. Reinsurance recoveries (income statement) due to ACA reinsurance payments or expected payments	18,689
9. ACA Reinsurance contributions - not reported as ceded premium	-
c. Temporary ACA Risk Corridors Program	
Assets —	
1. Accrued retrospective premium due to ACA Risk Corridors	-
Liabilities —	
2. Reserve for rate credits or policy experience rating refunds due to ACA Risk Corridors	-
Operations (Revenue & Expense):	
3. Effect of ACA Risk Corridors on net premium income (paid/received)	-
4. Effect of ACA Risk Corridors on change in reserves for rate credits	-

(3) The following table is a rollforward of the prior year ACA risk-sharing provisions for asset and liability balances, along with reasons for adjustments to prior year balances:

	Accrued during the Prior Year on Business Written before December 31 of the Prior Year		Received or Paid as of the Current Year on Business Written before December 31 of the Prior Year		Differences		Adjustments			Unsettled Balances as of the Reporting Date	
					Prior Year Accrued Less Payments (Col 1 - 3)	Prior Year Accrued Less Payments (Col 2 - 4)	To Prior Year Balances	To Prior Year Balances		Cumulative Balance from Prior Years (Col 1 - 3 + 7)	Cumulative Balance from Prior Years (Col 2 - 4 + 8)
	1 Receivable	2 (Payable)	3 Receivable	4 (Payable)	5 Receivable	6 (Payable)	7 Receivable	8 (Payable)	Ref	9 Receivable	10 (Payable)
a. Permanent ACA Risk Adjustment Program											
1. Premium Adjustment Receivable (including high risk pool payments)	$ 247,904	$ -	$ 488,406	$ -	$ (240,502)	$ -	$ 240,502	$ -	A	$ -	$ -
2. Premium Adjustment (Payable) (including high risk pool premium)	-	-	-	(14,211)	-	14,211	-	(14,211)	B	-	-
3. Subtotal ACA Permanent Risk Adjustment Program	247,904	-	488,406	(14,211)	(240,502)	14,211	240,502	(14,211)		-	-
b. Transitional ACA Reinsurance Program											
1. Amounts recoverable for claims paid	23,686	-	42,375	-	(18,689)	-	18,689	-	C	-	-
2. Amounts recoverable for claims unpaid (contra liability)	-	-	-	-	-	-	-	-	D	-	-
3. Amounts receivable relating to uninsured plans	-	-	-	-	-	-	-	-	E	-	-
4. Liabilities for contributions payable due to ACA Reinsurance — not reported as ceded premium	-	-	-	-	-	-	-	-	F	-	-
5. Ceded reinsurance premiums payable	-	-	-	-	-	-	-	-	G	-	-
6. Liability for amounts held under uninsured plans	-	-	-	-	-	-	-	-	H	-	-
7. Subtotal ACA Transitional Reinsurance Program	23,686	-	42,375	-	(18,689)	-	18,689	-		-	-
c. Temporary ACA Risk Corridors Program											
1. Accrued retrospective premium	-	-	-	-	-	-	-	-	I	-	-
2. Reserve for rate credits or policy experience rating refunds	-	-	-	-	-	-	-	-	J	-	-
3. Subtotal ACA Risk Corridors Program	-	-	-	-	-	-	-	-		-	-
d. Total for ACA Risk-Sharing Provisions	$ 271,590	$ -	$ 530,781	$ (14,211)	$ (259,191)	$ 14,211	$ 259,191	$ (14,211)		$ -	$ -

Explanation of Adjustments

A. The risk adjustment receivable as of December 31, 2019 w as adjusted based on the final CMS Summary Report on Permanent Risk Adjustment Transfers for the 2018 Benefit Year. The risk adjustment receivable as of December 31, 2018 utilized paid claims through October 31, 2018. The adjustment to the December receivable balance reflects the true up to final results for the 2018 Benefit Year. The risk adjustment receivable w as further adjusted based on the CMS Summary Report of 2017 Benefit Year Risk Adjustment Data Validation Adjustments to Risk Adjustment Transfers.

B. The risk adjustment payable as of December 31, 2019 w as adjusted based on the final CMS Summary Report on Permanent Risk Adjustment Transfers for the 2018 Benefit Year. The risk adjustment payable as of December 31, 2018 utilized paid claims through October 31, 2018. The adjustment to the December payable balance reflects the true up to final results for the 2018 Benefit Year. The risk adjustment payable as of December 31, 2019 w as further adjusted based on the CMS Summary Report of 2017 Benefit Year Risk Adjustment Data Validation Adjustments to Risk Adjustment Transfers.

C. Actual reinsurance receipts exceeded anticipated results due to a higher final coinsurance rate.

D. N/A

E. N/A

F. N/A

G. N/A

H. N/A

(4) The Company does not have any risk corridor receivables or payables to present in the table below:

	Accrued during the Prior Year on Business Written Before December 31 of the Prior Year		Received or Paid as of the Current Year on Business Written before December 31 of the Prior Year		Differences		Adjustments			Unsettled Balances as of the Reporting Date	
					Prior Year Accrued Less Payments (Col 1 – 3)	Prior Year Accrued Less Payments (Col 2 – 4)	To Prior Year Balances	To Prior Year Balances		Cumulative Balance from Prior Years (Col 1 – 3 + 7)	Cumulative Balance from Prior Years (Col 2 – 4 + 8)
	1	2	3	4	5	6	7	8		9	10
Risk Corridors Program Year	Receivable	(Payable)	Receivable	(Payable)	Receivable	(Payable)	Receivable	(Payable)	Ref	Receivable	(Payable)
a. 2014											
1. Accrued retrospective premium	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	A	$ -	$ -
2. Reserve for rate credits or policy experience rating refunds	-	-	-	-	-	-	-	-	B	-	-
b. 2015											
1. Accrued retrospective premium	-	-	-	-	-	-	-	-	C	-	-
2. Reserve for rate credits or policy experience rating refunds	-	-	-	-	-	-	-	-	D	-	-
c. 2016											
1. Accrued retrospective premium	-	-	-	-	-	-	-	-	E	-	-
2. Reserve for rate credits or policy experience rating refunds	-	-	-	-	-	-	-	-	F	-	-
d. Total for Risk Corridors	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -		$ -	$ -

Explanation of Adjustments

A. N/A
B. N/A
C. N/A
D. N/A
E. N/A
F. N/A

(5) The following table discloses ACA risk corridor receivable balances by risk corridor program year:

Risk Corridors Program Year	1 Estimated Amount to be Filed or Final Amount Filed with CMS	2 Non-Accrued Amounts for Impairment or Other Reasons	3 Amounts Received from CMS	4 Asset Balance (Gross of Non-admissions) (1 - 2 - 3)	5 Non-admitted Amount	6 Net Admitted Asset (4 - 5)
a. 2014	$ -	$ -	$ -	$ -	$ -	$ -
b. 2015	809,174	809,174	-	-	-	-
c. 2016	3,906,593	3,906,593	-	-	-	-
d. Total (a + b + c)	$4,715,767	$4,715,767	$ -	$ -	$ -	$ -

25. CHANGE IN INCURRED CLAIMS AND CLAIMS ADJUSTMENT EXPENSES

A. Changes in estimates related to the prior year incurred claims are included in total hospital and medical expenses in the current year in the statutory basis statements of operations. The following tables disclose paid claims, incurred claims, and the balance in claims unpaid, accrued

medical incentive pool and bonus amounts, aggregate health claim reserves, health care receivables and reinsurance recoverables for the years ended December 31, 2019 and 2018:

	2019		
	Current Year Incurred Claims	Prior Years Incurred Claims	Total
Beginning of year claim reserve	$ -	$ (81,634,992)	$ (81,634,992)
Paid claims — net of health care receivables and reinsurance recoveries collected	799,782,753	60,319,821	860,102,574
End of year claim reserve	64,780,408	1,861,194	66,641,602
Incurred claims excluding the change in health care receivables and reinsurance recoverables as presented below	864,563,161	(19,453,977)	845,109,184
Beginning of year health care receivables and reinsurance recoverables	-	6,237,405	6,237,405
End of year health care receivables and reinsurance recoverables	(1,350,259)	(1,767,934)	(3,118,193)
Total incurred claims	$ 863,212,902	$ (14,984,506)	$ 848,228,396

	2018		
	Current Year Incurred Claims	Prior Years Incurred Claims	Total
Beginning of year claim reserve	$ -	$ (85,195,058)	$ (85,195,058)
Paid claims — net of health care receivables and reinsurance recoveries collected	923,852,050	64,843,877	988,695,927
End of year claim reserve	70,627,136	11,007,856	81,634,992
Incurred claims excluding the change in health care receivables and reinsurance recoverables as presented below	994,479,186	(9,343,325)	985,135,861
Beginning of year health care receivables and reinsurance recoverables	-	8,759,936	8,759,936
End of year health care receivables and reinsurance recoverables	(3,134,693)	(3,102,712)	(6,237,405)
Total incurred claims	$ 991,344,493	$ (3,686,101)	$ 987,658,392

The liability for claims unpaid, accrued medical incentive pool and bonus amounts and aggregate health claim reserves, net of health care receivables and reinsurance recoverables as of December 31, 2018 was $75,397,587. As of December 31, 2019, $60,319,821 has been paid for incurred claims attributable to insured events of prior years. Reserves remaining for prior years, net of health care receivables, are now $93,260 as a result of re-estimation of unpaid claims. Therefore, there has been $14,984,506 favorable prior year development since December 31, 2018 to December 31, 2019. The primary drivers consist of favorable development as a result of

physician claims payable of $10,411,012, a change in the provision for adverse deviations in experience of $5,275,323 and retroactivity for inpatient, outpatient, physician, and pharmacy claims of $2,793,952, partially offset by unfavorable development of $2,891,968 in claims recoveries. At December 31, 2018, the Company recorded favorable development as a result of a change in the provision for adverse deviations in experience of $4,799,927 and provider settlements of $3,309,380, partially offset by unfavorable development of $4,360,216 in retroactivity for inpatient, outpatient, physician, and pharmacy claims. Original estimates are increased or decreased, as additional information becomes known regarding individual claims, which could have an impact to the accruals for medical loss ratio rebates and retrospectively rated contracts. As a result of the prior year effects, on a regular basis, the Company adjusts revenue and the corresponding liability and/or receivable related to retrospectively rated policies and the impact of the change is included as a component of change in unearned premium reserves in the statutory basis statements of operations.

The Company incurred CAE of $44,809,281 and $42,748,017 in 2019 and 2018, respectively. These costs are included in the management service fees paid by the Company to UHS as a part of the Agreement (see Note 10). The following table discloses paid CAE, incurred CAE, and the balance in unpaid CAE reserve for 2019 and 2018:

	2019	2018
Total claims adjustment expenses	$44,809,281	$42,748,017
Less: current year unpaid claims adjustment expenses	(652,988)	(769,995)
Add: prior year unpaid claims adjustment expenses	769,995	958,982
Total claims adjustment expenses paid	$44,926,288	$42,937,004

B. The Company did not make any significant changes in methodologies and assumptions used in the calculation of the liability for claims unpaid and unpaid CAE in 2019.

26. INTERCOMPANY POOLING ARRANGEMENTS

A–G. The Company did not have any intercompany pooling arrangements in 2019 or 2018.

27. STRUCTURED SETTLEMENTS

A–B. The Company did not have structured settlements in 2019 or 2018.

28. HEALTH CARE RECEIVABLES

A. Pharmacy rebates receivable are recorded when reasonably estimated or billed by the affiliated pharmaceutical benefit manager in accordance with pharmaceutical rebate contract provisions. Information used to support rebates billed to the manufacturer is based on utilization information gathered by the pharmaceutical benefit manager and adjusted for significant changes in pharmaceutical contract provisions.

The Company evaluates admissibility of all pharmacy rebates receivable based on the administration of each underlying pharmaceutical benefit management agreement. The Company has nonadmitted and excluded all pharmacy rebates receivable that do not meet the admissibility criteria of SSAP No. 84, *Certain Health Care Receivables and Receivables under Government Insured Plans* (“SSAP No. 84”) from the statutory basis statements of admitted assets, liabilities, and capital and surplus.

For each pharmaceutical management agreement for which a portion of the total pharmacy rebates receivable can be admitted based on the admissibility criteria of SSAP No. 84, the pharmacy rebate transaction history is summarized as follows:

Quarter	Estimated Pharmacy Rebates as Reported on Financial Statements	Pharmacy Rebates as Billed or Otherwise Confirmed	Actual Rebates Received within 90 Days of Billing	Actual Rebates Received within 91 to 180 Days of Billing	Actual Rebates Received More than 180 Days after Billing
12/31/2019	$ 521,237	$ -	$ -	$ -	$ -
9/30/2019	540,325	520,986	164,560	-	-
6/30/2019	543,520	539,433	127,383	380,835	-
3/31/2019	565,486	584,319	231,419	156,963	166,375
12/31/2018	642,511	637,646	310,198	295,053	25,229
9/30/2018	625,829	659,821	335,053	248,839	71,915
6/30/2018	662,115	684,486	316,806	295,872	62,094
3/31/2018	608,686	618,355	159,857	375,853	77,088
12/31/2017	659,446	628,435	221,988	343,820	60,065
9/30/2017	666,645	638,042	190,595	351,396	91,581
6/30/2017	589,141	621,443	136,499	323,833	159,045
3/31/2017	644,693	682,258	61,914	291,103	322,583

Of the amount reported as health care receivables, $878,157 and $963,262 relates to pharmacy rebates receivable and $137,013 and $201,944 relates to claims overpayments as of December 31, 2019 and 2018, respectively. This decrease is primarily due to decreased membership along with the change in generic/name brand mix.

B. The Company does not have any risk-sharing receivables.

29. PARTICIPATING POLICIES

The Company did not have any participating contracts in 2019 or 2018.

30. PREMIUM DEFICIENCY RESERVES

The Company has not recorded any PDR as of December 31, 2019 or 2018. The analysis of PDR was completed as of December 31, 2019 and 2018. The Company did consider anticipated investment income when calculating the PDR.

The following table summarizes the Company's PDR as of December 31, 2019 and 2018:

	2019
1. Liability carried for premium deficiency reserves	$ -
2. Date of the most recent evaluation of this liability	12/31/2019
3. Was anticipated investment income utilized in this calculation?	Yes [X] No [ ]

	2018
1. Liability carried for premium deficiency reserves	$ -
2. Date of the most recent evaluation of this liability	12/31/2018
3. Was anticipated investment income utilized in this calculation?	Yes [X] No [ ]

31. ANTICIPATED SALVAGE AND SUBROGATION

Due to the type of business being written, the Company has no salvage. As of December 31, 2019 and 2018, the Company had no specific accruals established for outstanding subrogation, as it is considered a component of the actuarial calculations used to develop the estimates of claims unpaid and aggregate health claim reserves.

* * * * * *

SUPPLEMENTAL SCHEDULES

EXHIBIT I:
SUPPLEMENTAL INVESTMENT RISKS INTERROGATORIES

SUPPLEMENTAL INVESTMENT RISKS INTERROGATORIES

For The Year Ended December 31, 2019
(To Be Filed by April 1)

Of The UnitedHealthcare of Mississippi, Inc.

ADDRESS (City, State and Zip Code) Minnetonka , MN 55343

NAIC Group Code 0707 NAIC Company Code 95716 Federal Employer's Identification Number (FEIN) 63-1036817

The Investment Risks Interrogatories are to be filed by April 1. They are also to be included with the Audited Statutory Financial Statements.

Answer the following interrogatories by reporting the applicable U.S. dollar amounts and percentages of the reporting entity's total admitted assets held in that category of investments.

1. Reporting entity's total admitted assets as reported on Page 2 of this annual statement. $ 255,816,526

2. Ten largest exposures to a single issuer/borrower/investment.

	1 Issuer	2 Description of Exposure	3 Amount	4 Percentage of Total Admitted Assets
2.01	FHLMC	Bonds	$ 9,267,912	3.6 %
2.02	Fannie Mae	Bonds	$ 8,830,631	3.5 %
2.03	Northern Inst - BGSXX	Bonds	$ 3,409,202	1.3 %
2.04	Goldman Sachs - FGTXX	Bonds	$ 3,050,375	1.2 %
2.05	Dreyfus - DGCXX	Bonds	$ 2,668,781	1.0 %
2.06	UTAH ST HSG CORP - HSG	Bonds	$ 2,156,696	0.8 %
2.07	VIRGINIA ST PUBL - APP	Bonds	$ 1,544,497	0.6 %
2.08	NATIONWIDE BLDG	Bonds	$ 1,501,978	0.6 %
2.09	PROV OF NEW BRUNSWICK	Bonds	$ 1,493,829	0.6 %
2.10	Goldman Sachs - FSMXX	Bonds	$ 1,437,511	0.6 %

3. Amounts and percentages of the reporting entity's total admitted assets held in bonds and preferred stocks by NAIC designation.

	Bonds	1	2		Preferred Stocks	3	4
3.01	NAIC-1	$ 137,151,423	53.6 %	3.07	P/RP-1	$ 0	0.0 %
3.02	NAIC-2	$ 15,705,496	6.1 %	3.08	P/RP-2	$ 0	0.0 %
3.03	NAIC-3	$ 0	0.0 %	3.09	P/RP-3	$ 0	0.0 %
3.04	NAIC-4	$ 0	0.0 %	3.10	P/RP-4	$ 0	0.0 %
3.05	NAIC-5	$ 0	0.0 %	3.11	P/RP-5	$ 0	0.0 %
3.06	NAIC-6	$ 0	0.0 %	3.12	P/RP-6	$ 0	0.0 %

4. Assets held in foreign investments:

4.01 Are assets held in foreign investments less than 2.5% of the reporting entity's total admitted assets? Yes [ ] No [X]

If response to 4.01 above is yes, responses are not required for interrogatories 5 - 10.

4.02	Total admitted assets held in foreign investments	$ 15,345,288	6.0 %
4.03	Foreign-currency-denominated investments	$ 0	0.0 %
4.04	Insurance liabilities denominated in that same foreign currency	$ 0	0.0 %

5. Aggregate foreign investment exposure categorized by NAIC sovereign designation:

		1	2
5.01	Countries designated NAIC-1	$ 15,198,253	5.9 %
5.02	Countries designated NAIC-2	$ 147,035	0.1 %
5.03	Countries designated NAIC-3 or below	$ 0	0.0 %

6. Largest foreign investment exposures by country, categorized by the country's NAIC sovereign designation:

		1	2
	Countries designated NAIC - 1:		
6.01	Country 1: UNITED KINGDOM	$ 4,992,732	2.0 %
6.02	Country 2: JAPAN	$ 2,074,036	0.8 %
	Countries designated NAIC - 2:		
6.03	Country 1: MEXICO	$ 147,035	0.1 %
6.04	Country 2:	$ 0	0.0 %
	Countries designated NAIC - 3 or below:		
6.05	Country 1:	$ 0	0.0 %
6.06	Country 2:	$ 0	0.0 %

		1	2
7.	Aggregate unhedged foreign currency exposure	$ 0	0.0 %

8. Aggregate unhedged foreign currency exposure categorized by NAIC sovereign designation:

		1	2
8.01	Countries designated NAIC-1	$ 0	0.0 %
8.02	Countries designated NAIC-2	$ 0	0.0 %
8.03	Countries designated NAIC-3 or below	$ 0	0.0 %

9. Largest unhedged foreign currency exposures by country, categorized by the country's NAIC sovereign designation:

		1	2
	Countries designated NAIC - 1:		
9.01	Country 1:	$ 0	0.0 %
9.02	Country 2:	$ 0	0.0 %
	Countries designated NAIC - 2:		
9.03	Country 1:	$ 0	0.0 %
9.04	Country 2:	$ 0	0.0 %
	Countries designated NAIC - 3 or below:		
9.05	Country 1:	$ 0	0.0 %
9.06	Country 2:	$ 0	0.0 %

10. Ten largest non-sovereign (i.e. non-governmental) foreign issues:

	1 Issuer	2 NAIC Designation	3	4
10.01	PROV OF NEW BRUNSWICK	1	$ 1,493,829	0.6 %
10.02	RENAISSANCERE	1	$ 1,381,721	0.5 %
10.03	NISSAN MOTOR ACC	1	$ 1,003,705	0.4 %
10.04	NATIONWIDE BLDG	1	$ 1,001,978	0.4 %
10.05	EUROPEAN BK RECON & DEV	1	$ 999,184	0.4 %
10.06	Inter Amer'n Development Bank	1	$ 998,109	0.4 %
10.07	MADISON PARK FUNDING LTD - MDPK 2019-37A	1	$ 830,000	0.3 %
10.08	STATOIL ASA	1	$ 741,990	0.3 %
10.09	UBS GROUP	1	$ 649,813	0.3 %
10.10	AIA GROUP	1	$ 641,931	0.3 %

11. Amounts and percentages of the reporting entity's total admitted assets held in Canadian investments and unhedged Canadian currency exposure:

11.01 Are assets held in Canadian investments less than 2.5% of the reporting entity's total admitted assets? ..... Yes [X] No [ ]

If response to 11.01 is yes, detail is not required for the remainder of interrogatory 11.

		1	2
11.02	Total admitted assets held in Canadian investments	$ 0	0.0 %
11.03	Canadian-currency-denominated investments	$ 0	0.0 %
11.04	Canadian-denominated insurance liabilities	$ 0	0.0 %
11.05	Unhedged Canadian currency exposure	$ 0	0.0 %

12. Report aggregate amounts and percentages of the reporting entity's total admitted assets held in investments with contractual sales restrictions:

12.01 Are assets held in investments with contractual sales restrictions less than 2.5% of the reporting entity's total admitted assets? ..... Yes [X] No [ ]

If response to 12.01 is yes, responses are not required for the remainder of Interrogatory 12.

	1	2	3
12.02	Aggregate statement value of investments with contractual sales restrictions	$ 0	0.0 %
	Largest three investments with contractual sales restrictions:		
12.03		$ 0	0.0 %
12.04		$ 0	0.0 %
12.05		$ 0	0.0 %

13. Amounts and percentages of admitted assets held in the ten largest equity interests:

13.01 Are assets held in equity interests less than 2.5% of the reporting entity's total admitted assets? ..... Yes [X] No [ ]

If response to 13.01 above is yes, responses are not required for the remainder of Interrogatory 13.

	1 Issuer	2	3
13.02		$ 0	0.0 %
13.03		$ 0	0.0 %
13.04		$ 0	0.0 %
13.05		$ 0	0.0 %
13.06		$ 0	0.0 %
13.07		$ 0	0.0 %
13.08		$ 0	0.0 %
13.09		$ 0	0.0 %
13.10		$ 0	0.0 %
13.11		$ 0	0.0 %

14. Amounts and percentages of the reporting entity's total admitted assets held in nonaffiliated, privately placed equities:

14.01 Are assets held in nonaffiliated, privately placed equities less than 2.5% of the reporting entity's total admitted assets? ..... Yes [X] No [ ]

If response to 14.01 above is yes, responses are not required for the remainder of Interrogatory 14.

	1	2	3
14.02	Aggregate statement value of investments held in nonaffiliated, privately placed equities	$ 0	0.0 %
	Largest three investments held in nonaffiliated, privately placed equities:		
14.03		$ 0	0.0 %
14.04		$ 0	0.0 %
14.05		$ 0	0.0 %

Ten largest fund managers:

	1 Fund Manager	2 Total Invested	3 Diversified	4 Nondiversified
14.06		$ 0	$ 0	$ 0
14.07		$ 0	$ 0	$ 0
14.08		$ 0	$ 0	$ 0
14.09		$ 0	$ 0	$ 0
14.10		$ 0	$ 0	$ 0
14.11		$ 0	$ 0	$ 0
14.12		$ 0	$ 0	$ 0
14.13		$ 0	$ 0	$ 0
14.14		$ 0	$ 0	$ 0
14.15		$ 0	$ 0	$ 0

15. Amounts and percentages of the reporting entity's total admitted assets held in general partnership interests:

15.01 Are assets held in general partnership interests less than 2.5% of the reporting entity's total admitted assets? ..... Yes [X] No [ ]

If response to 15.01 above is yes, responses are not required for the remainder of Interrogatory 15.

	1	2	3
15.02	Aggregate statement value of investments held in general partnership interests	$ 0	0.0 %
	Largest three investments in general partnership interests:		
15.03		$ 0	0.0 %
15.04		$ 0	0.0 %
15.05		$ 0	0.0 %

16. Amounts and percentages of the reporting entity's total admitted assets held in mortgage loans:

16.01 Are mortgage loans reported in Schedule B less than 2.5% of the reporting entity's total admitted assets? Yes [X] No [ ]

If response to 16.01 above is yes, responses are not required for the remainder of Interrogatory 16 and Interrogatory 17.

	1 Type (Residential, Commercial, Agricultural)	2	3
16.02		$ 0	0.0 %
16.03		$ 0	0.0 %
16.04		$ 0	0.0 %
16.05		$ 0	0.0 %
16.06		$ 0	0.0 %
16.07		$ 0	0.0 %
16.08		$ 0	0.0 %
16.09		$ 0	0.0 %
16.10		$ 0	0.0 %
16.11		$ 0	0.0 %

Amount and percentage of the reporting entity's total admitted assets held in the following categories of mortgage loans:

		Loans	
16.12	Construction loans	$ 0	0.0 %
16.13	Mortgage loans over 90 days past due	$ 0	0.0 %
16.14	Mortgage loans in the process of foreclosure	$ 0	0.0 %
16.15	Mortgage loans foreclosed	$ 0	0.0 %
16.16	Restructured mortgage loans	$ 0	0.0 %

17. Aggregate mortgage loans having the following loan-to-value ratios as determined from the most current appraisal as of the annual statement date:

		Residential		Commercial		Agricultural	
	Loan to Value	1	2	3	4	5	6
17.01	above 95%	$ 0	0.0 %	$ 0	0.0 %	$ 0	0.0 %
17.02	91 to 95%	$ 0	0.0 %	$ 0	0.0 %	$ 0	0.0 %
17.03	81 to 90%	$ 0	0.0 %	$ 0	0.0 %	$ 0	0.0 %
17.04	71 to 80%	$ 0	0.0 %	$ 0	0.0 %	$ 0	0.0 %
17.05	below 70%	$ 0	0.0 %	$ 0	0.0 %	$ 0	0.0 %

18. Amounts and percentages of the reporting entity's total admitted assets held in each of the five largest investments in real estate:

18.01 Are assets held in real estate reported less than 2.5% of the reporting entity's total admitted assets? Yes [X] No [ ]

If response to 18.01 above is yes, responses are not required for the remainder of Interrogatory 18.

Largest five investments in any one parcel or group of contiguous parcels of real estate.

	Description 1	2	3
18.02		$ 0	0.0 %
18.03		$ 0	0.0 %
18.04		$ 0	0.0 %
18.05		$ 0	0.0 %
18.06		$ 0	0.0 %

19. Report aggregate amounts and percentages of the reporting entity's total admitted assets held in investments held in mezzanine real estate loans:

19.01 Are assets held in investments held in mezzanine real estate loans less than 2.5% of the reporting entity's total admitted assets? Yes [X] No [ ]

If response to 19.01 is yes, responses are not required for the remainder of Interrogatory 19.

	1	2	3
19.02	Aggregate statement value of investments held in mezzanine real estate loans:	$ 0	0.0 %
	Largest three investments held in mezzanine real estate loans:		
19.03		$ 0	0.0 %
19.04		$ 0	0.0 %
19.05		$ 0	0.0 %

20. Amounts and percentages of the reporting entity's total admitted assets subject to the following types of agreements:

		At Year End		At End of Each Quarter		
				1st Quarter	2nd Quarter	3rd Quarter
		1	2	3	4	5
20.01	Securities lending agreements (do not include assets held as collateral for such transactions)	$ 0	0.0 %	$ 0	$ 0	$ 0
20.02	Repurchase agreements	$ 0	0.0 %	$ 0	$ 0	$ 0
20.03	Reverse repurchase agreements	$ 0	0.0 %	$ 0	$ 0	$ 0
20.04	Dollar repurchase agreements	$ 0	0.0 %	$ 0	$ 0	$ 0
20.05	Dollar reverse repurchase agreements	$ 0	0.0 %	$ 0	$ 0	$ 0

21. Amounts and percentages of the reporting entity's total admitted assets for warrants not attached to other financial instruments, options, caps, and floors:

		Owned		Written	
		1	2	3	4
21.01	Hedging	$ 0	0.0 %	$ 0	0.0 %
21.02	Income generation	$ 0	0.0 %	$ 0	0.0 %
21.03	Other	$ 0	0.0 %	$ 0	0.0 %

22. Amounts and percentages of the reporting entity's total admitted assets of potential exposure for collars, swaps, and forwards:

		At Year End		At End of Each Quarter		
				1st Quarter	2nd Quarter	3rd Quarter
		1	2	3	4	5
22.01	Hedging	$ 0	0.0 %	$ 0	$ 0	$ 0
22.02	Income generation	$ 0	0.0 %	$ 0	$ 0	$ 0
22.03	Replications	$ 0	0.0 %	$ 0	$ 0	$ 0
22.04	Other	$ 0	0.0 %	$ 0	$ 0	$ 0

23. Amounts and percentages of the reporting entity's total admitted assets of potential exposure for futures contracts:

		At Year End		At End of Each Quarter		
				1st Quarter	2nd Quarter	3rd Quarter
		1	2	3	4	5
23.01	Hedging	$ 0	0.0 %	$ 0	$ 0	$ 0
23.02	Income generation	$ 0	0.0 %	$ 0	$ 0	$ 0
23.03	Replications	$ 0	0.0 %	$ 0	$ 0	$ 0
23.04	Other	$ 0	0.0 %	$ 0	$ 0	$ 0

EXHIBIT II:
SUMMARY INVESTMENT SCHEDULE

SUMMARY INVESTMENT SCHEDULE

Investment Categories	Gross Investment Holdings		Admitted Assets as Reported in the Annual Statement			
	1	2	3	4	5	6
	Amount	Percentage of Column 1 Line 13	Amount	Securities Lending Reinvested Collateral Amount	Total (Col. 3 + 4) Amount	Percentage of Column 5 Line 13
1. Long-Term Bonds (Schedule D, Part 1):						
1.01 U.S. governments	2,609,283	1.245	2,609,283	0	2,609,283	1.245
1.02 All other governments	4,282,869	2.043	4,282,869	0	4,282,869	2.043
1.03 U.S. states, territories and possessions, etc. guaranteed	716,483	0.342	716,483	0	716,483	0.342
1.04 U.S. political subdivisions of states, territories, and possessions, guaranteed	3,022,065	1.442	3,022,065	0	3,022,065	1.442
1.05 U.S. special revenue and special assessment obligations, etc. non-guaranteed	40,535,004	19.338	40,535,004	0	40,535,004	19.338
1.06 Industrial and miscellaneous	101,691,215	48.514	101,691,215	0	101,691,215	48.514
1.07 Hybrid securities	0	0.000	0	0	0	0.000
1.08 Parent, subsidiaries and affiliates	0	0.000	0	0	0	0.000
1.09 SVO identified funds	0	0.000	0	0	0	0.000
1.10 Unaffiliated Bank loans	0	0.000	0	0	0	0.000
1.11 Total long-term bonds	152,856,919	72.924	152,856,919	0	152,856,919	72.924
2. Preferred stocks (Schedule D, Part 2, Section 1):						
2.01 Industrial and miscellaneous (Unaffiliated)	0	0.000	0	0	0	0.000
2.02 Parent, subsidiaries and affiliates	0	0.000	0	0	0	0.000
2.03 Total preferred stocks	0	0.000	0	0	0	0.000
3. Common stocks (Schedule D, Part 2, Section 2):						
3.01 Industrial and miscellaneous Publicly traded (Unaffiliated)	0	0.000	0	0	0	0.000
3.02 Industrial and miscellaneous Other (Unaffiliated)	0	0.000	0	0	0	0.000
3.03 Parent, subsidiaries and affiliates Publicly traded	0	0.000	0	0	0	0.000
3.04 Parent, subsidiaries and affiliates Other	0	0.000	0	0	0	0.000
3.05 Mutual funds	0	0.000	0	0	0	0.000
3.06 Unit investment trusts	0	0.000	0	0	0	0.000
3.07 Closed-end funds	0	0.000	0	0	0	0.000
3.08 Total common stocks	0	0.000	0	0	0	0.000
4. Mortgage loans (Schedule B):						
4.01 Farm mortgages	0	0.000	0	0	0	0.000
4.02 Residential mortgages	0	0.000	0	0	0	0.000
4.03 Commercial mortgages	0	0.000	0	0	0	0.000
4.04 Mezzanine real estate loans	0	0.000	0	0	0	0.000
4.05 Total mortgage loans	0	0.000	0	0	0	0.000
5. Real estate (Schedule A):						
5.01 Properties occupied by company	0	0.000	0	0	0	0.000
5.02 Properties held for production of income	0	0.000	0	0	0	0.000
5.03 Properties held for sale	0	0.000	0	0	0	0.000
5.04 Total real estate	0	0.000	0	0	0	0.000
6. Cash, cash equivalents and short-term investments:						
6.01 Cash (Schedule E, Part 1)	49,541	0.024	49,541	0	49,541	0.024
6.02 Cash equivalents (Schedule E, Part 2)	56,705,676	27.053	56,705,676	0	56,705,676	27.053
6.03 Short-term investments (Schedule DA)	0	0.000	0	0	0	0.000
6.04 Total cash, cash equivalents and short-term investments	56,755,217	27.076	56,755,217	0	56,755,217	27.076
7. Contract loans	0	0.000	0	0	0	0.000
8. Derivatives (Schedule DB)	0	0.000	0	0	0	0.000
9. Other invested assets (Schedule BA)	0	0.000	0	0	0	0.000
10. Receivables for securities	0	0.000	0	0	0	0.000
11. Securities Lending (Schedule DL, Part 1)	0	0.000	0	XXX	XXX	XXX
12. Other invested assets (Page 2, Line 11)	0	0.000	0	0	0	0.000
13. Total invested assets	209,612,136	100.000	209,612,136	0	209,612,136	100.000

OTHER ATTACHMENT

Deloitte.

Deloitte & Touche LLP
50 South 6th Street
Suite 2800
Minneapolis, MN 55402-1538
USA

Tel: +1 612 397 4000
Fax: +1 612 397 4450
www.deloitte.com

To the Audit Committee of
UnitedHealthcare of Mississippi, Inc.
795 Woodlands Parkway, Suite 301
Ridgeland, MS 39157

The Management of
UnitedHealthcare of Mississippi, Inc.
795 Woodlands Parkway, Suite 301
Ridgeland, MS 39157

Dear Members of the Audit Committee and Management:

We have audited, in accordance with auditing standards generally accepted in the United States of America, the statutory basis financial statements of UnitedHealthcare of Mississippi, Inc. (the "Company") for the years ended December 31, 2019, and 2018, and have issued our report thereon dated April 21, 2020. In connection therewith, we advise you as follows:

1. We are independent certified public accountants with respect to the Company and conform to the standards of the accounting profession as contained in the *Code of Professional Conduct* and pronouncements of the American Institute of Certified Public Accountants, the rules and regulations of the Mississippi Insurance Department, and the Rules of Professional Conduct of the Minnesota State Board of Accountancy.

2. The engagement partner and engagement manager, who are certified public accountants, have 30 years and 11 years, respectively, of experience in public accounting and are experienced in auditing insurance enterprises. Members of the engagement team, most of whom have had experience in auditing insurance enterprises and 33% percent of whom are certified public accountants, were assigned to perform tasks commensurate with their training and experience.

3. We understand that the Company intends to file its audited statutory basis financial statements and our report thereon with the Mississippi Insurance Department and other state insurance departments in states in which the Company is licensed and that the insurance commissioners of those states will be relying on that information in monitoring and regulating the statutory basis financial condition of the Company.

   While we understand that an objective of issuing a report on the statutory basis financial statements is to satisfy regulatory requirements, our audit was not planned to satisfy all objectives or responsibilities of insurance regulators. In this context, the Company and insurance commissioners should understand that the objective of an audit of statutory basis financial statements in accordance with auditing standards generally accepted in the United States of America is to form an opinion and issue a report on whether the statutory basis financial statements present fairly, in all material respects, the admitted assets, liabilities, and capital and surplus, results of operations and cash flows in accordance with accounting practices prescribed or permitted by the Mississippi Insurance Department. Consequently, under auditing standards generally accepted in the United States of America, we have the responsibility, within the

inherent limitations of the auditing process, to plan and perform our audit to obtain reasonable assurance regarding whether the statutory basis financial statements are free from material misstatement, whether due to error or fraud, and to exercise due professional care in the conduct of the audit. The Company is not required to have, nor were we engaged to perform, an audit of internal control over financial reporting. Our audit included consideration of internal control relevant to the entity's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of internal control over financial reporting. The concept of selective testing of the data being audited, which involves judgment both as to the number of transactions to be audited and the areas to be tested, has been generally accepted as a valid and sufficient basis for an auditor to express an opinion on financial statements. Audit procedures that are effective for detecting errors, if they exist, may be ineffective for detecting misstatements resulting from fraud. Because of the characteristics of fraud, particularly those involving concealment and falsified documentation (including forgery), a properly planned and performed audit may not detect a material misstatement resulting from fraud. In addition, an audit does not address the possibility that material misstatements may occur in the future. Also, our use of professional judgment and the assessment of materiality for the purpose of our audit mean that matters may exist that would have been assessed differently by insurance commissioners.

It is the responsibility of the management of the Company to adopt sound accounting policies, to maintain an adequate and effective system of accounts, and to establish and maintain internal control that will, among other things, provide reasonable, but not absolute, assurance that assets are safeguarded against loss from unauthorized use or disposition and that transactions are executed in accordance with management's authorization and are recorded properly to permit the preparation of financial statements in conformity with accounting practices prescribed or permitted by the Mississippi Insurance Department.

The Insurance Commissioner should exercise due diligence to obtain whatever other information that may be necessary for the purpose of monitoring and regulating the statutory basis financial position of insurers and should not rely solely on the independent auditors' report.

4. We will retain the working papers (including those kept in a hard copy or electronic medium) prepared in the conduct of our audit until the Mississippi Insurance Department has filed a Report of Examination covering 2019, but no longer than seven years. After notification to the Company, we will make the working papers available for review by the Mississippi Insurance Department or its delegates, at the offices of the insurer, at our offices, at the Mississippi Insurance Department, or at any other reasonable place designated by the Insurance Commissioner. Furthermore, in the conduct of the aforementioned periodic review by the Mississippi Insurance Department, photocopies of pertinent audit working papers may be made (under the control of Deloitte & Touche LLP) and such copies may be retained by the Mississippi Insurance Department. In addition, to the extent requested, we may provide the Mississippi Insurance Department with copies of certain audit working papers (such as unlocked copies of Excel spreadsheets that do not contain password protection or encryption). As such, these audit working papers will be subject to potential modification by Mississippi Insurance Department or by others. We are not responsible for any modifications made to the copies, electronic or otherwise, after they are

provided to the Mississippi Insurance Department; and we are likewise not responsible for any effect that any such modifications, whether intentional or not, might have on the process, substance, or outcome of your regulatory examination.

5. The engagement partner has served in this capacity with respect to the Company since 2017, is licensed by the Minnesota State Board of Accountancy, and is a member in good standing of the American Institute of Certified Public Accountants.

6. To the best of our knowledge and belief, we are in compliance with the requirements of section 7 of the *NAIC's Model Rule (Regulation) Requiring Annual Audited Financial Reports* regarding qualifications of independent certified public accountants.

This letter is intended solely for the information and use of the Audit Committee and management of UnitedHealthcare of Mississippi, Inc. and for filing with the Mississippi Insurance Department and other state insurance departments to whose jurisdiction the Company is subject and is not intended to be and should not be used by anyone other than these specified parties.

Deloitte & Touche LLP

April 21, 2020

Att. 4.3.2.6-3
UnitedHealthcare of Mississippi, Inc. 2020 Audited Financial Statement

UnitedHealthcare of Mississippi, Inc.

Statutory Basis Financial Statements as of and for the Years Ended December 31, 2020 and 2019, Supplemental Schedules as of and for the Year Ended December 31, 2020, Independent Auditors' Report and Qualification Letter

UNITEDHEALTHCARE OF MISSISSIPPI, INC.

TABLE OF CONTENTS

Deloitte.

Deloitte & Touche LLP
50 South 6th Street
Suite 2800
Minneapolis, MN 55402-1538
USA

Tel:+1 612 397 4000
Fax:+1 612 397 4450
www.deloitte.com

INDEPENDENT AUDITORS' REPORT

To the Audit Committee of
UnitedHealthcare of Mississippi, Inc.
795 Woodlands Parkway, Suite 301, MS010-1000
Ridgeland, MS 39157

We have audited the accompanying statutory-basis financial statements of UnitedHealthcare of Mississippi, Inc. (the "Company"), which comprise the statutory-basis statements of admitted assets, liabilities, and capital and surplus as of December 31, 2020 and 2019, and the related statutory-basis statements of operations, changes in capital and surplus, and cash flows for the years then ended, and the related notes to the statutory-basis financial statements.

Management's Responsibility for the Statutory-Basis Financial Statements

Management is responsible for the preparation and fair presentation of these statutory-basis financial statements in accordance with the accounting practices prescribed or permitted by the Mississippi Insurance Department. Management is also responsible for the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

Auditors' Responsibility

Our responsibility is to express an opinion on these statutory-basis financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the statutory-basis financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the statutory-basis financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the statutory-basis financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the Company's preparation and fair presentation of the statutory-basis financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Company's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the statutory-basis financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, the statutory-basis financial statements referred to above present fairly, in all material respects, the admitted assets, liabilities, and capital and surplus of UnitedHealthcare of Mississippi, Inc. as of December 31, 2020 and 2019, and the results of its operations and its cash flows for the years then ended in accordance with the accounting practices prescribed or permitted by the Mississippi Insurance Department described in Note 1 to the statutory-basis financial statements.

Basis of Accounting

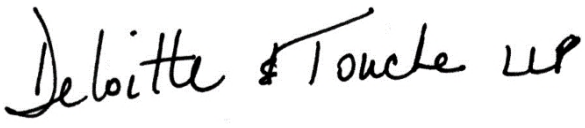
We draw attention to Note 1 of the statutory-basis financial statements, which describes the basis of accounting. As described in Note 1 to the statutory-basis financial statements, the statutory-basis financial statements are prepared by UnitedHealthcare of Mississippi, Inc. using accounting practices prescribed or permitted by the Mississippi Insurance Department, which is a basis of accounting other than accounting principles generally accepted in the United States of America, to meet the requirements of the Mississippi Insurance Department. Our opinion is not modified with respect to this matter.

Report on Supplemental Schedules

Our 2020 audit was conducted for the purpose of forming an opinion on the 2020 statutory-basis financial statements as a whole. The supplemental schedule of investment risks interrogatories and the supplemental summary investment schedule, and the supplemental schedule of Reinsurance Contracts with Risk-Limiting Features as of and for the year ended December 31, 2020 are presented for purposes of additional analysis and are not a required part of the 2020 statutory-basis financial statements. These schedules are the responsibility of the Company's management and were derived from and relate directly to the underlying accounting and other records used to prepare the statutory-basis financial statements. Such schedules have been subjected to the auditing procedures applied in our audit of the 2020 statutory-basis financial statements and certain additional procedures, including comparing and reconciling such schedules directly to the underlying accounting and other records used to prepare the statutory-basis financial statements or to the statutory-basis financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States of America. In our opinion, such schedules are fairly stated in all material respects in relation to the 2020 statutory-basis financial statements as a whole.

Restriction on Use

Our report is intended solely for the information and use of the Audit Committee and the management of UnitedHealthcare of Mississippi, Inc. and for filing with state insurance departments to whose jurisdiction the Company is subject and is not intended to be and should not be used by anyone other than these specified parties.



May 26, 2021

UNITEDHEALTHCARE OF MISSISSIPPI, INC.

STATUTORY BASIS STATEMENTS OF ADMITTED ASSETS,
LIABILITIES, AND CAPITAL AND SURPLUS
AS OF DECEMBER 31, 2020 AND 2019

	2020	2019
ADMITTED ASSETS		
CASH AND INVESTED ASSETS:		
Bonds	$ 152,307,729	$ 152,856,919
Cash of $47,921 and $49,541 and cash equivalents of $153,446,114 and $56,705,676 in 2020 and 2019 respectively	153,494,035	56,755,217
Subtotal cash and invested assets	305,801,764	209,612,136
OTHER ASSETS:		
Investment income due and accrued	889,867	959,294
Premiums and considerations	14,890,639	43,310,114
Amounts recoverable from reinsurers	8,580	4,514
Amounts receivable relating to uninsured plans	1,817,987	-
Current federal income tax recoverable	5,032,790	-
Net deferred tax asset	1,138,652	915,298
Receivables from parent, subsidiaries, and affiliates, net	4,876,784	-
Health care receivables	1,013,186	1,015,170
State income tax recoverable	853,707	-
Subtotal other assets	30,522,192	46,204,390
TOTAL ADMITTED ASSETS	$ 336,323,956	$ 255,816,526
LIABILITIES AND CAPITAL AND SURPLUS		
LIABILITIES:		
Claims unpaid	$ 67,019,034	$ 63,948,758
Accrued medical incentive pool and bonus amounts	284,870	1,436,114
Unpaid claims adjustment expenses	756,738	652,988
Aggregate health policy reserves	61,621,072	39,599
Aggregate health claim reserves	1,444,059	1,256,730
Premiums received in advance	165,553	9,031,531
General expenses due or accrued	6,199,814	3,656,429
Current federal income tax payable	-	707,861
Amounts withheld or retained for the account of others	13,445	-
Remittances and items not allocated	182	36,854
Amounts due to parent, subsidiaries, and affiliates, net	-	5,390,800
Payable for securities	2,000,876	-
Liability for amounts held under uninsured plans	1,906,308	932,571
Other liabilities	5,734,447	-
Total liabilities	147,146,398	87,090,235
CAPITAL AND SURPLUS:		
Section 9010 ACA subsequent fee year assessment	-	18,820,864
Common capital stock, $0.01 par value — 2,000 shares authorized; 2,000 shares issued and outstanding	20	20
Gross paid-in and contributed surplus	119,827,293	145,327,293
Unassigned surplus	69,350,245	4,578,114
Total capital and surplus	189,177,558	168,726,291
TOTAL LIABILITIES AND CAPITAL AND SURPLUS	$ 336,323,956	$ 255,816,526

See notes to statutory basis financial statements.

UNITEDHEALTHCARE OF MISSISSIPPI, INC.

STATUTORY BASIS STATEMENTS OF OPERATIONS
AS OF DECEMBER 31, 2020 AND 2019

	2020	2019
REVENUES:		
Net premium income	$ 1,083,761,007	$ 993,404,401
Change in unearned premium reserves and reserve for rate credits	(61,573,350)	(5,348)
Total revenues	1,022,187,657	993,399,053
UNDERWRITING DEDUCTIONS:		
Hospital and medical:		
Hospital/medical benefits	576,623,762	597,066,689
Other professional services	51,041,370	63,106,623
Prescription drugs	183,667,774	186,603,946
Incentive pool, withhold adjustments, and bonus amounts	695,035	1,297,497
Net reinsurance incurred	24,813	153,641
Total hospital and medical	812,052,754	848,228,396
Claims adjustment expenses	44,754,004	44,809,281
General administrative expenses	96,746,343	78,313,042
Total underwriting deductions	953,553,101	971,350,719
NET UNDERWRITING GAIN	68,634,556	22,048,334
NET INVESTMENT GAINS:		
Net investment income earned	4,746,836	5,272,428
Net realized capital (losses) gains less capital gains (tax benefit) tax of $(169,838) and $51,015 in 2020 and 2019, respectively	(638,914)	157,593
Total net investment gains	4,107,922	5,430,021
NET LOSS FROM PREMIUM BALANCES CHARGED OFF	(186,729)	(9,367)
OTHER LOSSES	-	(10,300)
NET INCOME BEFORE FEDERAL INCOME TAXES	72,555,749	27,458,688
FEDERAL INCOME TAXES INCURRED	18,755,048	5,980,846
NET INCOME	$ 53,800,701	$ 21,477,842

See notes to statutory basis financial statements.

UNITEDHEALTHCARE OF MISSISSIPPI, INC.

STATUTORY BASIS STATEMENTS OF CHANGES IN CAPITAL AND SURPLUS
FOR THE YEARS ENDED DECEMBER 31, 2020 AND 2019

	Section 9010 ACA Subsequent Fee Year Assessment	Common Capital Stock		Gross Paid-In and Contributed Surplus	Unassigned Surplus	Total Capital and Surplus
		Shares	Amount			
BALANCE—January 1, 2019	$ -	2,000	$ 20	$ 165,327,293	$ (575,588)	$ 164,751,725
Net income	-	-	-	-	21,477,842	21,477,842
Dividend to parent	-	-	-	(20,000,000)	-	(20,000,000)
Change in net unrealized capital gains on investments less capital gains tax of $101	-	-	-	-	380	380
Section 9010 ACA subsequent fee year assessment	18,820,864	-	-	-	(18,820,864)	-
Change in nonadmitted assets	-	-	-	-	2,740,480	2,740,480
Change in net deferred income taxes	-	-	-	-	(244,136)	(244,136)
BALANCE—December 31, 2019	18,820,864	2,000	20	145,327,293	4,578,114	168,726,291
Net income	-	-	-	-	53,800,701	53,800,701
Dividend to parent	-	-	-	(25,500,000)	(4,500,000)	(30,000,000)
Change in net unrealized capital (losses) on investments less capital gains (tax benefit) of $(102)	-	-	-	-	(382)	(382)
Section 9010 ACA subsequent fee year assessment	(18,820,864)	-	-	-	18,820,864	-
Change in nonadmitted assets	-	-	-	-	(3,572,304)	(3,572,304)
Change in net deferred income taxes	-	-	-	-	223,252	223,252
BALANCE—December 31, 2020	$ -	2,000	$ 20	$ 119,827,293	$ 69,350,245	$ 189,177,558

See notes to statutory basis financial statements.

UNITEDHEALTHCARE OF MISSISSIPPI, INC.

STATUTORY BASIS STATEMENTS OF CASH FLOWS
FOR THE YEARS ENDED DECEMBER 31, 2020 AND 2019

	2020	2019
CASH FLOWS FROM OPERATIONS:		
Premiums collected, net of reinsurance	$ 1,103,323,651	$ 1,012,455,647
Net investment income	5,115,020	5,909,490
Benefit and loss related payments	(810,226,760)	(860,102,574)
Commissions and other expenses paid	(140,706,476)	(139,966,066)
Federal income taxes paid, net	(24,325,860)	(8,729,803)
Net cash provided by operations	133,179,575	9,566,694
CASH FLOWS FROM INVESTMENTS:		
Proceeds from investments:		
Bonds sold or matured	42,216,048	66,570,710
Miscellaneous proceeds	1,998,279	482
Total investment proceeds	44,214,327	66,571,192
Cost of investments acquired:		
Bonds	(42,775,941)	(69,916,434)
Total cost of investments acquired	(42,775,941)	(69,916,434)
Net cash provided by (used in) investments	1,438,386	(3,345,242)
CASH FLOWS FROM FINANCING AND MISCELLANEOUS ACTIVITIES:		
Cash (used in) provided through net transfers (to) from affiliates	(10,267,584)	1,594,787
Dividend paid	(30,000,000)	(20,000,000)
Other cash provided	2,388,441	36,852
Net cash used in financing and miscellaneous activities	(37,879,143)	(18,368,361)
RECONCILIATION OF CASH AND CASH EQUIVALENTS:		
NET CHANGE IN CASH AND CASH EQUIVALENTS	96,738,818	(12,146,909)
CASH AND CASH EQUIVALENTS — Beginning of year	56,755,217	68,902,126
CASH AND CASH EQUIVALENTS — End of year	$ 153,494,035	$ 56,755,217

See notes to statutory basis financial statements.

1. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES AND GOING CONCERN

Organization and Operation

UnitedHealthcare of Mississippi, Inc. (the "Company"), licensed as a health maintenance organization ("HMO"), offers its enrollees a variety of managed care programs and products through contractual arrangements with health care providers. The Company is a wholly owned subsidiary of UnitedHealthcare, Inc. ("UHC"). UHC is a wholly owned subsidiary of United HealthCare Services, Inc. ("UHS"), a management corporation that provides services to the Company under the terms of a management agreement (the "Agreement"). UHS is a wholly owned subsidiary of UnitedHealth Group Incorporated ("UnitedHealth Group"). UnitedHealth Group is a publicly held company trading on the New York Stock Exchange.

The Company was incorporated on August 6, 1990, as an HMO and operations commenced in January 1993. The Company is certified as an HMO by the Mississippi Insurance Department ("the Department"). The Company has entered into contracts with physicians, hospitals, and other health care provider organizations to deliver health care services for all enrollees. The Company is licensed in the State of Mississippi.

The Company offers comprehensive commercial products to employer groups. Each contract outlines the coverage provided and renewal provisions.

The Company has a contract with the State of Mississippi, Division of Medicaid ("Mississippi DOM") to provide health care services to Medicaid eligible beneficiaries in Mississippi. The program referred to as the Mississippi Coordinated Access Network ("Mississippi CAN"), targets high-risk Medicaid beneficiaries. The current contract has been renewed through June 30, 2021 and there is one (1) one-year extensions thereafter.

The Company also has a contract with the Mississippi DOM to provide health care services to eligible beneficiaries under the Children's Health Insurance Program ("CHIP") in Mississippi. The current contract is effective through July 31, 2022 and includes an option for two (2) one-year extensions thereafter.

A. Accounting Practices

The statutory basis financial statements of the Company are presented on the basis of accounting practices prescribed or permitted by the Department.

The Department recognizes only statutory accounting practices, prescribed or permitted by the State of Mississippi, for determining and reporting the financial condition and results of operations of an HMO, for determining its solvency under Mississippi Insurance Law. The state prescribes the use of the National Association of Insurance Commissioners' ("NAIC") Accounting Practices and Procedures manual ("NAIC SAP") in effect for the accounting periods covered in the statutory basis financial statements.

No significant differences exist between the practices prescribed or permitted by the State of Mississippi and the NAIC SAP which materially affect the statutory basis net income and capital and surplus, as illustrated in the table below:

Net Income	SSAP #	AFS Line	December 31, 2020	December 31, 2019
(1) Company state basis	XXX	XXX	$ 53,800,701	$ 21,477,842
(2) State prescribed practices that are an increase/(decrease) from NAIC SAP: Not applicable			-	-
(3) State permitted practices that are an increase/(decrease) from NAIC SAP: Not applicable			-	-
(4) NAIC SAP (1 - 2 - 3 = 4)	XXX	XXX	$ 53,800,701	$ 21,477,842
Capital and Surplus				
(5) Company state basis	XXX	XXX	$ 189,177,558	$ 168,726,291
(6) State prescribed practices that are an increase/(decrease) from NAIC SAP: Not applicable			-	-
(7) State permitted practices that are an increase/(decrease) from NAIC SAP: Not applicable			-	-
(8) NAIC SAP (5 - 6 - 7 = 8)	XXX	XXX	$ 189,177,558	$ 168,726,291

B. Use of Estimates in the Preparation of the Statutory Basis Financial Statements

The preparation of these statutory basis financial statements in conformity with the NAIC Annual Statement Instructions and the NAIC SAP include certain amounts that are based on the Company's estimates and judgments. These estimates require the Company to apply complex assumptions and judgments, often because the Company must make estimates about the effects of matters that are inherently uncertain and will change in subsequent periods. The most significant estimates relate to hospital and medical benefits, claims unpaid, aggregate health policy reserves (including state risk corridor payable and state medical loss ratio rebate), aggregate health claim reserves, and risk adjustment estimates. The Company adjusts these estimates each period as more current information becomes available. The impact of any changes in estimates is included in the determination of net income in the period in which the estimate is adjusted.

C. Accounting Policy

Basis of Presentation — The Company prepares its statutory basis financial statements on the basis of accounting practices prescribed or permitted by the Department. These statutory practices differ from accounting principles generally accepted in the United States of America ("GAAP").

Accounting policy disclosures that are required by the NAIC Annual Statement instructions are as follows:

(1–2) Bonds are stated at book/adjusted carrying value if they meet NAIC designation of one or two and stated at the lower of book/adjusted carrying value or fair value if they meet an NAIC designation of three or higher. The Company does not have any mandatory convertible securities or Securities Valuation Office of the NAIC ("SVO") identified funds (i.e.: exchange traded funds or bond mutual funds) in its bond portfolio. Amortization of bond premium or accretion of discount is calculated using the constant-yield interest method. Bonds are valued and reported using market prices published by the SVO in accordance with the NAIC Valuation of Securities manual prepared by the SVO or an external pricing service;

(3–4) The Company holds no common or preferred stock;

(5) The Company holds no mortgage loans on real estate;

(6) U.S. government and agency securities and corporate debt securities include loan-backed securities (mortgage-backed securities and asset-backed securities), which are valued using the retrospective adjustment methodology. Prepayment assumptions for the determination of the book/adjusted carrying value, commonly referred to as amortized cost, of loan-backed securities are based on a three-month constant prepayment rate history obtained from external data source vendors. The Company's investment policy limits investments in nonagency residential mortgage-backed securities, including home equity and sub-prime mortgages, to 10% of total cash and invested assets. Total combined investments in mortgage-backed securities and asset-backed securities cannot exceed more than 30% of total cash and invested assets;

(7) The Company holds no investments in subsidiaries, controlled, or affiliated entities;

(8) The Company has no investment interests with respect to joint ventures, partnerships, or limited liability companies;

(9) The Company holds no derivatives;

(10) Premium deficiency reserves ("PDR") (inclusive of conversion reserves) and the related expenses are recognized when it is probable that expected future health care expenses, claims adjustment expenses ("CAE"), direct administration costs, and an allocation of indirect administration costs under a group of existing contracts will exceed anticipated future premiums and reinsurance recoveries considered over the remaining lives of the contracts, and are recorded as aggregate health policy reserves in the statutory basis statements of admitted assets, liabilities, and capital and surplus. Indirect administration costs arise from activities that are not specifically identifiable to a specific group of existing contracts, and therefore, those costs are fully allocated among the various contract groupings. The allocation of indirect administration costs to each contract grouping is made proportionately to the expected margins remaining in the premiums after future health care expenses, CAE and direct administration costs are considered. The data and assumptions underlying such estimates and the resulting reserves are periodically updated, and any adjustments are reflected as an increase or decrease in reserves for life and accident and health contracts in the statutory basis statements of operations in the period in which the change in estimate is identified. The Company does anticipate investment income as a factor in the PDR calculation (see Note 30);

(11) CAE are those costs expected to be incurred in connection with the adjustment and recording of accident and health claims. Pursuant to the terms of the Agreement (see Note 10), the Company pays a management fee to its affiliate, UHS, in exchange for administrative and management services. A detailed review of the administrative expenses of the Company and UHS is performed to determine the allocation between CAE and general administrative expenses ("GAE") to be reported in the statutory basis statements of operations. It is the responsibility of UHS to pay CAE in the event the Company ceases operations. The Company has recorded an estimate of unpaid CAE associated with incurred but unpaid claims, which is included in unpaid CAE in the statutory basis statements of admitted assets, liabilities, and capital and surplus. Management believes the amount of the liability for unpaid CAE as of December 31, 2020 is adequate to cover the Company's cost for the adjustment and recording of unpaid claims; however, actual expenses may differ from those established estimates. Adjustments to the estimates for unpaid CAE are reflected in operating results in the period in which the change in estimate is identified;

(12) The Company does not carry any fixed assets in the statutory basis financial statements;

(13) Health care receivables consist of pharmacy rebates receivable estimated based on the most currently available data from the Company's claims processing systems and from data provided by the Company's affiliated pharmaceutical benefit manager, OptumRx, Inc. ("OptumRx"). Health care receivables also include claim overpayments to providers, hospitals and other health care organizations. Health care receivables are considered nonadmitted assets under the NAIC SAP if they do not meet admissibility requirements. Accordingly, the Company has excluded receivables that do not meet the admissibility criteria from the statutory basis statements of admitted assets, liabilities, and capital and surplus (see Note 28).

The Company has also deemed the following to be significant accounting policies and/or differences between statutory practices and GAAP:

ASSETS

Cash and Invested Assets

- The Company holds no short-term investments;
- Bonds include U.S. government and agency securities, state and agency municipal securities, city and county municipal securities, and corporate debt securities, with a maturity of greater than one year at the time of purchase;
- Certain debt investments categorized as available-for-sale or held-to-maturity under GAAP are presented at the lower of book/adjusted carrying value or fair value in accordance with the NAIC designations in the statutory basis financial statements, whereas under GAAP, these investments are shown at fair value or book/adjusted carrying value, respectively;
- Cash and cash equivalents in the statutory basis financial statements represent cash balances and investments with original maturities of one year or less from the time of acquisition, whereas under GAAP, the corresponding caption of cash and cash equivalents includes cash balances and investments that will mature in one year or less from the balance sheet date;
- Cash represents cash held by the Company in operating accounts. Claims and other payments are made from the operating accounts daily;
- Cash equivalents include money-market funds. Cash equivalents have original maturity dates of three months or less from the date of acquisition. Cash equivalents, excluding money-market funds, are reported at cost or book/adjusted carrying value depending on the nature of the underlying security, which approximates fair value. Money-market funds are reported at fair value or net asset value ("NAV") as a practical expedient;
- Realized capital gains and losses on sales of investments are calculated based upon specific identification of the investments sold. These losses and gains are reported as net realized capital (losses) gains less capital gains (tax benefit) tax ("net realized capital (losses) gains less taxes") in the statutory basis statements of operations;
- The Company continually monitors the difference between amortized cost and estimated fair value of its investments. If any of the Company's investments experience a decline in value that the Company has determined is other-than-temporary, or if the Company has determined it will sell a security that is in an impaired status, the Company will record a realized loss in net realized capital (losses) gains less taxes. The new cost basis is not

changed for subsequent recoveries in fair value. The prospective adjustment method is utilized for loan-backed securities for periods subsequent to the loss recognition. The Company recognized an other-than-temporary impairment ("OTTI") of $716,096 and $833 for the years ended December 31, 2020 and 2019, respectively;

- The NAIC SAP requires the following captions to be taken into consideration in the reconciliation of the statutory basis statements of cash flows: cash, including cash overdrafts and cash equivalents, which can include restricted cash reserves, with original maturities of one year or less from the time of acquisition, whereas under GAAP, pursuant to Accounting Standards Update 2016-18, *Statement of Cash Flows, Restricted Cash*, the statements of cash flows reconcile the corresponding captions of cash, cash equivalents and restricted cash with maturities of three months or less. In addition, there are classification differences within the presentation of the cash flow categories between GAAP and NAIC SAP. The statutory basis statements of cash flows are prepared in accordance with the NAIC Annual Statement Instructions.

Other Assets

- **Investment Income Due and Accrued** — Investment income earned and due as of the reporting date, in addition to investment income earned but not paid or collected until subsequent periods, is reported as investment income due and accrued in the statutory basis statements of admitted assets, liabilities, and capital and surplus. The Company evaluates the collectability of the amounts due and accrued and amounts determined to be uncollectible are written off in the period in which the determination is made. In addition, the remaining balance is assessed for admissibility and any balance greater than 90 days past due is considered a nonadmitted asset.

- **Premiums and Considerations** — The Company reports uncollected premium balances from its insured members, groups, and state Medicaid agency as premiums and considerations in the statutory basis statements of admitted assets, liabilities, and capital and surplus. Uncollected premium balances that are over 90 days past due, with the exception of amounts due from government insured plans, are considered nonadmitted assets. In addition to those balances, current balances are also considered nonadmitted if the corresponding balance greater than 90 days past due is deemed more than inconsequential. Premiums and considerations also include the following (see Note 24):

  a) commercial risk adjustment receivables as defined in Section 1343 of the Affordable Care Act ("ACA"). Premium adjustments are based upon the risk scores (health status) of enrollees participating in risk adjustment covered plans, rather than the actual loss experience of the insured. The risk adjustments and distributions are calculated using a high-cost risk pool which adds a reinsurance-like element to this program. A risk adjustment receivable is recorded when the Company estimates its average actuarial risk score for policies included in this program is greater than the average actuarial risk scores in that market and state risk pool; and

  b) pay for performance program receivables based upon the Company's performance against various quality and operational measures established in the Company's contract with the State which is based on a stated percentage of total direct premiums written.

  Premium adjustments for the commercial ACA Section 1343 risk adjustment and pay for performance program are accounted for as premium adjustments subject to redetermination.

- **Amounts Receivable Relating to Uninsured Plans** — Effective December 1, 2015, the Company has contracted with the Mississippi DOM to participate in the Mississippi Hospital Access Program ("MHAP"). This program helps to ensure sufficient access to inpatient hospital services for the Medicaid population by including enhanced hospital reimbursement in the capitation rates to be "passed-through" from Mississippi DOM to its hospitals. Effective July 1, 2019, the Company has contracted with the Mississippi DOM to participate in the Mississippi Medicaid Access to Physician Services Program ("MAPS"). This program provides enhanced pass-through payments to physicians- and other service practitioners who are employed by a qualifying hospital or assigned Mississippi Medicaid payments to a qualifying hospital. The Company has no financial or member risk under this pass-through arrangement. The Company records a receivable for any MHAP amount due from Mississippi DOM, which is included in amounts receivable relating to uninsured plans in the statutory basis statements of admitted assets, liabilities, and capital and surplus (see Note 18).

- **Current Federal Income Tax Recoverable** — The Company is included in the consolidated federal income tax return with its ultimate parent, UnitedHealth Group, under which taxes approximate the amount that would have been computed on a separate company basis, with the exception of net operating losses and capital losses. For these losses, the Company receives a benefit at the federal rate in the current year for current taxable losses incurred in that year to the extent losses can be utilized in the consolidated federal income tax return of UnitedHealth Group. A current federal income tax recoverable is recognized when the Company's allocated intercompany estimated payments are more than its actual calculated obligation based on the Company's stand-alone federal income tax return (see Note 9).

- **Net Deferred Tax Asset** — The NAIC SAP provides for an amount to be recorded for deferred taxes on temporary differences between the financial reporting and tax bases of assets, subject to a valuation allowance and admissibility limitations on deferred tax assets (see Note 9). In addition, under the NAIC SAP, the change in deferred tax assets is recorded directly to unassigned surplus in the statutory basis financial statements, whereas under GAAP, the change in deferred tax assets is recorded as a component of the income tax provision within the income statement and is based on the ultimate recoverability of the deferred tax assets. Based on the admissibility criteria under the NAIC SAP, any deferred tax assets determined to be nonadmitted are charged directly to surplus and excluded from the statutory basis financial statements, whereas under GAAP, such assets are included in the balance sheet.

- **Receivables from Parent, Subsidiaries, and Affiliates, Net** — In the normal course of business, the Company has various transactions with related parties (see Note 10). The Company reports any unsettled amounts due as receivables from parent, subsidiaries, and affiliates, net, in the statutory basis statements of admitted assets, liabilities, and capital and surplus. The Company has excluded receivables that do not meet the admissibility criteria from the statutory basis statements of admitted assets, liabilities, and capital and surplus.

- **State Income Tax Recoverable** — State income tax recoverable represents amounts that are expected to be recovered as a result of an overpayment of estimated tax carrybacks, or items for which the reporting entity has authority to recover under a state regulation or statute.

LIABILITIES

- **Claims Unpaid and Aggregate Health Claim Reserves** — Claims unpaid and aggregate health claim reserves include claims processed but not yet paid, estimates for claims received but not yet processed, estimates for the costs of health care services enrollees have received but for which claims have not yet been submitted, and payments and liabilities for physician, hospital, and other medical costs disputes.

  The estimates for incurred but not yet reported claims are developed using an actuarial process that is consistently applied, centrally controlled, and automated. The actuarial models consider factors such as historical submission and payment data, cost trends, customer and product mix, seasonality, utilization of health care services, contracted service rates, and other relevant factors. The Company estimates such liabilities for physician, hospital, and other medical cost disputes based upon an analysis of potential outcomes, assuming a combination of litigation and settlement strategies. These estimates may change as actuarial methods change or as underlying facts upon which estimates are based change. The Company did not change actuarial methods during 2020 and 2019. Management believes the amount of claims unpaid and aggregate health claim reserves is a best estimate of the Company's liability for unpaid claims and aggregate health claim reserves as of December 31, 2020; however, actual payments may differ from those established estimates.

  The reserves ceded to reinsurers for claims unpaid have been reported as reductions of the related reserves rather than as assets, which would be required under GAAP.

  The Company contracts with hospitals, physicians, and other providers of health care under capitated or discounted fee for service arrangements, including a hospital per diem to provide medical care services to enrollees. Some of these contracts are with related parties (see Note 10). Capitated providers are at risk for the cost of medical care services provided to the Company's enrollees; however, the Company is ultimately responsible for the provision of services to its enrollees should the capitated provider be unable to provide the contracted services.

- **Accrued Medical Incentive Pool and Bonus Amounts** — The Company has agreements with certain independent physicians and physician network organizations that provide for the establishment of a fund into which the Company places monthly premiums payable for members assigned to the physician. The Company manages the disbursement of funds from this account as well as reviews the utilization of nonprimary care medical services of members assigned to the physicians. Any surpluses in the fund are shared by the Company and the physician based upon predetermined risk-sharing percentage and the liability is included in accrued medical incentive pool and bonus amounts in the statutory basis statements of admitted assets, liabilities, and capital and surplus. The Company also has incentive and bonus arrangements with providers that are based on quality, utilization, and/or various health outcome measures. The estimated amount due to providers that meet the established metrics is included in accrued medical incentive pool and bonus amounts in the statutory basis statements of admitted assets, liabilities, and capital and surplus.

- **Aggregate Health Policy Reserves** — The Company establishes a liability, net of ceded reinsurance, for estimated accrued retrospective and redetermination premiums due from the Company based on the actuarial method and assumptions for each respective contract. Aggregate health policy reserves also includes:

  a) commercial risk adjustment payables as defined in Section 1343 of the ACA. Premium adjustments are based upon the risk scores (health status) of enrollees participating in risk adjustment covered plans, rather than the actual loss experience of the insured. The risk adjustments and distributions are calculated using a high-

cost risk pool which adds a reinsurance-like element to this program. A risk adjustment payable is recorded when the Company estimates its average actuarial risk score for policies included in this program is less than the average actuarial risk scores in that market and state risk pool. The data used by Centers for Medicare and Medicaid Services ("CMS") to determine the risk adjustment amount is subject to risk adjustment data validation audits along with the true-up to the final CMS report, which may result in a material change to arrive at the final risk adjustment amount from the initial risk adjustment estimate recorded (see Note 24);

b) estimated rebates payable on the CHIP, if the medical loss ratio ("MLR"), as calculated under the State statutes and implementing regulations, falls below the target MLR of 85%. The Company is required to rebate the ratable portions of the premiums annually (see Note 24);

c) unearned premiums are established for the portion of premiums received during the current period that are partially unearned at the end of the period; and

d) state risk corridor payables due to DOM to address the uncertainty of medical costs given the COVID-19 pandemic, if the MLR on CHIP and Mississippi CAN falls below the target MLRs. The Company is required to rebate the ratable portions of the premiums (see Note 24).

- **Premiums Received in Advance** — Premiums received in full for the policies processed during the current period, but prior to the commencement of the service period, are recorded as premiums received in advance in the statutory basis statements of admitted assets, liabilities, and capital and surplus.

- **General Expenses Due or Accrued** — General expenses that are due as of the reporting date in addition to general expenses that have been incurred but are not due until a subsequent period are reported as general expenses due or accrued in the statutory basis statements of admitted assets, liabilities, and capital and surplus. General expenses due or accrued also include the amounts for unpaid assessments, commissions payable, premium taxes, state income taxes and the unpaid portion of the contributions required under the ACA risk adjustment program (see Note 24).

- **Current Federal Income Tax Payable** — The Company is included in the consolidated federal income tax return with its ultimate parent, UnitedHealth Group under which taxes approximate the amount that would have been computed on a separate company basis, with the exception of net operating losses and capital losses. For these losses, the Company receives a benefit at the federal rate in the current year for current taxable losses incurred in that year to the extent losses can be utilized in the consolidated federal income tax return of UnitedHealth Group. A liability for federal income taxes payable is recognized when its allocated intercompany estimated payments are less than its actual calculated obligation based on the Company's stand-alone federal income tax return (see Note 9).

- **Remittances and Items Not Allocated** — Remittances and items not allocated generally represent monies received from policyholders for monthly premium billings or providers that have not been specifically identified or applied prior to year-end. The majority is from monies received in the lockbox account on the last day of the year.

- **Amounts due to Parent, Subsidiaries, and Affiliates, Net** — In the normal course of business, the Company has various transactions with related parties (see Note 10). The Company reports any unsettled amounts owed as amounts payable to parent, subsidiaries, and affiliates, net, in the statutory basis statements of admitted assets, liabilities, and capital and surplus.

- **Liability for Amounts Held Under Uninsured Plans** — Liability for amounts held under uninsured plans include the pass-through payments to the hospitals that are unpaid under the MHAP and MAPS programs (see Amounts Receivable Relating to Uninsured Plans in Note 1). The Company has no financial or member risk under these pass-through arrangements. The Company records the unpaid pass-through payments in liability for amounts held under uninsured plans in the statutory basis statements of admitted assets, liabilities, and capital and surplus (see Note 18).

- **Payable for Securities** — The Company reports payable for securities when investments are traded at the end of an accounting period for which the settlement does not occur until the following month in the statutory basis statements of admitted assets, liabilities, and capital and surplus.

CAPITAL AND SURPLUS AND MINIMUM STATUTORY REQUIREMENTS

- **Nonadmitted Assets** — Certain assets, including certain aged premium receivables, certain health care receivables and prepaid expenses, are considered nonadmitted assets under the NAIC SAP and are excluded from the statutory basis statements of admitted assets, liabilities, and capital and surplus and charged directly to unassigned surplus. Under GAAP, such assets are included in the balance sheet.

- **Restricted Cash Reserves** — The Company held regulatory deposits in the amount of $539,837 and $606,921 as of December 31, 2020 and 2019, respectively, in compliance with the state requirements for qualification purposes as a domestic insurer. These restricted cash reserves consist principally of government obligations and are stated at book/adjusted carrying value, which approximates fair value. These restricted deposits are included in bonds in the statutory basis statements of admitted assets, liabilities, and capital and surplus. Interest earned on these deposits accrues to the Company.

- **Minimum Capital and Surplus** — Under the laws of the State of Mississippi, the Department requires the Company to maintain a minimum capital and surplus equal to the greater of $1,000,000; 2% of the first $150,000,000 of annual premium revenue and 1% of annual premium revenue over $150,000,000; or an amount equal to three months of uncovered health care expenditures. The minimum capital and surplus requirement was $11,721,877 and $11,433,991, for December 31, 2020 and 2019, respectively, which was based on premium revenue, as that produced the highest minimum requirement. The Company is in compliance with the required amount.

  Risk-based capital (“RBC”) is a regulatory tool for measuring the minimum amount of capital appropriate for a managed care organization to support its overall business operations in consideration of its size and risk profile. The Department requires the Company to maintain minimum capital and surplus equal to the greater of the state statute as outlined above, or the company action level as calculated by the RBC formula, or the level needed to avoid action pursuant to the trend test in the RBC formula. The Company is in compliance with the required amount.

  The Company has $189,177,558 and $168,726,291 in total statutory basis capital and surplus as of December 31, 2020 and 2019, respectively, which is in compliance with the required amounts where it is licensed to do business.

- **Section 9010 ACA subsequent fee year assessment** — The Company is subject to the Section 9010 ACA subsequent fee year assessment. Under the NAIC SAP, as of December 31, 2019, an amount equal to the estimated subsequent year fee was apportioned out of unassigned surplus and reported as Section 9010 ACA subsequent fee year assessment, in the statutory basis statements of admitted assets, liabilities, and

capital and surplus, whereas under GAAP, no such special surplus designation is required. In accordance with the 2021 Health Insurer Fee ("HIF") repeal, no HIF will be payable in 2021 or thereafter, therefore no amounts will be apportioned out of unassigned surplus after December 31, 2019.

STATEMENTS OF OPERATIONS

- **Net Premium Income and Change in Unearned Premium Reserves and Reserve for Rate Credits** — Revenues consist of net premium income that is recognized in the period in which enrollees are entitled to receive health care services. The corresponding change in unearned premium from year to year is reflected as a change in unearned premium reserves and reserve for rate credits in the statutory basis statements of operations. Under GAAP, the change in unearned premium from year to year is reported through premium income.

  Comprehensive commercial health plans with medical loss ratios on fully insured products, as calculated under the definitions in the ACA and implementing regulations, that fall below certain targets are required to rebate ratable portions of premiums annually. The Company classifies its estimated rebates as change in unearned premium reserves and reserve for rate credits in the statutory basis statements of operations.

  Mississippi CAN and CHIP are subject to MLR requirements, similar to those of the Health Reform Legislation, under the terms of the contract. Plans with medical loss ratios that fall below certain targets are required to rebate ratable portions of premiums annually. The Company classifies its estimated rebates as change in unearned premium reserves and reserve for rate credits in the statutory basis statements of operations.

  Pursuant to Section 1343 of the ACA, the Company records premium adjustments for changes to the commercial risk adjustment balances which are reflected in net premium income, respectively, in the statutory basis statements of operations (see Note 24).

  Net premium income also includes amounts paid by state and federal governments on a per member basis in exchange for the provision and administration of medical benefits under the Mississippi CAN and CHIP. Premiums are contractual and are recognized in the coverage period in which members are entitled to receive services, except in the case of maternity payments. Maternity income is billed on contractual rates and recognized as income as each birth case is identified by the Company. Included in net premium income are capitated payments, home nursing risk-sharing payments, high-dollar risk pool payments, and maternity payments. The majority of net premium income recorded is based on capitated rates, which are monthly premiums paid for each member enrolled. Home nursing risk-sharing income is payable based upon the number of members that qualify for such reimbursement.

- **Total Hospital and Medical Expenses** — Total hospital and medical expenses include claims paid, claims processed but not yet paid, estimates for claims received but not yet processed, estimates for the costs of health care services enrollees have received but for which claims have not yet been submitted, and payments and liabilities for physician, hospital, and other medical costs disputes.

  Total hospital and medical expenses also include amounts incurred for incentive pool, withhold adjustments, and bonus amounts that are based on the underlying contractual provisions with the respective providers. In addition, adjustments to claims unpaid estimates and aggregate health claim reserves are reflected in the period once the change in estimate is identified and included in total hospital and medical expenses in the statutory basis statements of operations.

- **General Administrative Expenses** — Pursuant to the terms of the Agreement (see Note 10), the Company pays a management fee to UHS in exchange for administrative and management services. Costs for items not included within the scope of the Agreement are directly expensed as incurred. State income taxes are also a component of GAE. A detailed review of the administrative expenses of the Company and UHS is performed to determine the allocation between CAE and GAE to be reported in the statutory basis statements of operations.

  The Company is subject to an annual fee under Section 9010 of the ACA. A health insurance entity's annual fee becomes payable once the entity provides health insurance for any U.S. health risk during the calendar year, which is nondeductible for tax purposes (see Note 22). Under the NAIC SAP, the entire amount of the estimated annual fee expense is recognized on January 1 of the fee year in GAE in the statutory basis statements of operations, whereas under GAAP, a deferred asset is created on January 1 of the fee year which is amortized to expense on a straight-line basis throughout the year.

- **Net Investment Income Earned** — Net investment income earned includes investment income collected during the period, as well as the change in investment income due and accrued on the Company's holdings. Amortization of premium or discount on bonds and certain external investment management costs are also included in net investment income earned (see Note 7).

- **Federal Income Taxes Incurred** — The provision for federal income taxes incurred is calculated based on applying the statutory federal income tax rate of 21% to net income before federal income taxes and net realized capital (losses) gains subject to certain adjustments (see Note 9).

- **Comprehensive Income** — Comprehensive income and its components are not separately presented in the statutory basis financial statements, whereas under GAAP, it is a requirement to present comprehensive income and its components in the financial statements.

REINSURANCE

- **Reinsurance Ceded** — The Company does not have any affiliated and unaffiliated reinsurance agreements in place of as December 31, 2020 or 2019.

  The Company had a reinsurance agreement with Unimerica Insurance Company ("Unimerica"), an affiliate, to cede obligations relating to mental health and substance abuse treatment and services (see Note 23). This reinsurance agreement was terminated effective December 31, 2017.

- **Amounts Recoverable from Reinsurers** — The Company records amounts recoverable from reinsurers which represents amounts contractually due to the Company under the reinsurance agreement with Unimerica in the statutory basis statements of admitted assets, liabilities, and capital and surplus and as net reinsurance incurred in the statutory basis statements of operations.

OTHER

- **Vulnerability Due to Certain Concentrations** — The Company is subject to substantial federal and state government regulation, including licensing and other requirements relating to the offering of the Company's existing products in new markets and offerings of new products, both of which may restrict the Company's ability to expand its business.

The Company has no commercial customers that individually exceed 10% of total direct premiums written and uncollected premiums, including receivables for contracts subject to redetermination, for the years ended December 31, 2020 and 2019.

Direct premiums written and uncollected premiums, including receivables for contracts subject to redetermination, from the Mississippi DOM as a percentage of total direct premiums written and total uncollected premiums, including receivables for contracts subject to redetermination, are 98.7% and 99.2% as of December 31, 2020 and 98.7% and 99.8% as of December 31, 2019, respectively.

Recently Issued Accounting Standards — The Company reviewed all recently issued guidance in 2020 and 2019 that has been adopted for 2020 or subsequent years' implementation and has determined that none of the items would have a significant impact to the statutory basis financial statements.

D. Going Concern

The Company has the ability and will continue to operate for a period of time sufficient to carry out its commitments, obligations and business objectives.

2. ACCOUNTING CHANGES AND CORRECTIONS OF ERRORS

No changes in accounting principles or corrections of errors have been recorded during the years ended December 31, 2020 and 2019.

3. BUSINESS COMBINATIONS AND GOODWILL

A–D. The Company was not party to a business combination during the years ended December 31, 2020 and 2019, and does not carry goodwill in its statutory basis statements of admitted assets, liabilities, and capital and surplus.

4. DISCONTINUED OPERATIONS

A. Discontinued Operation Disposed of or Classified as Held for Sale

(1–4) The Company did not have any discontinued operations disposed of or classified as held for sale during 2020 and 2019.

B. Change in Plan of Sale of Discontinued Operation — Not applicable.

C. Nature of any Significant Continuing Involvement with Discontinued Operations after Disposal — Not applicable.

D. Equity Interest Retained in the Discontinued Operation after Disposal — Not applicable.

5. INVESTMENTS

For purposes of calculating gross realized gains and losses on sales of investments, the amortized cost of each investment sold is used. The gross realized gains and losses on sales of long-term investments were $442,756 and $533,299, respectively, for 2020 and $286,121 and $76,680, respectively, for 2019. There were no gross realized gains and losses on sales of short-term investments in 2020 and 2019. The net realized (loss) gain are included in net realized capital (losses) gains less taxes in the statutory basis statements of operations. Total proceeds on the sale of long-term investments were $5,045,014 and $37,784,552 and for short-term investments were $0 and $2,688 in 2020 and 2019, respectively.

As of December 31, 2020 and 2019, the book/adjusted carrying value, fair value, and gross unrecognized unrealized gains and losses of the Company's investments, excluding cash and cash equivalents of $153,494,035 and $56,755,217 respectively, are disclosed in the table below.

	2020				
	Book/Adjusted Carrying Value	Gross Unrecognized Unrealized Gains	Gross Unrecognized Unrealized Losses < 1 Year	Gross Unrecognized Unrealized Losses > 1 Year	Fair Value
U.S. government and agency securities	$ 15,946,364	$ 657,113	$ 14,068	$ -	$ 16,589,409
State and agency municipal securities	14,448,801	907,071	-	-	15,355,872
City and county municipal securities	13,092,300	948,981	-	-	14,041,281
Corporate debt securities	108,820,264	5,974,206	18,197	-	114,776,273
Total bonds	$ 152,307,729	$ 8,487,371	$ 32,265	$ -	$ 160,762,835

	2020				
	Book/Adjusted Carrying Value	Gross Unrecognized Unrealized Gains	Gross Unrecognized Unrealized Losses < 1 Year	Gross Unrecognized Unrealized Losses > 1 Year	Fair Value
Less than one year	$ 11,801,769	$ 132,220	$ 266	$ -	$ 11,933,723
One to five years	34,356,603	1,637,878	508	-	35,993,973
Five to ten years	37,748,128	3,821,604	-	-	41,569,732
Over ten years	68,401,229	2,895,669	31,491	-	71,265,407
Total bonds	$ 152,307,729	$ 8,487,371	$ 32,265	$ -	$ 160,762,835

	2019				
	Book/Adjusted Carrying Value	Gross Unrecognized Unrealized Gains	Gross Unrecognized Unrealized Losses < 1 Year	Gross Unrecognized Unrealized Losses > 1 Year	Fair Value
U.S. government and agency securities	$ 20,707,826	$ 288,570	$ -	$ 2,586	$ 20,993,810
State and agency municipal securities	12,883,403	415,968	30,964	-	13,268,407
City and county municipal securities	13,291,608	359,735	41,190	-	13,610,153
Corporate debt securities	105,974,082	2,681,533	78,218	6,714	108,570,683
Total bonds	$ 152,856,919	$ 3,745,806	$ 150,372	$ 9,300	$ 156,443,053

Included in U.S. government and agency securities and corporate debt securities in the tables above are mortgage-related loan-backed securities, which do not have a single maturity date. For the years to maturity table above, these securities have been presented in the maturity group based on the securities' final maturity date and at a book/adjusted carrying value of $36,472,623 and fair value of $37,860,893.

The following table illustrates the fair value and gross unrecognized unrealized losses, aggregated by investment category and length of time that the individual securities have been in a continuous unrecognized unrealized loss position as of December 31, 2020 and 2019:

	2020					
	< 1 Year		> 1 Year		Total	
	Fair Value	Gross Unrecognized Unrealized Losses	Fair Value	Gross Unrecognized Unrealized Losses	Fair Value	Gross Unrecognized Unrealized Losses
U.S. government and agency securities	$ 3,168,720	$ 14,068	$ -	$ -	$ 3,168,720	$ 14,068
Corporate debt securities	4,693,805	18,197	-	-	4,693,805	18,197
Total bonds	$ 7,862,525	$ 32,265	$ -	$ -	$ 7,862,525	$ 32,265

	2019					
	< 1 Year		> 1 Year		Total	
	Fair Value	Gross Unrecognized Unrealized Losses	Fair Value	Gross Unrecognized Unrealized Losses	Fair Value	Gross Unrecognized Unrealized Losses
U.S. government and agency securities	$ -	$ -	$ 2,008,012	$ 2,586	$ 2,008,012	$ 2,586
State and agency municipal securities	3,173,359	30,964	-	-	3,173,359	30,964
City and county municipal securities	2,433,811	41,190	-	-	2,433,811	41,190
Corporate debt securities	15,793,954	78,218	3,948,465	6,714	19,742,419	84,932
Total bonds	$ 21,401,124	$ 150,372	$ 5,956,477	$ 9,300	$ 27,357,601	$ 159,672

The unrecognized unrealized losses on investments in U.S. government and agency securities, state and agency municipal securities, city and county municipal securities, and corporate debt securities at December 31, 2020 and 2019, were mainly caused by interest rate fluctuations and not by unfavorable changes in the credit ratings associated with these securities. The Company evaluates impairment at each reporting period for each of the securities whereby the fair value of the investment is less than its book/adjusted carrying value. The contractual cash flows of the U.S. government and agency securities are guaranteed either by the U.S. government or an agency of the U.S. government. It is expected that the securities would not be settled at a price less than the cost of the investment, and the Company does not intend to sell the investment until the unrealized loss is fully recovered. The Company assessed the credit quality of the state and agency municipal securities, city and county municipal securities and corporate debt securities, noting whether a significant deterioration since purchase or other factors that may indicate an OTTI, such as the length of time and extent to which fair value has been less than cost, the financial condition, and near-term prospects of the issuer as well as specific events or circumstances that may influence the operations of the issuer and the Company's intent to sell the investment. Additionally, the Company evaluated its intent and ability to retain loan-backed securities for a period of time sufficient to recover the amortized cost. As a result of these reviews, the Company recorded an OTTI of $716,096 and $833 as of December 31, 2020 and 2019, respectively, which are included in net realized capital (losses) gains less taxes in the statutory basis statements of operations.

A–C. The Company has no mortgage loans, real estate loans, restructured debt, or reverse mortgages. The Company also has no real estate property occupied by the Company, real estate property held for the production of income, or real estate property held for sale.

D. Loan-Backed Securities

(1) U.S. government and agency securities and corporate debt securities include loan-backed securities (mortgage-backed securities and asset-backed securities), which are valued using the retrospective adjustment methodology. Prepayment assumptions for the determination of the book/adjusted carrying value, commonly referred to as amortized cost, of loan-backed securities are based on a three-month constant prepayment rate history obtained from external data source vendors.

(2) The Company did not recognize any OTTI on loan-backed securities as of December 31, 2020.

As of December 31, 2019, the Company has classified loan-backed securities that have OTTI as intent to sell. For the remaining loan-backed securities, the Company has the intent and ability to retain the investment in the security for a period of time sufficient to recover the amortized cost basis and determined that the present value of cash flows to be collected is equal to or exceeds the amortized cost basis of the security, as of December 31, 2019. The table below illustrates the aggregate OTTI recognized on loan-backed securities classified on the basis for the OTTI during 2019:

	1 Amortized Cost Basis Before Other-than-Temporary Impairment	2 Other-than-Temporary Impairment Recognized in Loss	3 Fair Value Fair Value 1 - 2
OTTI Recognized 1st Quarter			
a. Intent to sell	$ -	$ -	$ -
b. Inability or lack of intent to retain the investment in the security for a period of time sufficient to recover the amortized cost basis	-	-	-
c. Total 1st Quarter	$ -	$ -	$ -
OTTI Recognized 2nd Quarter			
d. Intent to sell	$ -	$ -	$ -
e. Inability or lack of intent to retain the investment in the security for a period of time sufficient to recover the amortized cost basis	-	-	-
f. Total 2nd Quarter	$ -	$ -	$ -
OTTI Recognized 3rd Quarter			
g. Intent to sell	$ 176,925	$ 833	$ 176,092
h. Inability or lack of intent to retain the investment in the security for a period of time sufficient to recover the amortized cost basis	-	-	-
i. Total 3rd Quarter	$ 176,925	$ 833	$ 176,092
OTTI Recognized 4th Quarter			
j. Intent to sell	$ -	$ -	$ -
k. Inability or lack of intent to retain the investment in the security for a period of time sufficient to recover the amortized cost basis	-	-	-
l. Total 4th Quarter	$ -	$ -	$ -
m. Annual aggregate total		$ 833	

The Company did not recognize any OTTI on loan-backed securities due to an inability or lack of intent to retain the investment in the security for a period of time sufficient to recover the amortized cost basis, or where the present value of cash flows expected to be collected is less than the amortized cost basis of the security, as of December 31, 2019.

(3) The Company did not have any loan-backed securities with OTTI to report by CUSIP as of December 31, 2020.

The table below represents the loan-backed securities with an OTTI for the year ended December 31, 2019, presented by CUSIP:

		2019				
1	2	3	4	5	6	7
CUSIP	Book/Adjusted Carrying Value Amortized Cost Before Current Period OTTI	Present Value of Projected Cash Flows	Recognized OTTI	Amortized Cost After OTTI	Fair Value Value at Time of OTTI	Date of Financial Statement Where Reported
12594MAZ1	$ 176,925	$ 176,092	$ 833	$ 176,092	$ 176,092	9/30/2019
Total	XXX	XXX	$ 833	XXX	XXX	

(4) The following table illustrates the fair value, gross unrecognized unrealized losses, and length of time that the loan-backed securities have been in a continuous unrecognized unrealized loss position as of December 31, 2020 and 2019:

	2020
The aggregate amount of unrealized losses:	
1. Less than 12 months	$ 31,490
2. 12 months or longer	-
The aggregate related fair value of securities with unrealized losses:	
1. Less than 12 months	7,461,297
2. 12 months or longer	-

	2019
The aggregate amount of unrealized losses:	
1. Less than 12 months	$ 64,232
2. 12 months or longer	2,353
The aggregate related fair value of securities with unrealized losses:	
1. Less than 12 months	14,238,752
2. 12 months or longer	1,164,748

(5) The Company believes that it will continue to collect timely the principal and interest due on its loan-backed securities that have an amortized cost in excess of fair value. The unrealized losses were primarily caused by interest rate changes and not by unfavorable changes in the credit quality associated with these securities that impacted the assessment on collectability of principle and interest. At each reporting period, the Company evaluates available-for-sale debt securities for any credit-related impairment when the fair value of the investment is less than its amortized cost. The Company evaluated the expected cash flows, the underlying credit quality and credit ratings of the issuers, and the potential economic impacts of COVID-19 on the issuers, noting no significant credit deterioration since purchase. As of December 31, 2020, the unrealized loss on any security that the Company classified as intent to sell was not material to the Company's investment portfolio. Any other securities in an unrealized loss position as of December 31, 2020, the Company considers to be temporary.

E. Dollar Repurchase Agreements and/or Securities Lending Transactions — Not applicable.

F. Repurchase Agreements Transactions Accounted for as Secured Borrowing — Not applicable.

G. Reverse Repurchase Agreements Transactions Accounted for as Secured Borrowing — Not applicable.

H. Repurchase Agreements Transactions Accounted for as a Sale — Not applicable.

I. Reverse Repurchase Agreements Transactions Accounted for as a Sale — Not applicable.

J. Real Estate — Not applicable.

K. Low-Income Housing Tax Credits — Not applicable.

L. Restricted Assets

(1) Restricted assets, including pledged securities as of December 31, 2020 and 2019, are presented below:

Restricted Asset Category	1 Total Gross (Admitted & Nonadmitted) Restricted From Current Year	2 Total Gross (Admitted & Nonadmitted) Restricted From Prior Year	3 Increase/ (Decrease) (1 Minus 2)	4 Total Current Year Nonadmitted Restricted	5 Total Current Year Admitted Restricted (1 minus 4)	6 Gross (Admitted & Nonadmitted) Restricted to Total Assets (a)	7 Admitted Restricted to Total Admitted Assets (b)
a. Subject to contractual obligation for which liability is not shown	$ -	$ -	$ -	$ -	$ -	- %	- %
b. Collateral held under security lending agreements	-	-	-	-	-	-	-
c. Subject to repurchase agreements	-	-	-	-	-	-	-
d. Subject to reverse repurchase agreements	-	-	-	-	-	-	-
e. Subject to dollar repurchase agreements	-	-	-	-	-	-	-
f. Subject to dollar reverse repurchase agreements	-	-	-	-	-	-	-
g. Placed under option contracts	-	-	-	-	-	-	-
h. Letter stock or securities restricted as to sale — excluding FHLB capital stock	-	-	-	-	-	-	-
i. FHLB capital stock	-	-	-	-	-	-	-
j. On deposit with states	539,837	606,921	(67,084)	-	539,837	-	-
k. On deposit with other regulatory bodies	-	-	-	-	-	-	-
l. Pledged as collateral to FHLB (including assets backing funding agreements)	-	-	-	-	-	-	-
m. Pledged as collateral not captured in other categories	-	-	-	-	-	-	-
n. Other restricted assets	-	-	-	-	-	-	-
o. Total restricted assets	$ 539,837	$ 606,921	$ (67,084)	$ -	$ 539,837	- %	- %

(a) Column 1 divided by Asset Page, Column 1, Line 28
(b) Column 5 divided by Asset Page, Column 3, Line 28

(2–4) The Company has no assets pledged as collateral not captured in other categories and no other restricted assets as of December 31, 2020 or 2019.

M. Working Capital Finance Investments — Not applicable.

N. Offsetting and Netting of Assets and Liabilities

The Company does not have any offsetting or netting of assets and liabilities as it relates to derivatives, repurchase and reverse repurchase agreements, and securities borrowing and securities lending activities.

O. 5GI Securities

The Company does not have any investments with an NAIC designation of 5GI as of December 31, 2020 and 2019.

P. Short Sales — Not applicable.

Q. Prepayment Penalty and Acceleration Fees —

The following table illustrates prepayment penalty and acceleration fees as of December 31, 2020:

	General Account
1. Number of CUSIPs	7
2. Aggregate Amount of Investment Income	$ 339,198

R. Reporting Entity's Share of Cash Pool by Asset Type — Not applicable.

6. JOINT VENTURES, PARTNERSHIPS, AND LIMITED LIABILITY COMPANIES

A–B. The Company has no investments in joint ventures, partnerships, or limited liability companies that exceed 10% of admitted assets and did not recognize any impairment write-down for its investments in joint ventures, partnerships, and limited liability companies during the statement periods.

7. INVESTMENT INCOME

A. The Company excludes all investment income due and accrued amounts that are over 90 days past due from the statutory basis statements of admitted assets, liabilities, and capital and surplus.

B. There were no investment income amounts excluded from the statutory basis financial statements.

8. DERIVATIVE INSTRUMENTS

A–B. The Company has no derivative instruments.

9. INCOME TAXES

A. Deferred Tax Asset/Liability

(1) The components of the net deferred tax asset at December 31, 2020 and 2019 are as follows:

	2020			2019			Change		
	1 Ordinary	2 Capital	3 (Col 1+2) Total	4 Ordinary	5 Capital	6 (Col 4+5) Total	7 (Col 1 - 4) Ordinary	8 (Col 2 - 5) Capital	9 (Col 7+8) Total
(a) Gross deferred tax assets	$ 1,219,404	$ -	$ 1,219,404	$ 1,039,992	$ 665	$ 1,040,657	$ 179,412	$ (665)	$ 178,747
(b) Statutory valuation allowance adjustments	-	-	-	-	665	665	-	(665)	(665)
(c) Adjusted gross deferred tax assets (1a - 1b)	1,219,404	-	1,219,404	1,039,992	-	1,039,992	179,412	-	179,412
(d) Deferred tax assets nonadmitted	-	-	-	-	-	-	-	-	-
(e) Subtotal net admitted deferred tax asset (1c - 1d)	1,219,404	-	1,219,404	1,039,992	-	1,039,992	179,412	-	179,412
(f) Deferred tax liabilities	80,752	-	80,752	124,592	102	124,694	(43,840)	(102)	(43,942)
(g) Net admitted deferred tax asset/(net deferred tax liability) (1e - 1f)	$ 1,138,652	$ -	$ 1,138,652	$ 915,400	$ (102)	$ 915,298	$ 223,252	$ 102	$ 223,354

(2) The components of the adjusted gross deferred tax assets admissibility calculation under Statement of Statutory Accounting Principles ("SSAP") No. 101, *Income Taxes*, are as follows:

	2020			2019			Change		
Admission Calculation Components SSAP No. 101	1 Ordinary	2 Capital	3 (Col 1 + 2) Total	4 Ordinary	5 Capital	6 (Col 4 + 5) Total	7 (Col 1 - 4) Ordinary	8 (Col 2 - 5) Capital	9 (Col 7 + 8) Total
(a) Federal income taxes paid in prior years recoverable through loss carrybacks	$ 1,219,404	$ -	$ 1,219,404	$ 1,039,992	$ -	$ 1,039,992	$ 179,412	$ -	$ 179,412
(b) Adjusted gross deferred tax assets expected to be realized (excluding the amount of deferred tax assets from 2(a) above) after application of the threshold limitation. (The lesser of 2(b)1 and 2(b)2 below)	-	-	-	-	-	-	-	-	-
1. Adjusted gross deferred tax assets expected to be realized following the balance sheet date	-	-	-	-	-	-	-	-	-
2. Adjusted gross deferred tax assets allowed per limitation threshold	XXX	XXX	28,205,836	XXX	XXX	25,171,649	XXX	XXX	3,034,187
(c) Adjusted gross deferred tax assets (excluding the amount of deferred tax assets from 2(a) and 2(b) above) offset by gross deferred tax liabilities	-	-	-	-	-	-	-	-	-
(d) Deferred tax assets admitted as the result of application of SSAP No. 101 Total (2(a) + 2(b) + 2(c))	$ 1,219,404	$ -	$ 1,219,404	$ 1,039,992	$ -	$ 1,039,992	$ 179,412	$ -	$ 179,412

(3) The ratio percentage and adjusted capital and surplus used to determine the recovery period and threshold limitations for the admissibility calculation are presented below:

	2020	2019
(a) Ratio percentage used to determine recovery period and threshold limitation amount	1,049 %	468 %
(b) Amount of adjusted capital and surplus used to determine recovery period and threshold limitation in 2(b)(2) above	$ 188,038,906	$ 167,810,933

(4) The impact to the gross deferred tax assets balances as a result of tax-planning strategies as of December 31, 2020 and 2019 is presented below:

	2020		2019		Change	
	1	2	3	4	5	6
Impact of Tax-Planning Strategies	**Ordinary**	**Capital**	**Ordinary**	**Capital**	**(Col 1 - 3) Ordinary**	**(Col 2 - 4) Capital**
(a) Determination of adjusted gross deferred tax assets and net admitted deferred tax assets by tax character as a percentage.						
1. Adjusted gross DTAs amount from Note 9A1(c)	$ 1,219,404	$ -	$ 1,039,992	$ -	$ 179,412	$ -
2. Percentage of adjusted gross DTAs by tax character attributable to the impact of tax-planning strategies	- %	- %	- %	- %	- %	- %
3. Net admitted adjusted gross DTAs amount from Note 9A1(e)	$ 1,219,404	$ -	$ 1,039,992	$ -	$ 179,412	$ -
4. Percentage of net admitted adjusted gross DTAs by tax character admitted because of the impact of tax-planning strategies	- %	- %	- %	- %	- %	- %
(b) Does the Company's tax-planning strategies include the use of reinsurance?			Yes ____		No X	

B. Unrecognized Deferred Tax Liabilities

(1–4) There are no unrecognized deferred tax liabilities for the years ended December 31, 2020 and 2019.

C. Significant Components of Income Taxes

(1) The current federal income taxes incurred for the years ended December 31, 2020 and 2019 are as follows:

	1 2020	2 2019	3 (Col 1 - 2) Change
1. Current income tax			
(a) Federal	$ 18,755,048	$ 5,980,846	$ 12,774,202
(b) Foreign	-	-	-
(c) Subtotal	18,755,048	5,980,846	12,774,202
(d) Federal income tax on net capital (losses) gains	(169,838)	51,015	(220,853)
(e) Utilization of capital loss carryforwards	-	-	-
(f) Other	-	-	-
(g) Total federal and foreign income taxes incurred	$ 18,585,210	$ 6,031,861	$ 12,553,349

(2–4) The tax effects of temporary differences that give rise to significant portions of the deferred tax assets and liabilities as of December 31, 2020 and 2019, are as follows:

	1 2020	2 2019	3 (Col 1 - 2) Change
2 Deferred tax assets:			
(a) Ordinary:			
(1) Discounting of unpaid losses	$ 221,363	$ 215,016	$ 6,347
(2) Unearned premium reserve	7,448	380,478	(373,030)
(3) Policyholder reserves	-	-	-
(4) Investments	-	-	-
(5) Deferred acquisition costs	-	-	-
(6) Policyholder dividends accrual	-	-	-
(7) Fixed assets	-	-	-
(8) Compensation and benefits accrual	-	-	-
(9) Pension accrual	-	-	-
(10) Receivables — nonadmitted	990,326	444,152	546,174
(11) Net operating loss carryforw ard	-	-	-
(12) Tax credit carryforw ard	-	-	-
(13) Other (including items <5% of total ordinary tax assets)	267	346	(79)
(99) Subtotal	1,219,404	1,039,992	179,412
(b) Statutory valuation allow ance adjustment	-	-	-
(c) Nonadmitted	-	-	-
(d) Admitted ordinary deferred tax assets (2a99 - 2b - 2c)	1,219,404	1,039,992	179,412
(e) Capital:			
(1) Investments	-	665	(665)
(2) Net capital loss carryforw ard	-	-	-
(3) Real estate	-	-	-
(4) Other (including items <5% of total capital tax assets)	-	-	-
(99) Subtotal	-	665	(665)
(f) Statutory valuation allow ance adjustment	-	665	(665)
(g) Nonadmitted	-	-	-
(h) Admitted capital deferred tax assets (2e99 - 2f - 2g)	-	-	-
(i) Admitted deferred tax assets (2d + 2h)	1,219,404	1,039,992	179,412
3 Deferred tax liabilities:			
(a) Ordinary:			
(1) Investments	-	27,690	(27,690)
(2) Fixed assets	-	-	-
(3) Deferred and uncollected premium	-	-	-
(4) Policyholder reserves	-	-	-
(5) Other (including items <5% of total ordinary tax liabilities)	80,752	96,902	(16,150)
(99) Subtotal	80,752	124,592	(43,840)
(b) Capital:			
(1) Investments	-	-	-
(2) Real estate	-	-	-
(3) Other (including items <5% of total capital tax liabilities)	-	102	(102)
(99) Subtotal	-	102	(102)
(c) Deferred tax liabilities (3a99 + 3b99)	80,752	124,694	(43,942)
4 Net deferred tax assets/liabilities (2i - 3c)	$ 1,138,652	$ 915,298	$ 223,354

The other ordinary deferred tax liability of $80,752 for 2020 consists of discounting of unpaid losses. The other ordinary deferred tax liability of $96,902 for 2019 consists of discounting of unpaid losses. The other capital deferred tax liability of $102 for 2019 consists of unrealized gain.

The Company assessed the potential realization of the gross deferred tax asset and established a valuation allowance of $0 and $665 to reduce the gross deferred tax asset to $1,219,404 and $1,039,992 as of December 31, 2020 and 2019, respectively, which represents the amount of the asset estimated to be recoverable via carryback of losses and reduction of future taxes. The change in the valuation allowance is attributable to the change in timing of deductibility of expenses and/or expectations for future taxable income.

D. The provision for federal income taxes incurred is different from that which would be obtained by applying the statutory federal income tax rate of 21% to net income before federal income taxes incurred, less capital gains tax (tax benefit) plus capital gains tax. A summarization of the significant items causing this difference as of December 31, 2020 and 2019 is as follows:

	2020		2019	
	Amount	Effective Tax Rate	Amount	Effective Tax Rate
Tax provision at the federal statutory rate	$ 15,201,042	21 %	$ 5,777,038	21 %
Tax-exempt interest	(77,703)	-	(76,953)	-
Health insurer fee	3,989,467	6	-	-
Tax effect of nonadmitted assets	(750,183)	(1)	575,501	2
Change in statutory valuation allowance	(665)	-	411	-
Total statutory income taxes	$ 18,361,958	26 %	$ 6,275,997	23 %
Federal income taxes incurred	$ 18,755,048	26 %	$ 5,980,846	22 %
Capital gains (tax benefit) tax	(169,838)	-	51,015	-
Change in net deferred income tax	(223,252)	-	244,136	1
Total statutory income taxes	$ 18,361,958	26 %	$ 6,275,997	23 %

E. At December 31, 2020, the Company had no net operating loss carryforwards.

Current federal income tax (recoverable) payable of $(5,032.790) and $707,861 as of December 31, 2020 and 2019, respectively, are included in the statutory basis statements of admitted assets, liabilities, and capital and surplus. Federal income taxes paid, net of refunds were $24,325,860 and $8,729,803 in 2020 and 2019, respectively.

Federal income taxes incurred of $18,585,210 and $6,031,861 for 2020 and 2019, respectively, are available for recoupment in the event of future net losses.

The Company has not admitted any aggregate amounts of deposits that are included within Section 6603 (“Deposits made to suspend running of interest on potential underpayments, etc.”) of the Internal Revenue Service (“IRS”) Code.

F. The Company is included in the consolidated federal income tax return with its ultimate parent, UnitedHealth Group. The entities included within the consolidated return are included in the NAIC Statutory Statement Schedule Y - Information Concerning Activities of Insurer Members Of A Holding Company Group. Federal income taxes are paid to or refunded by UnitedHealth Group pursuant to the terms of a tax-sharing agreement, approved by the Board of Directors, under which taxes approximate the amount that would have been computed on a separate company basis, with the exception of net operating losses and capital losses. For these losses the Company receives a benefit at the federal rate in the current year for current taxable losses incurred in that year to the extent losses can be utilized in the consolidated federal income tax return of UnitedHealth Group. UnitedHealth Group currently files income tax returns in the U.S. federal jurisdiction, various states, and foreign jurisdictions. The U.S. IRS has completed exams on UnitedHealth Group’s consolidated income tax returns for fiscal years 2016 and prior.

UnitedHealth Group's 2017 through 2020 tax returns are under review by the IRS under its Compliance Assurance Program. With the exception of a few states, UnitedHealth Group is no longer subject to income tax examinations prior to the 2013 tax year. In general, the Company is subject to examination in non-U.S. jurisdictions for years 2015 and forward. The Company does not believe any adjustments that may result from these examinations will be material to the Company.

G. Tax Contingencies — Not applicable.

H. Repatriation Transition Tax — Not applicable.

I. Alternative Minimum Tax Credit — Not applicable.

10. INFORMATION CONCERNING PARENT, SUBSIDIARIES, AND AFFILIATES

A–B. In the ordinary course of business, the Company contracts with several affiliates to provide a wide variety of services to the Company's members. These agreements are filed with and approved by the Department according to Management's understanding of the current requirements and standards. Within the confines of the applicable filed and approved agreements (including subsequent amendments thereto), the amount and types of services provided by these affiliated entities can change year over year.

The Company has a tax-sharing agreement with UnitedHealth Group (see Note 9).

The Company paid dividends of $30,000,000 and $20,000,000 in 2020 and 2019, respectively, to its parent (see Note 13).

The Company holds a $75,000,000 subordinated revolving credit agreement with UnitedHealth Group at an interest rate of London InterBank Offered Rate plus a margin of 0.50%. This credit agreement is subordinate to the extent it does not conflict with any credit facility held by either party. The credit agreement is for a one-year term and automatically renews annually, unless terminated by either party. The agreement was renewed effective November 01, 2018. No amounts were outstanding under the line of credit as of December 31, 2020 and 2019, respectively.

C. Transactions With Related Parties Who Are Not Reported On Schedule Y

The Company has no material related party transactions that meet the disclosure requirements pursuant to SSAP No. 25, *Affiliates and Other Related Parties* ("SSAP No. 25") that are not included in NAIC Statutory Statement Schedule Y — Part 2 Summary Of Insurer's Transactions With Any Affiliates.

D. At December 31, 2020 and 2019, the Company reported $4,876,784 and $0, respectively, as receivables from parent, subsidiaries and affiliates, net and $0 and $5,390,800, respectively, as amounts due to parent, subsidiaries, and affiliates, net which are included in the statutory basis statements of admitted assets, liabilities, and capital and surplus. These balances are generally settled within 90 days from the incurred date. Any balances due to the Company that are not settled within 90 days are considered nonadmitted assets.

E. The administrative services, access fees, and cost of care services provided by affiliates are calculated using one or more of the following methods: (1) a percentage of premiums; (2) use of assets; (3) direct pass-through of charges; (4) per member per month; (5) per employee per month; (6) per claim; or (7) a combination thereof consistent with the provisions contained in each contract. These amounts are included in GAE, CAE, and hospital and medical expenses in the statutory basis statements of operations. The following table identifies the amounts reported for

the administrative services, access fees, and cost of care services provided by related parties for the years ended December 31, 2020 and 2019, which meet the disclosure requirements pursuant to SSAP No. 25, regardless of the effective date of the contract:

	2020	2019
OptumRx	$ 187,700,489	$ 190,257,377
UHS	54,757,066	61,703,075
United Behavioral Health	10,950,597	10,160,225
Dental Benefit Providers, Inc.	6,292,463	5,900,939
OptumInsight, Inc.	3,850,943	1,721,821

OptumRx provides services that may include, but are not limited to, administrative services related to pharmacy management and pharmacy claims processing for enrollees, manufacturer rebate administration, pharmacy incentive services, specialty drug pharmacy services, durable medical equipment services including orthotics and prosthetics and personal health products catalogues showing the healthcare products and benefit credits enrollees needed to redeem the respective products.

UHS provides, or arranges for the provision of, management, administrative, and other services deemed necessary or appropriate for UHS to provide management and operational support to the Company. The services can include, but are not limited to, the categories of management and operational services outlined in the Agreement, such as human resources, legal, facilities, general administration, treasury and investment functions, claims adjudication and payment, benefit administration, disease management, health care decision support, medical management, credentialing, preventative health services, and utilization management reporting.

United Behavioral Health provides services related to mental health and substance abuse treatment.

Dental Benefit Providers, Inc. provides dental care assistance.

OptumInsight, Inc. provides services that may include, but are not limited to, claim analytics and recovery of medical expense overpayments, retroactive fraud, waste and abuse, subrogation and premium audit services. All recoveries are returned to the Company by OptumInsight, Inc. on a monthly basis.

The Company has premium payments that are received and claim payments and direct expenses such as broker commissions, Department exam fees, ACA assessments and premium taxes that are processed and paid by an affiliated UnitedHealth Group entity. Premiums, claims, and direct expenses applicable to the Company are settled at regular intervals throughout the month via the intercompany settlement process and any amounts outstanding are reflected in receivables from parent, subsidiaries, and affiliates, net or payable amounts due to parent, subsidiaries, and affiliates, net in the statutory basis statements of admitted assets, liabilities, and capital and surplus.

F. The Company has not extended any guarantees or undertakings for the benefit of an affiliate or related party.

G. The Company is part of an insurance holding company system with UnitedHealth Group as the ultimate parent. Management believes that the Company's transactions with affiliates are fair and reasonable; however, operations of the Company may not be indicative of those that would have occurred if it had operated as an independent company.

H. The Company does not have any amount deducted from the value of an upstream intermediate entity or ultimate parent owned, either directly or indirectly, via a downstream subsidiary, controlled, or affiliated entity.

I. The Company does not have any investments in a subsidiary, controlled, or affiliated entity that exceeds 10% of admitted assets.

J. The Company does not have any investments in impaired subsidiaries, controlled, or affiliated entities.

K. The Company does not have any investments in foreign insurance subsidiaries.

L. The Company does not hold any investments in a downstream noninsurance holding company.

M. The Company does not have any investments in noninsurance subsidiaries, controlled, or affiliated entities.

N. The Company does not have any investments in insurance subsidiaries, controlled, or affiliated entities.

O. The Company does not have any investments in subsidiary, controlled, or affiliated entities or joint ventures, partnerships and limited liability companies in which the Company's share of losses exceeds the investment.

11. DEBT

A–B. The Company had no outstanding debt with third-parties or outstanding Federal Home Loan Bank agreements during 2020 and 2019.

12. RETIREMENT PLANS, DEFERRED COMPENSATION, POSTEMPLOYMENT BENEFITS AND COMPENSATED ABSENCES AND OTHER POSTRETIREMENT BENEFIT PLANS

A–I. The Company has no defined benefit plans, defined contribution plans, multiemployer plans, consolidated/holding company plans, postemployment benefits, or compensated absences plans and is not impacted by the Medicare Modernization Act on postretirement benefits, since all personnel are employees of UHS, which provides services to the Company under the terms of the Agreement (see Note 10).

13. CAPITAL AND SURPLUS, DIVIDEND RESTRICTIONS, AND QUASI-REORGANIZATIONS

A–B The Company has 2,000 shares authorized and 2,000 shares issued and outstanding of $0.01 par value common stock. The Company has no preferred stock outstanding. All issued and outstanding shares of common stock are held by the Company's parent, UHC.

C. Dividend payment requirements are outlined in the domiciliary state statutes and may be further restricted by the Department.

D. The Company paid an extraordinary cash dividend of $30,000,000 on September 28, 2020, to UHC, which was approved by the Mississippi Insurance Commissioner. The Company recorded $25,500,000 as a reduction to gross paid in-and contributed surplus and $4,500,000 was recorded as a reduction to unassigned surplus in the statutory basis statements of admitted assets, liabilities, and capital and surplus.

The Company paid an extraordinary cash dividend of $20,000,000 on December 30, 2019 to UHC, which was approved by the Mississippi Insurance Commissioner and recorded as a reduction to gross paid-in and contributed surplus in the statutory basis statements of admitted assets, liabilities, and capital and surplus.

The Company did not receive any capital infusions during 2020 or 2019.

E. The amount of ordinary dividends that may be paid out during any given period is subject to certain restrictions as specified by state statute.

F. There are no restrictions placed on the Company's unassigned surplus.

G. The Company is not a mutual reciprocal or a similarly organized entity and does not have advances to surplus not repaid.

H. The Company does not hold any stock, including stock of affiliated companies for special purposes, such as conversion of preferred stock, employee stock options, or stock purchase warrants.

I. As discussed in Note 1, in 2020 no amount was required to be apportioned out of unassigned surplus as the HIF was repealed by Congress, effective January 1, 2021. For the year ended December 31, 2019, the amount of the estimated Section 9010 ACA subsequent fee year assessment apportioned out of unassigned surplus was $18,820,864.

J. The portion of unassigned surplus, excluding the apportionment of estimated Section 9010 ACA subsequent fee year assessment, net income, and dividends, represented (or reduced) by each item below is as follows:

	2020	2019
Unrealized capital gains on investments	$ -	$ 484
Net deferred income taxes	1,138,652	915,298
Nonadmitted assets	(5,689,175)	(2,116,871)
Total	$ (4,550,523)	$ (1,201,089)

K–M. The Company does not have any outstanding surplus notes and has never been a party to a quasi-reorganization.

14. LIABILITIES, CONTINGENCIES AND ASSESSMENTS

A. Contingent Commitments

The Company has no contingent commitments.

B. Assessments

The Company is not aware of any guaranty fund assessments or premium tax offsets, potential or accrued, that could have a material financial effect on the operations of the entity.

C. Gain Contingencies

The Company is not aware of any gain contingencies that should be disclosed in the statutory basis financial statements.

D. Claims Related Extra Contractual Obligation and Bad Faith Losses Stemming from Lawsuits — Not applicable.

E. Joint and Several Liabilities — Not applicable.

F. All Other Contingencies

The Company's business is regulated at the federal, state, and local levels. The laws and rules governing the Company's business and interpretations of those laws and rules are subject to frequent change. Broad latitude is given to the agencies administering those regulations. Further, the Company must obtain and maintain regulatory approvals to market and sell many of its products.

The Company has been, or is currently involved, in various governmental investigations, audits and reviews. These include routine, regular and special investigations, audits and reviews by CMS, state insurance and health and welfare departments and other governmental authorities. The Company cannot reasonably estimate the range of loss, if any, that may result from any material government investigations, audits and reviews in which it is currently involved given the inherent difficulty in predicting regulatory action, fines and penalties, if any, and the various remedies and levels of judicial review available to the Company in the event of an adverse finding.

Because of the nature of its businesses, the Company is frequently made party to a variety of legal actions and regulatory inquiries, including class actions and suits brought by members, care providers, consumer advocacy organizations, customers and regulators, relating to the Company's businesses, including management and administration of health benefit plans and other services.

The Company records liabilities for its estimates of probable costs resulting from these matters where appropriate. Estimates of costs resulting from legal and regulatory matters involving the Company are inherently difficult to predict, particularly where the matters involve: indeterminate claims for monetary damages or may involve fines, penalties or punitive damages; present novel legal theories or represent a shift in regulatory policy; involve a large number of claimants or regulatory bodies; are in the early stages of the proceedings; or could result in a change in business practices. Accordingly, the Company is often unable to estimate the losses or ranges of losses for those matters where there is a reasonable possibility, or it is probable that a loss may be incurred. Although the outcomes of any such legal actions cannot be predicted, in the opinion of management, the resolution of any currently pending or threatened actions will not have a material adverse effect on the statutory basis statements of admitted assets, liabilities, and capital and surplus or statutory basis statements of operations of the Company.

The Company routinely evaluates the collectability of all receivable amounts included in the statutory basis statements of admitted assets, liabilities, and capital and surplus. Impairment reserves are established for those amounts where collectability is uncertain. Based on the Company's past experience, exposure related to uncollectible balances and the potential of loss for those balances not currently reserved for is not material to the Company's statutory basis financial condition.

There are no other assets that the Company considers to be impaired at December 31, 2020 and 2019, except as disclosed in Note 5 and Note 20.

15. LEASES

A–B. According to the Agreement between the Company and UHS (see Note 10), operating leases for the rental of office facilities and equipment are the responsibility of UHS. Fees associated with the lease agreements are included as a component of the Company's management fee.

16. INFORMATION ABOUT FINANCIAL INSTRUMENTS WITH OFF-BALANCE-SHEET RISK AND FINANCIAL INSTRUMENTS WITH CONCENTRATIONS OF CREDIT RISK

(1–4) The Company does not hold any financial instruments with off-balance-sheet risk or have any concentrations of credit risk.

17. SALE, TRANSFER, AND SERVICING OF FINANCIAL ASSETS AND EXTINGUISHMENTS OF LIABILITIES

A–C. The Company did not participate in any transfer of receivables, financial assets or wash sales.

18. GAIN OR LOSS TO THE REPORTING ENTITY FROM UNINSURED PLANS AND THE UNINSURED PORTION OF PARTIALLY INSURED PLANS

A–B. The Company has no operations from Administrative Services Only Contracts or Administrative Services Contracts in 2020 and 2019.

C. Medicare or Other Similarly Structured Cost Based Reimbursement Contract

Effective December 1, 2015, the Company has contracted with the Mississippi DOM to participate in the MHAP. This program helps to ensure sufficient access to inpatient hospital services for the Medicaid population by including enhanced hospital reimbursement in the capitation rates. Effective July 1, 2019, the Company has contracted with the Mississippi DOM to participate in the MAPS. This program provides enhanced pass-through payments to physicians and other service practitioners who are employed by a qualifying hospital or assigned Mississippi Medicaid payments to a qualifying hospital. Year to date 2020 and 2019 receipts and expenditures related to these pass-through programs are reported in the table below:

Mississippi Hospital Access Program / Mississippi Medicaid Access to Physician Services Program	Year to Date December 31, 2020	Quarter to Date as of December 31, 2020	Prior Year to Date December 31, 2019
MHAP Capitation	$ 220,289,790	$ 56,732,374	$ 235,870,301
MAPS Capitation	7,852,813	1,515,387	3,168,713
Total Premium Tax Payments	6,035,568	1,745,628	5,999,741
MHAP Payments to Providers	222,649,427	56,615,695	234,284,200
MAPS Payments to Providers	6,337,426	-	3,168,713

19. DIRECT PREMIUM WRITTEN/PRODUCED BY MANAGING GENERAL AGENTS/THIRD-PARTY ADMINISTRATORS

The Company did not have any direct premiums written or produced by managing general agents or third-party administrators in 2020 and 2019.

20. FAIR VALUE MEASUREMENTS

The NAIC SAP defines fair value, establishes a framework for measuring fair value, and outlines the disclosure requirements related to fair value measurements. The fair value hierarchy is as follows:

Level 1 — Quoted (unadjusted) prices for identical assets in active markets.

Level 2 — Other observable inputs, either directly or indirectly, including:

- Quoted prices for similar assets in active markets;
- Quoted prices for identical or similar assets in nonactive markets (few transactions, limited information, noncurrent prices, high variability over time, etc.);
- Inputs other than quoted prices that are observable for the asset (interest rates, yield curves, volatilities, default rates, etc.);
- Inputs that are derived principally from or corroborated by other observable market data.

Level 3 — Unobservable inputs that cannot be corroborated by observable market data.

The estimated fair values of bonds and cash equivalents (collectively “investment holdings”) are based on quoted market prices, where available. The Company obtains one price for each security primarily from a third-party pricing service (“pricing service”), which generally uses quoted prices or other observable inputs for the determination of fair value. The pricing service normally derives the security prices through recently reported trades for identical or similar securities, making adjustments through the reporting date based upon available observable market information. For securities not actively traded, the pricing service may use quoted market prices of comparable instruments or discounted cash flow analyses, incorporating inputs that are currently observable in the markets for similar securities. Inputs that are often used in the valuation methodologies include, but are not limited to, non-binding broker quotes, benchmark yields, credit spreads, default rates, and prepayment speeds. As the Company is responsible for the determination of fair value, it performs quarterly analyses on the prices received from the pricing service to determine whether the prices are reasonable estimates of fair value. Specifically, the Company compares the prices received from the pricing service to a secondary pricing source, prices reported by its custodian, its investment consultant, and third-party investment advisors. Additionally, the Company compares changes in the reported market values and returns to relevant market indices to test the reasonableness of the reported prices. The Company’s internal price verification procedures and review of fair value methodology documentation provided by independent pricing services have not historically resulted in an adjustment in the prices obtained from the pricing service.

In instances in which the inputs used to measure fair value fall into different levels of the fair value hierarchy, the fair value measurement has been determined based on the lowest-level input that is significant to the fair value measurement in its entirety. The Company’s assessment of the significance of a particular item to the fair value measurement in its entirety requires judgment, including the consideration of inputs specific to the asset or liability.

A. Fair Value

(1) Fair Value Measurements at Reporting Date

The following tables present information about the Company's financial assets that are measured and reported at fair value at December 31, 2020 and 2019, in the statutory basis statements of admitted assets, liabilities, and capital and surplus according to the valuation techniques the Company used to determine their fair values:

	December 31, 2020				
Description for Each Class of Asset or Liability	(Level 1)	(Level 2)	(Level 3)	Net Asset Value (NAV)	Total
a. Assets at fair value:					
Perpetual preferred stock:					
Industrial and misc	$ -	$ -	$ -	$ -	$ -
Parent, subsidiaries, and affiliates	-	-	-	-	-
Total perpetual preferred stocks	-	-	-	-	-
Bonds:					
U.S. governments	-	-	-	-	-
Industrial and misc	-	-	-	-	-
Hybrid securities	-	-	-	-	-
Parent, subsidiaries, and affiliates	-	-	-	-	-
Total bonds	-	-	-	-	-
Common stock:					
Industrial and misc	-	-	-	-	-
Parent, subsidiaries, and affiliates	-	-	-	-	-
Total common stocks	-	-	-	-	-
Derivative assets:					
Interest rate contracts	-	-	-	-	-
Foreign exchange contracts	-	-	-	-	-
Credit contracts	-	-	-	-	-
Commodity futures contracts	-	-	-	-	-
Commodity forward contracts	-	-	-	-	-
Total derivatives	-	-	-	-	-
Money-market funds	153,446,114	-	-	-	153,446,114
Separate account assets	-	-	-	-	-
Total assets at fair value/NAV	$ 153,446,114	$ -	$ -	$ -	$ 153,446,114
b. Liabilities at fair value:					
Derivative liabilities	$ -	$ -	$ -	$ -	$ -
Total liabilities at fair value	$ -	$ -	$ -	$ -	$ -

Description for Each Class of Asset or Liability	December 31, 2019 (Level 1)	(Level 2)	(Level 3)	Net Asset Value (NAV)	Total
a. Assets at fair value:					
Perpetual preferred stock:					
Industrial and misc	$ -	$ -	$ -	$ -	$ -
Parent, subsidiaries, and affiliates	-	-	-	-	-
Total perpetual preferred stocks	-	-	-	-	-
Bonds:					
U.S. governments	-	-	-	-	-
Industrial and misc	-	-	-	-	-
Hybrid securities	-	-	-	-	-
Parent, subsidiaries, and affiliates	-	-	-	-	-
Total bonds	-	-	-	-	-
Common stock:					
Industrial and misc	-	-	-	-	-
Parent, subsidiaries, and affiliates	-	-	-	-	-
Total common stocks	-	-	-	-	-
Derivative assets:					
Interest rate contracts	-	-	-	-	-
Foreign exchange contracts	-	-	-	-	-
Credit contracts	-	-	-	-	-
Commodity futures contracts	-	-	-	-	-
Commodity forward contracts	-	-	-	-	-
Total derivatives	-	-	-	-	-
Money-market funds	56,705,676	-	-	-	56,705,676
Separate account assets	-	-	-	-	-
Total assets at fair value/NAV	$ 56,705,676	$ -	$ -	$ -	$ 56,705,676
b. Liabilities at fair value:					
Derivative liabilities	$ -	$ -	$ -	$ -	$ -
Total liabilities at fair value	$ -	$ -	$ -	$ -	$ -

(2) The Company does not have any financial assets with a fair value hierarchy of Level 3 that were measured and reported at fair value.

(3) Transfers between fair value hierarchy levels, if any, are recorded as of the beginning of the reporting period in which the transfer occurs. There were no transfers between Levels 1, 2 or 3 of any financial assets or liabilities during the years ended December 31, 2020 or 2019.

(4) The Company has no investments reported with a fair value hierarchy of Level 2 or Level 3 and therefore has no valuation technique to disclose.

(5) The Company has no derivative assets and liabilities to disclose.

B. Fair Value Combination — Not applicable.

C. Aggregate Fair Value Hierarchy

The aggregate fair value by hierarchy of all financial instruments as of December 31, 2020 and 2019 is presented in the table below:

	December 31, 2020						
Type of Financial Instrument	Aggregate Fair Value	Admitted Assets	(Level 1)	(Level 2)	(Level 3)	Net Asset Value (NAV)	Not Practicable (Carrying Value)
U.S. government and agency securities	$ 16,589,409	$ 15,946,364	$ 540,478	$ 16,048,931	$ -	$ -	$ -
State and agency municipal securities	15,355,872	14,448,801	-	15,355,872	-	-	-
City and county municipal securities	14,041,281	13,092,300	-	14,041,281	-	-	-
Corporate debt securities	114,776,273	108,820,264	-	114,776,273	-	-	-
Cash equivalents	153,446,114	153,446,114	153,446,114	-	-	-	-
Total bonds and cash equivalents	$ 314,208,949	$ 305,753,843	$ 153,986,592	$ 160,222,357	$ -	$ -	$ -

	December 31, 2019						
Type of Financial Instrument	Aggregate Fair Value	Admitted Assets	(Level 1)	(Level 2)	(Level 3)	Net Asset Value (NAV)	Not Practicable (Carrying Value)
U.S. government and agency securities	$ 20,993,810	$ 20,707,826	$ 2,609,155	$ 18,384,655	$ -	$ -	$ -
State and agency municipal securities	13,268,407	12,883,403	-	13,268,407	-	-	-
City and county municipal securities	13,610,153	13,291,608	-	13,610,153	-	-	-
Corporate debt securities	108,570,683	105,974,082	-	108,570,683	-	-	-
Cash equivalents	56,705,676	56,705,676	56,705,676	-	-	-	-
Total bonds and cash equivalents	$ 213,148,729	$ 209,562,595	$ 59,314,831	$ 153,833,898	$ -	$ -	$ -

D. Not Practicable to Estimate Fair Value — Not applicable.

E. Investments Measured Using the NAV Practical Expedient — Not applicable.

21. OTHER ITEMS

COVID-19 Trends and Uncertainties

The COVID-19 pandemic continues to evolve and the ultimate impact on the Company and its statutory basis results of operations, financial condition and cash flows remains uncertain. During the second quarter, the global health system experienced unprecedented levels of care deferral. As the pandemic advanced, access to and demand for care was most constrained from mid-March through April, began to recover in May and June and restored to near normal seasonal levels in the third quarter. Care patterns continued to normalize in the fourth quarter, including COVID-19 treatment and testing costs. The temporary deferral of care experienced in 2020 may cause care patterns to moderately exceed normal baselines in future periods as utilization of health system capacity continues to increase. The Company has taken various measures which could include expanded benefit coverage in areas such as COVID-19 care and testing, telemedicine, and pharmacy benefits; provided customers assistance in the form of co-pay waivers and premium forgiveness; offered additional enrollment opportunities to those who previously declined employer-sponsored offerings; extended certain premium payment terms for customers experiencing financial hardship; simplified administrative practices; and accelerated payments to care providers, all with the aim of assisting customers, care providers, members and communities in addressing the COVID-19 crisis. Temporary care deferrals impacted the Company's results of operations for the year ended December 31, 2020. The impact of temporary care deferrals was partially offset by COVID-19 related care and testing, the financial assistance provided to customers, rebate requirements and broader economic impacts.

Increased consumer demand for care, potentially even higher acuity care, along with continued COVID-19 care and testing costs may result in increased future medical costs. Disrupted care patterns, as a result of the pandemic, may temporarily affect the ability to obtain complete member health status information, impacting future revenue in businesses utilizing risk adjustment methodologies. The ultimate overall impact is uncertain and dependent on the future pacing and intensity of the pandemic, the duration of policies and initiatives to address COVID-19, and general economic uncertainty.

Throughout 2020, the Company's ultimate parent announced a number of programs to directly support people affected by the COVID-19 pandemic, including a plan to grant premium credits to the Company's fully insured commercial customers. The total amount of premium credits granted through December 31, 2020 of $76,361 has been reflected as a reduction to net premium income in the statutory basis statements of revenue and expenses.

A. Unusual or Infrequent Items

The Company did not encounter any unusual or infrequent items for the years ended December 31, 2020 and 2019.

B. Troubled Debt Restructuring: Debtors

The Company has no troubled debt restructurings as of December 31, 2020 and 2019.

C. Other Disclosures

The Company does not have any amounts not recorded in the statutory basis financial statements that represent segregated funds held for others. The Company also does not have any exposures related to forward commitments that are not derivative instruments.

D. Business Interruption Insurance Recoveries

The Company has not received any business interruption insurance recoveries during 2020 and 2019.

E. State Transferable and Non-transferable Tax Credits

The Company has no transferable or non-transferable state tax credits.

F. Sub-Prime Mortgage-Related Risk Exposure

(1) The investment policy for the Company limits investments in loan-backed securities, which includes sub-prime issuers. Further, the policy limits investments in private-issuer mortgage securities to 10% of the portfolio, which also includes sub-prime issuers. The exposure to unrealized losses on sub-prime issuers is due to changes in market prices. There are no realized losses due to not receiving anticipated cash flows. The investments covered have an NAIC designation of 1 or 2.

(2) The Company has no direct exposure through investments in sub-prime mortgage loans.

(3) The Company has no direct exposure through other investments.

(4) The Company has no underwriting exposure to sub-prime mortgage risk through mortgage guaranty or financial guaranty insurance coverage.

G. Retained Assets

The Company does not have any retained asset accounts for beneficiaries.

H. Insurance-Linked Securities Contracts

As of December 31, 2020, the Company is not aware of any possible proceeds of insurance-linked securities.

I. The Amount That Could Be Realized on Life Insurance Where the Reporting Entity is Owner and Beneficiary or Has Otherwise Obtained Rights to Control the Policy — Not applicable.

22. EVENTS SUBSEQUENT

Subsequent events have been evaluated through May 26, 2021, which is the date these statutory basis financial statements were available for issuance.

TYPE I — Recognized Subsequent Events

Any material Type I events subsequent to December 31, 2020, have been recognized in the statutory basis financial statements and corresponding disclosures.

TYPE II — Non-Recognized Subsequent Events

For the years ended December 31, 2020 and 2019, the Company was subject to the annual fee under Section 9010 of the ACA. The fee is allocated to individual health insurers based on the ratio of the amount of the entity's net premiums written during the preceding calendar year to the amount of the health insurance for any U.S. health risk that is written during the preceding calendar year. A health insurance entity's portion of the annual fee becomes payable once the entity provides health insurance for any U.S. health risk for each calendar year beginning on or after January 1, of the year the fee is due. The HIF was repealed by Congress, effective January 1, 2021.

The table below presents information regarding the annual fee under Section 9010 of the ACA as of December 31, 2020 and 2019:

	2020	2019
A. Did the reporting entity write accident and health insurance premium that is subject to Section 9010 of the Federal Affordable Care Act (YES/NO)?	YES	
B. ACA fee assessment payable for the upcoming year	$ -	$ 18,820,864
C. ACA fee assessment paid	18,997,463	-
D. Premium written subject to ACA 9010 assessment	-	986,655,634
E. Total Adjusted Capital before surplus adjustment (Five-Year Historical Line 14)	189,177,558	
F. Total Adjusted Capital after surplus adjustment (Five-Year Historical Line 14 minus 22B above)	189,177,558	
G. Authorized Control Level (Five-Year Historical Line 15)	17,933,796	
H. Would reporting the ACA assessment as of December 31, 2020, have triggered an RBC action level (YES/NO)?	NO	

There are no other material non-recognized Type II events that require disclosure.

23. REINSURANCE

Reinsurance Agreements — The Company does not have any affiliated and unaffiliated reinsurance agreements in place as of December 31, 2020 or 2019.

The Company entered into a reinsurance agreement with an affiliated entity, Unimerica, to cede obligations relating to mental health and substance abuse treatments and services. This reinsurance agreement was terminated on December 31, 2017.

Pursuant to Section 1341 of the ACA, through 2017, the Company was subject to the reinsurance provisions for compliant individual policies (see Note 24).

The effect of both internal and external reinsurance agreement outlined above on net premium income and hospital and medical expenses is presented below:

	2020	2019
Premiums:		
Direct	$ 1,083,761,007	$ 993,404,401
Ceded:		
Affiliate	-	-
Nonaffiliate	-	-
Net premium income	$ 1,083,761,007	$ 993,404,401
Hospital and medical expenses:		
Direct	$ 812,027,941	$ 848,074,754
Ceded:		
Affiliate	(24,813)	(172,330)
Nonaffiliate	-	18,688
Net hospital and medical expenses	$ 812,052,754	$ 848,228,396

The Company recognized reinsurance incurred related to internal and external reinsurance agreements of $24,813 and $153,641 in 2020 and 2019, respectively, which are recorded as net reinsurance incurred in the statutory basis statements of operations. In addition, reinsurance recoverables related to internal and external reinsurance agreements of $8,580 and $4,514 for paid losses are recorded as amounts recoverable from reinsurers and $1,121 and $23,289 for unpaid losses are recorded as a reduction to claims unpaid in 2020 and 2019, respectively, in the statutory basis statements of admitted assets, liabilities, and capital and surplus.

A. Ceded Reinsurance Report

Section 1 — General Interrogatories

(1) Are any of the reinsurers, listed in Schedule S as non-affiliated, owned in excess of 10% or controlled, either directly or indirectly, by the Company or by any representative, officer, trustee, or director of the Company?

Yes ( ) No (X)

(2) Have any policies issued by the Company been reinsured with a company chartered in a country other than the United States (excluding U.S. branches of such companies) that is owned in excess of 10% or controlled directly or indirectly by an insured, a beneficiary, a creditor, or any other person not primarily engaged in the insurance business?

Yes ( ) No (X)

Section 2 — Ceded Reinsurance Report — Part A

(1) Does the Company have any reinsurance agreements in effect under which the reinsurer may unilaterally cancel any reinsurance for reasons other than for nonpayment of premium or other similar credit?

Yes ( ) No (X)

(2) Does the reporting entity have any reinsurance agreements in effect that the amount of losses paid or accrued through the statement date may result in a payment to the reinsurer of amounts that, in aggregate and allowing for offset of mutual credits from other reinsurance agreements with the same reinsurer, exceed the total direct premium collected under the reinsured policies?

Yes ( ) No (X)

Section 3 — Ceded Reinsurance Report — Part B

(1) What is the estimated amount of the aggregate reduction in surplus (for agreements other than those under which the reinsurer may unilaterally cancel for reasons other than for nonpayment of premium or other similar credits that are reflected in Section 2 above) of termination of all reinsurance agreements, by either party, as of the date of this statement? Where necessary, the Company may consider the current or anticipated experience of the business reinsured in making this estimate.

The Company estimates there should be no aggregate reduction in surplus for termination of all reinsurance agreements as of December 31, 2020.

(2) Have any new agreements been executed or existing agreements amended, since January 1 of the year of this statement, to include policies or contracts that were in force or which had existing reserves established by the Company as of the effective date of the agreement?

Yes ( ) No (X)

B. **Uncollectible Reinsurance** — During 2020 and 2019, there were no uncollectible reinsurance recoverables.

C. **Commutation of Ceded Reinsurance** — There was no commutation of reinsurance in 2020 or 2019.

D. **Certified Reinsurer Rating Downgraded or Status Subject to Revocation** — Not applicable.

E. **Reinsurance Credit**

(1) The Company has no reinsurance contracts subject to Appendix A-791 — *Life and Health Reinsurance Agreements* (“A-791”) that includes a provision which limits the reinsurer’s assumption of significant risk.

(2) The Company has no reinsurance contracts not subject to A-791, for which reinsurance accounting was applied and which includes provisions that limits the reinsurer’s assumption of risk.

(3) The Company’s reinsurance contracts do not contain features which result in delays in payment in form or in fact.

(4) The Company has not reflected a reinsurance accounting credit for any contracts not subject to Appendix A-791 and not yearly renewable term, which meet the risk transfer requirements of SSAP No. 61R, *Life, Deposit-Type, and Accident and Health Reinsurance* (“SSAP No. 61R”).

(5) The Company did not cede any risk which is not subject to A-791 and not yearly renewable term reinsurance, under any reinsurance contract during the period covered by these financial statements, for which the statutory accounting treatment and GAAP accounting treatment were not the same.

(6) The Company's ceded reinsurance contract which is not subject to A-791 and not yearly renewable term reinsurance, is treated the same for GAAP and statutory accounting principles.

24. RETROSPECTIVELY RATED CONTRACTS AND CONTRACTS SUBJECT TO REDETERMINATION

A. The Company estimates accrued retrospective premium adjustments for its group health insurance business based on mathematical calculations in accordance with contractual terms.

B. Estimated accrued retrospective premiums from the Company are recorded in aggregate health policy reserves in the statutory basis statements of admitted assets, liabilities, and capital and surplus and as an adjustment to change in unearned premium reserves and reserve for rate credits in the statutory basis statements of operations.

C. Pursuant to the ACA, the Company's commercial business is subject to retrospectively rated features based on the actual medical loss ratios experienced on the commercial lines of business and redetermination features for premium adjustments for changes to each member's health scores based on guidelines determined by the ACA. The total amount of direct premiums written for the commercial lines of business for which a portion is subject to the retrospectively rated and redetermination features was $14,283,999 and $12,609,370, representing 1.3% and 1.3% of total direct premiums written as of December 31, 2020 and December 31, 2019, respectively.

CMS released the final Medicaid and CHIP Managed Care Rule which is subject to each State's administration elections. This rule is the first major update to the Medicaid and CHIP Managed Care regulations in more than a decade, which includes a minimum loss ratio requirement. Pursuant to the regulations, premiums associated with the Company's Medicaid and CHIP line of business are subject to retrospectively rated features based on the actual medical loss ratios experienced on these products. The calculation is pursuant to the Medicaid and CHIP Managed Care guidance. The total amount of direct premiums written for the Medicaid and CHIP line of business for which a portion is subject to the retrospectively rated features was $1,069,477,008 and $980,795,032, representing 98.7% and 98.7% of total direct premiums written as of December 31, 2020 and December 31, 2019, respectively.

The Medicaid contract with the State of Mississippi has a redetermination feature for which a portion of total direct premiums written is subject to a risk adjustment model that apportions premiums paid according to a health plan's health severity and certain demographic factors. Changes in risk score assignments can result in changes to the Company's Medicaid revenues and result in a net liability or a net receivable. The total amount of direct premiums written for the Medicaid line of business for which a portion is subject to redetermination was $963,857,325 and $887,448,611, representing 88.9% and 89.3% of total direct premiums written as of December 31, 2020 and December 31, 2019, respectively.

D. The Company does not have Medicare business subject to specific minimum loss ratio requirements as of December 31, 2020 and 2019.

The Company is required to maintain a specific minimum loss ratio on the comprehensive commercial line of business.

The Company's actual loss ratios on the comprehensive commercial line of business was in excess of the minimum requirements and as a result, no minimum MLR rebate liability was required to be established at December 31, 2020 and 2019.

Pursuant to the Medicaid and CHIP Managed Care Rule, based on the State's election and state contractual minimum loss ratio requirements, the Company is required to maintain specific MLR on its Mississippi CAN and CHIP populations. The Company has estimated $1,575,852 and $0 in estimated Medicaid Managed Care Rule and state minimum loss ratio rebates on its CHIP population as of December 31, 2020 and December 31, 2019, respectively, which is included in aggregate health policy reserves in the statutory basis statements of admitted assets, liabilities, and capital and surplus.

In 2020, Mississippi DOM implemented risk corridor provisions to address the uncertainty of medical costs given the COVID-19 pandemic. The Company's actual MLR was below the established target. The Company has estimated a risk corridor payable of $60,013,201 as of December 31, 2020, which is included in aggregate health policy reserves in the statutory basis statements of admitted assets, liabilities, and capital and surplus.

E. Risk-Sharing Provisions of the Affordable Care Act

(1) The Company has accident and health insurance premiums in 2020 and 2019 subject to the risk-sharing provisions of the ACA.

The ACA imposed fees and premium stabilization provisions on health insurance issuers offering comprehensive commercial health insurance. The three premium stabilization programs are commonly referred to as the 3Rs — risk adjustment, reinsurance, and risk corridors.

Risk Adjustment — The permanent risk adjustment program, designed to mitigate the potential impact of adverse selection and provide stability for health insurance issuers, applies to all non-grandfathered plans not subject to transitional relief in the individual and small group markets both inside and outside of the insurance exchanges. The risk adjustments and distributions are calculated using a high-cost risk pool which adds a reinsurance-like element to this program. The operation of the high-cost risk pools excludes a percentage of costs above a threshold level determined by federal regulations. The program operates two national high-cost risk pools, one for individuals and one for small groups. The data used by CMS to determine the risk adjustment amount is subject to risk adjustment data validation audits along with the true-up to the final CMS report, which may result in a material change to arrive at the final risk adjustment amount from the initial risk adjustment estimate recorded. The risk adjustment data validation audits for 2017 and 2018 have been finalized and any adjustment from the estimate recorded is included in net premium income in the statutory basis financial statements in the period in which the amount became known. The remaining audits for the open years have not been completed. Estimates related to the open years have incorporated CMS' Final Rule on Amendments to the U.S. Department of Health & Human Services ("HHS") operated Risk Adjustment Data Validation under the ACA's HHS operated Risk Adjustment Program published December 1, 2020 and any estimated amounts receivable from or due to CMS are included in premiums and considerations and aggregate health policy reserves, respectively, in the statutory basis statements of assets, liabilities, and capital and surplus. Premium adjustments pursuant to the risk adjustment program are accounted for as premium subject to redetermination and user fees are accounted for as assessments.

Reinsurance — The transitional reinsurance program was designed to protect issuers in the individual market from an expected increase in large claims due to the elimination of preexisting condition limitations. The transitional reinsurance program expired at the end of 2016.

Risk Corridors — The temporary risk corridors program, designed to provide some aggregate protection against variability for issuers in the individual and small group markets during the period 2014 through 2016, applied to Qualified Health Plans in the individual and small group markets both inside and outside of the insurance exchanges. The Company received $4,715,767 from CMS for the settlement of the temporary ACA risk corridor program which has been reflected in net premium income in the statutory basis statements of operations. The details of the years impacted and the amounts received are included in Note 24E 4 and Note 24E 5 below.

(2) The following table presents the current year impact of risk-sharing provisions of the ACA on assets, liabilities and operations:

		December 31, 2020
a.	**Permanent ACA Risk Adjustment Program**	
	Assets	
1.	Premium adjustments receivable due to ACA Risk Adjustment (including high-risk pool payments)	$ 18,411
	Liabilities	
2.	Risk adjustment user fees payable for ACA Risk Adjustment	909
3.	Premium adjustments payable due to ACA Risk Adjustment (including high-risk pool premium)	20,251
	Operations (Revenue & Expense)	
4.	Reported as revenue in premium for accident and health contracts (w ritten/collected) due to ACA Risk Adjustment	(117,440)
5.	Reported in expenses as ACA Risk Adjustment user fees (incurred/paid)	910
b.	**Transitional ACA Reinsurance Program**	
	Assets	
1.	Amounts recoverable for claims paid due to ACA Reinsurance	$ -
2.	Amounts recoverable for claims unpaid due to ACA Reinsurance (Contra Liability)	-
3.	Amounts receivable relating to uninsured plans for contributions for ACA Reinsurance	-
	Liabilities	
4.	Liabilities for contributions payable due to ACA Reinsurance - not reported as ceded premium	-
5.	Ceded reinsurance premiums payable due to ACA Reinsurance	-
6.	Liabilities for amounts held under uninsured plans contributions for ACA Reinsurance	-
	Operations (Revenue & Expense)	
7.	Ceded reinsurance premiums due to ACA Reinsurance	-
8.	Reinsurance recoveries (income statement) due to ACA reinsurance payments or expected payments	-
9.	ACA Reinsurance contributions - not reported as ceded premium	-
c.	**Temporary ACA Risk Corridors Program**	
	Assets	
1.	Accrued retrospective premium due to ACA Risk Corridors	$ -
	Liabilities	
2.	Reserve for rate credits or policy experience rating refunds due to ACA Risk Corridors	-
	Operations (Revenue & Expense)	
3.	Effect of ACA Risk Corridors on net premium income (paid/received)	4,715,767
4.	Effect of ACA Risk Corridors on change in reserves for rate credits	-

(3) The following table is a rollforward of the prior year ACA risk-sharing provisions for asset and liability balances, along with reasons for adjustments to prior year balances:

	Accrued During the Prior Year on Business Written Before December 31 of the Prior Year		Received or Paid as of the Current Year on Business Written Before December 31 of the Prior Year		Differences		Adjustments			Unsettled Balances as of the Reporting Date	
					Prior Year Accrued Less Payments (Col 1 - 3)	Prior Year Accrued Less Payments (Col 2 - 4)				Cumulative Balance From Prior Years (Col 1 - 3 + 7)	Cumulative Balance From Prior Years (Col 2 - 4 + 8)
	1	2	3	4	5	6	7	8		9	10
	Receivable	(Payable)	Receivable	(Payable)	Receivable	(Payable)	To Prior Year Balances Receivable	To Prior Year Balances (Payable)	Ref	Receivable	(Payable)
a. Permanent ACA Risk Adjustment Program											
1. Premium adjustment receivable (including high-risk pool payments)	$ 4,146	$ -	$ -	$ -	$ 4,146	$ -	$ 3,912	$ -	A	$ 8,058	$ -
2. Premium adjustment (payable) (including high-risk pool premium)	-	(12,129)	-	(123,583)	-	111,454	-	(111,454)	B	-	-
3. Subtotal ACA Permanent Risk Adjustment Program	4,146	(12,129)	-	(123,583)	4,146	111,454	3,912	(111,454)		8,058	-
b. Transitional ACA Reinsurance Program											
1. Amounts recoverable for claims paid	-	-	-	-	-	-	-	-	C	-	-
2. Amounts recoverable for claims unpaid (contra liability)	-	-	-	-	-	-	-	-	D	-	-
3. Amounts receivable relating to uninsured plans	-	-	-	-	-	-	-	-	E	-	-
4. Liabilities for contributions payable due to ACA Reinsurance — not reported as ceded premium	-	-	-	-	-	-	-	-	F	-	-
5. Ceded reinsurance premiums payable	-	-	-	-	-	-	-	-	G	-	-
6. Liability for amounts held under uninsured plans	-	-	-	-	-	-	-	-	H	-	-
7. Subtotal ACA Transitional Reinsurance Program	-	-	-	-	-	-	-	-		-	-
c. Temporary ACA Risk Corridors Program											
1. Accrued retrospective premium	-	-	4,715,767	-	(4,715,767)	-	4,715,767	-	I	-	-
2. Reserve for rate credits or policy experience rating refunds	-	-	-	-	-	-	-	-	J	-	-
3. Subtotal ACA Risk Corridors Program	-	-	4,715,767	-	(4,715,767)	-	4,715,767	-		-	-
d. Total for ACA Risk-Sharing Provisions	$ 4,146	$ (12,129)	$ 4,715,767	$ (123,583)	$ (4,711,621)	$ 111,454	$ 4,719,679	$ (111,454)		$ 8,058	$ -

Explanation of Adjustments

A. The risk adjustment receivable as of December 31, 2019 utilized paid claims through October 31, 2019. As of the Reporting Date, the risk adjustment receivable related to prior periods was adjusted based on CMS' Summary Report on Permanent Risk Adjustment Transfers for the 2019 Benefit Year. The risk adjustment receivable was further adjusted based on CMS' Summary Report of 2018 Benefit Year Risk Adjustment Data Validation Adjustments to Risk Adjustment Transfers and estimates related to the open years have incorporated CMS' Final Rule on Amendments to the HHS-operated Risk Adjustment Data Validation (HHS - RADV) under the Patient Protection and Affordable Care Act's HHS-operated Risk Adjustment Program published Dec 1, 2020.

B. The risk adjustment payable as of December 31, 2019 utilized paid claims through October 31, 2019. As of the Reporting Date, the risk adjustment payable related to the prior period was adjusted based on CMS' Summary Report on Permanent Risk Adjustment Transfers for the 2019 Benefit Year. The risk adjustment payable was further adjusted based on CMS' Summary Report of 2018 Benefit Year Risk Adjustment Data Validation Adjustments to Risk Adjustment Transfers and estimates related to the open years have incorporated CMS' Final Rule on Amendments to the HHS-operated Risk Adjustment Data Validation (HHS - RADV) under the Patient Protection and Affordable Care Act's HHS-operated Risk Adjustment Program published Dec 1, 2020.

C. N/A

D. N/A

E. N/A

F. N/A

G. N/A

H. N/A

I. As a result of the United States Supreme Court decision on April 27, 2020 in Maine Community Health Options vs. United States, the Federal Government paid the full amount due to the Company under the temporary risk corridors program for the 2014, 2015, and 2016 benefit years. The risk corridor payment was recognized in the statutory basis statements of operations upon receipt in full during the quarter ended December 31, 2020.

J. N/A

(4) The following table discloses risk corridor receivables and payables by risk corridor program year:

Risk Corridors Program Year	Accrued During the Prior Year on Business Written Before December 31 of the Prior Year 1 Receivable	2 (Payable)	Received or Paid as of the Current Year on Business Written Before December 31 of the Prior Year 3 Receivable	4 (Payable)	Differences Prior Year Accrued Less Payments (Col 1 - 3) 5 Receivable	Prior Year Accrued Less Payments (Col 2 - 4) 6 (Payable)	Adjustments To Prior Year Balances 7 Receivable	To Prior Year Balances 8 (Payable)	Ref	Unsettled Balances as of the Reporting Date Cumulative Balance From Prior Years (Col 1 - 3 + 7) 9 Receivable	Cumulative Balance From Prior Years (Col 2 - 4 + 8) 10 (Payable)
a. 2014											
1. Accrued retrospective premium	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	A	$ -	$ -
2. Reserve for rate credits or policy experience rating refunds	-	-	-	-	-	-	-	-	B	-	-
b. 2015											
1. Accrued retrospective premium	-	-	809,174	-	(809,174)	-	809,174	-	C	-	-
2. Reserve for rate credits or policy experience rating refunds	-	-	-	-	-	-	-	-	D	-	-
c. 2016											
1. Accrued retrospective premium	-	-	3,906,593	-	(3,906,593)	-	3,906,593	-	E	-	-
2. Reserve for rate credits or policy experience rating refunds	-	-	-	-	-	-	-	-	F	-	-
d. Total for Risk Corridors	$ -	$ -	$ 4,715,767	$ -	$ (4,715,767)	$ -	$ 4,715,767	$ -		$ -	$ -

Explanation of Adjustments

A. N/A
B. N/A
C. As a result of the United States Supreme Court decision on April 27, 2020 in Maine Community Health Options vs. United States, the Federal Government paid the full amount due to the Company under the temporary risk corridor program covering issuers of qualified health plans in the individual and small group markets for the 2015 benefit year. As of December 31, 2020, the risk corridor payment has been received and is included in net premium income in the statutory basis statements of operations.
D. N/A
E. As a result of the United States Supreme Court decision on April 27, 2020 in Maine Community Health Options vs. United States, the Federal Government paid the full amount due to the Company under the temporary risk corridor program covering issuers of qualified health plans in the individual and small group markets for the 2015 benefit year As of December 31, 2020, the risk corridor payment has been received and is included in net premium income in the statutory basis statements of operations.
F. N/A

(5) The following table discloses ACA risk corridor receivable balances by risk corridor program year:

Risk Corridors Program Year	1 Estimated Amount to be Filed or Final Amount Filed with CMS	2 Non-Accrued Amounts for Impairment or Other Reasons	3 Amounts Received from CMS	4 Asset Balance (Gross of Non-Admissions) (1-2-3)	5 Non-Admitted Amount	6 Net Admitted Asset (4-5)
a. 2014	$ -	$ -	$ -	$ -	$ -	$ -
b. 2015	809,174	-	809,174	-	-	-
c. 2016	3,906,593	-	3,906,593	-	-	-
d. Total (a+b+c)	$ 4,715,767	$ -	$ 4,715,767	$ -	$ -	$ -

25. CHANGE IN INCURRED CLAIMS AND CLAIMS ADJUSTMENT EXPENSES

A. Changes in estimates related to the prior year incurred claims are included in total hospital and medical expenses in the current year in the statutory basis statements of operations. The following tables disclose paid claims, incurred claims, and the balance in claims unpaid, accrued medical incentive pool and bonus amounts, aggregate health claim reserves, health care receivables and reinsurance recoverables for the years ended December 31, 2020 and 2019:

	2020		
	Current Year Incurred Claims	Prior Years Incurred Claims	Total
Beginning of year claim reserve	$ -	$ (66,641,602)	$ (66,641,602)
Paid claims—net of health care receivables and reinsurance recoveries collected	751,458,415	58,768,345	810,226,760
End of year claim reserve	66,231,515	2,516,448	68,747,963
Incurred claims excluding the change in health care receivables and reinsurance recoverables as presented below	817,689,930	(5,356,809)	812,333,121
Beginning of year health care receivables and reinsurance recoverables	-	3,118,193	3,118,193
End of year health care receivables and reinsurance recoverables	(1,432,820)	(1,965,740)	(3,398,560)
Total incurred claims	$ 816,257,110	$ (4,204,356)	$ 812,052,754

	2019		
	Current Year Incurred Claims	Prior Years Incurred Claims	Total
Beginning of year claim reserve	$ -	$ (81,634,992)	$ (81,634,992)
Paid claims—net of health care receivables and reinsurance recoveries collected	799,782,753	60,319,821	860,102,574
End of year claim reserve	64,780,408	1,861,194	66,641,602
Incurred claims excluding the change in health care receivables and reinsurance recoverables as presented below	864,563,161	(19,453,977)	845,109,184
Beginning of year health care receivables and reinsurance recoverables	-	6,237,405	6,237,405
End of year health care receivables and reinsurance recoverables	(1,350,259)	(1,767,934)	(3,118,193)
Total incurred claims	$ 863,212,902	$ (14,984,506)	$ 848,228,396

The liability for claims unpaid, accrued medical incentive pool and bonus amounts, aggregate health claim reserves, net of health care receivables and reinsurance recoverables as of December 31, 2019 was $63,523,409. As of December 31, 2020, $58,768,345 has been paid for incurred claims attributable to insured events of prior years. Reserves remaining for prior years, net of health care receivables and reinsurance recoverables are now $550,708, as a result of re-estimation of unpaid claims. Therefore, there has been $4,204,356 favorable prior year

development since December 31, 2019 to December 31, 2020. The primary drivers consist of favorable development as a result of a change in the provision for adverse deviations in experience of $3,710,639, favorable development of $2,130,212 due to recoupment of the transportation expenses overpayment, favorable development of $1,614,000 due to the release of an accrual related to ACA program, $852,769 due to provider settlement and favorable development of $623,512 due to risk share, partially offset by unfavorable development of $4,979,953 in retroactivity for inpatient, outpatient, physician, and pharmacy claims. At December 31, 2019, the Company recorded a favorable development of $14,984,506 as a result of physician claims payable of $10,411,012, a change in the provision for adverse deviation in experience of $5,275,323 and retroactivity for inpatient, outpatient, physician, and pharmacy claims of $2,793,952, partially offset by unfavorable development of $2,891,968 in claims recoveries. Original estimates are increased or decreased, as additional information becomes known regarding individual claims, which could have an impact to the accruals for MLR rebates and retrospectively rated contracts. As a result of the prior year effects, on a regular basis, the Company adjusts revenue and the corresponding liability and/or receivable related to retrospectively rated policies and the impact of the change is included as a component of change in unearned premium reserves in the statutory basis statements of operations.

The Company incurred CAE of $44,754,004 and $44,809,281 in 2020 and 2019, respectively. These costs are included in the management service fees paid by the Company to UHS as a part of the Agreement (see Note 10). The following table discloses paid CAE, incurred CAE, and the balance in unpaid CAE reserve for 2020 and 2019:

	2020	2019
Total claims adjustment expenses	$ 44,754,004	$ 44,809,281
Less: current year unpaid claims adjustment expenses	(756,738)	(652,988)
Add: prior year unpaid claims adjustment expenses	652,988	769,995
Total claims adjustment expenses paid	$ 44,650,254	$ 44,926,288

B. The Company did not make any significant changes in methodologies and assumptions used in the calculation of the liability for claims unpaid and unpaid CAE in 2020.

26. INTERCOMPANY POOLING ARRANGEMENTS

A–G. The Company did not have any intercompany pooling arrangements in 2020 or 2019.

27. STRUCTURED SETTLEMENTS

A–B. The Company did not have structured settlements in 2020 or 2019.

28. HEALTH CARE RECEIVABLES

A. Pharmacy rebates receivable are recorded when reasonably estimated or billed by the affiliated pharmaceutical benefit manager in accordance with pharmaceutical rebate contract provisions. Information used to support rebates billed to the manufacturer is based on utilization information gathered by the pharmaceutical benefit manager and adjusted for significant changes in pharmaceutical contract provisions.

The Company evaluates admissibility of all pharmacy rebates receivable based on the administration of each underlying pharmaceutical benefit management agreement. The Company has nonadmitted and excluded all pharmacy rebates receivable that do not meet the admissibility criteria of SSAP No. 84, *Health Care and Government Insured Plan Receivables* (“SSAP No. 84”) from the statutory basis statements of admitted assets, liabilities, and capital and surplus.

For each pharmaceutical management agreement for which a portion of the total pharmacy rebates receivable can be admitted based on the admissibility criteria of SSAP No. 84, the pharmacy rebate transaction history is summarized as follows:

Quarter	Estimated Pharmacy Rebates as Reported on Financial Statements	Pharmacy Rebates as Billed or Otherwise Confirmed	Actual Rebates Received within 90 Days of Billing	Actual Rebates Received within 91 to 180 Days of Billing	Actual Rebates Received More than 180 Days after Billing
12/31/2020	$ 450,771	$ 102,797	$ -	$ -	$ -
9/30/2020	478,591	421,457	224,650	-	-
6/30/2020	417,983	378,099	188,940	162,834	-
3/31/2020	438,621	408,121	15,157	336,208	29,336
12/31/2019	521,237	497,821	139,582	240,697	86,380
9/30/2019	540,325	534,855	164,560	210,500	144,242
6/30/2019	543,520	559,899	127,383	380,835	44,251
3/31/2019	565,486	597,848	231,419	156,963	197,303
12/31/2018	642,511	621,768	310,198	295,053	27,662
9/30/2018	625,829	655,767	335,053	248,839	72,680
6/30/2018	662,115	684,582	316,806	295,872	62,276
3/31/2018	608,686	618,834	159,857	375,853	77,925

Of the amount reported as health care receivables, $634,306 and $878,157 relates to pharmacy rebates receivable and $378,880 and $137,013 relates to claims overpayments as of December 31, 2020 and 2019, respectively. This decrease is primarily due to decreased membership along with the change in generic/name brand mix.

B. The Company does not have any risk-sharing receivables.

29. PARTICIPATING POLICIES

The Company did not have any participating contracts in 2020 or 2019.

30. PREMIUM DEFICIENCY RESERVES

The Company has not recorded any PDR as of December 31, 2020 or 2019. The analysis of PDR was completed as of December 31, 2020 and 2019. The Company did consider anticipated investment income when calculating the PDR.

The following table summarizes the Company's PDR as of December 31, 2020 and 2019:

	2020
1. Liability carried for premium deficiency reserves	$ -
2. Date of the most recent evaluation of this liability	12/31/2020
3. Was anticipated investment income utilized in this calculation?	Yes [X] No [ ]

	2019
1. Liability carried for premium deficiency reserves	$ -
2. Date of the most recent evaluation of this liability	12/31/2019
3. Was anticipated investment income utilized in this calculation?	Yes [X] No [ ]

31. ANTICIPATED SALVAGE AND SUBROGATION

Due to the type of business being written, the Company has no salvage. As of December 31, 2020 and 2019, the Company had no specific accruals established for outstanding subrogation, as it is considered a component of the actuarial calculations used to develop the estimates of claims unpaid and aggregate health claim reserves.

* * * * * *

SUPPLEMENTAL SCHEDULES

EXHIBIT I:
SUPPLEMENTAL INVESTMENT RISKS INTERROGATORIES

SUPPLEMENTAL INVESTMENT RISKS INTERROGATORIES

For The Year Ended December 31, 2020
(To Be Filed by April 1)

Of The UnitedHealthcare of Mississippi, Inc.

ADDRESS (City, State and Zip Code) Minnetonka , MN 55343

NAIC Group Code 0707 NAIC Company Code 95716 Federal Employer's Identification Number (FEIN) 63-1036817

The Investment Risks Interrogatories are to be filed by April 1. They are also to be included with the Audited Statutory Financial Statements.

Answer the following interrogatories by reporting the applicable U.S. dollar amounts and percentages of the reporting entity's total admitted assets held in that category of investments.

1. Reporting entity's total admitted assets as reported on Page 2 of this annual statement. $ 336,323,956

2. Ten largest exposures to a single issuer/borrower/investment.

	1 Issuer	2 Description of Exposure	3 Amount	4 Percentage of Total Admitted Assets
2.01	Northern Inst - BGSXX	Bonds	$ 9,716,785	2.9 %
2.02	FHLMC	Bonds	$ 7,900,886	2.3 %
2.03	FNMA	Bonds	$ 7,505,641	2.2 %
2.04	HSBC - HGIXX	Bonds	$ 5,956,660	1.8 %
2.05	UTAH ST HSG CORP - HSG	Bonds	$ 2,616,354	0.8 %
2.06	COCA-COLA CO/THE	Bonds	$ 1,961,720	0.6 %
2.07	SIMON PROP GP LP	Bonds	$ 1,601,660	0.5 %
2.08	TOYOTA MTR CORP	Bonds	$ 1,522,752	0.5 %
2.09	VIRGINIA ST PUBL - APP	Bonds	$ 1,518,193	0.5 %
2.10	KINDER MORGAN	Bonds	$ 1,513,888	0.5 %

3. Amounts and percentages of the reporting entity's total admitted assets held in bonds and preferred stocks by NAIC designation.

	Bonds	1	2		Preferred Stocks	3	4
3.01	NAIC-1	$ 128,344,635	38.2 %	3.07	P/RP-1	$ 0	0.0 %
3.02	NAIC-2	$ 23,963,094	7.1 %	3.08	P/RP-2	$ 0	0.0 %
3.03	NAIC-3	$ 0	0.0 %	3.09	P/RP-3	$ 0	0.0 %
3.04	NAIC-4	$ 0	0.0 %	3.10	P/RP-4	$ 0	0.0 %
3.05	NAIC-5	$ 0	0.0 %	3.11	P/RP-5	$ 0	0.0 %
3.06	NAIC-6	$ 0	0.0 %	3.12	P/RP-6	$ 0	0.0 %

4. Assets held in foreign investments:

4.01 Are assets held in foreign investments less than 2.5% of the reporting entity's total admitted assets? Yes [ ] No [X]

If response to 4.01 above is yes, responses are not required for interrogatories 5 - 10.

4.02	Total admitted assets held in foreign investments	$ 19,987,840	5.9 %
4.03	Foreign-currency-denominated investments	$ 0	0.0 %
4.04	Insurance liabilities denominated in that same foreign currency	$ 0	0.0 %

5. Aggregate foreign investment exposure categorized by NAIC sovereign designation:

		1	2
5.01	Countries designated NAIC-1	$ 17,843,811	5.3 %
5.02	Countries designated NAIC-2	$ 2,144,029	0.6 %
5.03	Countries designated NAIC-3 or below	$ 0	0.0 %

6. Largest foreign investment exposures by country, categorized by the country's NAIC sovereign designation:

		1	2
	Countries designated NAIC - 1:		
6.01	Country 1: CAYMAN ISLANDS	$ 6,810,000	2.0 %
6.02	Country 2: UNITED KINGDOM	$ 3,836,358	1.1 %
	Countries designated NAIC - 2:		
6.03	Country 1: MEXICO	$ 1,959,645	0.6 %
6.04	Country 2: URUGUAY	$ 184,384	0.1 %
	Countries designated NAIC - 3 or below:		
6.05	Country 1:	$ 0	0.0 %
6.06	Country 2:	$ 0	0.0 %

		1	2
7.	Aggregate unhedged foreign currency exposure	$ 0	0.0 %

8. Aggregate unhedged foreign currency exposure categorized by NAIC sovereign designation:

		1	2
8.01	Countries designated NAIC-1	$ 0	0.0 %
8.02	Countries designated NAIC-2	$ 0	0.0 %
8.03	Countries designated NAIC-3 or below	$ 0	0.0 %

9. Largest unhedged foreign currency exposures by country, categorized by the country's NAIC sovereign designation:

		1	2
	Countries designated NAIC - 1:		
9.01	Country 1:	$ 0	0.0 %
9.02	Country 2:	$ 0	0.0 %
	Countries designated NAIC - 2:		
9.03	Country 1:	$ 0	0.0 %
9.04	Country 2:	$ 0	0.0 %
	Countries designated NAIC - 3 or below:		
9.05	Country 1:	$ 0	0.0 %
9.06	Country 2:	$ 0	0.0 %

10. Ten largest non-sovereign (i.e. non-governmental) foreign issues:

	1 Issuer	2 NAIC Designation	3	4
10.01	KINDER MORGAN	2	$ 1,513,888	0.5 %
10.02	NATIONWIDE BLDG	1 and 2	$ 1,500,727	0.4 %
10.03	CARLYLE GLOBAL MKT STRTG - CGMS 2020-2A	1	$ 1,500,000	0.4 %
10.04	York Capital - YCLO 2020-1A	1	$ 1,500,000	0.4 %
10.05	Octagon Investment Partnership - OCT49 2020-5A	1	$ 1,500,000	0.4 %
10.06	RENAISSANCERE	1	$ 1,383,401	0.4 %
10.07	EUROPEAN BK RECON & DEV	1	$ 999,712	0.3 %
10.08	Inter Amer'n Development Bank	1	$ 998,301	0.3 %
10.09	UBS GROUP	1	$ 850,000	0.3 %
10.10	MADISON PARK FUNDING LTD - MDPK 2019-37A	1	$ 830,000	0.2 %

11. Amounts and percentages of the reporting entity's total admitted assets held in Canadian investments and unhedged Canadian currency exposure:

11.01 Are assets held in Canadian investments less than 2.5% of the reporting entity's total admitted assets? ..... Yes [X] No [ ]

If response to 11.01 is yes, detail is not required for the remainder of interrogatory 11.

		1	2
11.02	Total admitted assets held in Canadian investments	$ 0	0.0 %
11.03	Canadian-currency-denominated investments	$ 0	0.0 %
11.04	Canadian-denominated insurance liabilities	$ 0	0.0 %
11.05	Unhedged Canadian currency exposure	$ 0	0.0 %

12. Report aggregate amounts and percentages of the reporting entity's total admitted assets held in investments with contractual sales restrictions:

12.01 Are assets held in investments with contractual sales restrictions less than 2.5% of the reporting entity's total admitted assets? ..... Yes [X] No [ ]

If response to 12.01 is yes, responses are not required for the remainder of Interrogatory 12.

	1	2	3
12.02	Aggregate statement value of investments with contractual sales restrictions	$ 0	0.0 %
	Largest three investments with contractual sales restrictions:		
12.03		$ 0	0.0 %
12.04		$ 0	0.0 %
12.05		$ 0	0.0 %

13. Amounts and percentages of admitted assets held in the ten largest equity interests:

13.01 Are assets held in equity interests less than 2.5% of the reporting entity's total admitted assets? ..... Yes [X] No [ ]

If response to 13.01 above is yes, responses are not required for the remainder of Interrogatory 13.

	1 Issuer	2	3
13.02		$ 0	0.0 %
13.03		$ 0	0.0 %
13.04		$ 0	0.0 %
13.05		$ 0	0.0 %
13.06		$ 0	0.0 %
13.07		$ 0	0.0 %
13.08		$ 0	0.0 %
13.09		$ 0	0.0 %
13.10		$ 0	0.0 %
13.11		$ 0	0.0 %

14. Amounts and percentages of the reporting entity's total admitted assets held in nonaffiliated, privately placed equities:

14.01 Are assets held in nonaffiliated, privately placed equities less than 2.5% of the reporting entity's total admitted assets? ..... Yes [X] No [ ]

If response to 14.01 above is yes, responses are not required for 14.02 through 14.05.

	1	2	3
14.02	Aggregate statement value of investments held in nonaffiliated, privately placed equities	$ 0	0.0 %
	Largest three investments held in nonaffiliated, privately placed equities:		
14.03		$ 0	0.0 %
14.04		$ 0	0.0 %
14.05		$ 0	0.0 %

Ten largest fund managers:

	1 Fund Manager	2 Total Invested	3 Diversified	4 Nondiversified
14.06		$ 0	$ 0	$ 0
14.07		$ 0	$ 0	$ 0
14.08		$ 0	$ 0	$ 0
14.09		$ 0	$ 0	$ 0
14.10		$ 0	$ 0	$ 0
14.11		$ 0	$ 0	$ 0
14.12		$ 0	$ 0	$ 0
14.13		$ 0	$ 0	$ 0
14.14		$ 0	$ 0	$ 0
14.15		$ 0	$ 0	$ 0

15. Amounts and percentages of the reporting entity's total admitted assets held in general partnership interests:

15.01 Are assets held in general partnership interests less than 2.5% of the reporting entity's total admitted assets? ..... Yes [X] No [ ]

If response to 15.01 above is yes, responses are not required for the remainder of Interrogatory 15.

	1	2	3
15.02	Aggregate statement value of investments held in general partnership interests	$ 0	0.0 %
	Largest three investments in general partnership interests:		
15.03		$ 0	0.0 %
15.04		$ 0	0.0 %
15.05		$ 0	0.0 %

16. Amounts and percentages of the reporting entity's total admitted assets held in mortgage loans:

16.01 Are mortgage loans reported in Schedule B less than 2.5% of the reporting entity's total admitted assets? ..... Yes [X] No [ ]

If response to 16.01 above is yes, responses are not required for the remainder of Interrogatory 16 and Interrogatory 17.

	1 Type (Residential, Commercial, Agricultural)	2	3
16.02		$ 0	0.0 %
16.03		$ 0	0.0 %
16.04		$ 0	0.0 %
16.05		$ 0	0.0 %
16.06		$ 0	0.0 %
16.07		$ 0	0.0 %
16.08		$ 0	0.0 %
16.09		$ 0	0.0 %
16.10		$ 0	0.0 %
16.11		$ 0	0.0 %

Amount and percentage of the reporting entity's total admitted assets held in the following categories of mortgage loans:

		Loans	
16.12	Construction loans	$ 0	0.0 %
16.13	Mortgage loans over 90 days past due	$ 0	0.0 %
16.14	Mortgage loans in the process of foreclosure	$ 0	0.0 %
16.15	Mortgage loans foreclosed	$ 0	0.0 %
16.16	Restructured mortgage loans	$ 0	0.0 %

17. Aggregate mortgage loans having the following loan-to-value ratios as determined from the most current appraisal as of the annual statement date:

		Residential		Commercial		Agricultural	
	Loan to Value	1	2	3	4	5	6
17.01	above 95%	$ 0	0.0 %	$ 0	0.0 %	$ 0	0.0 %
17.02	91 to 95%	$ 0	0.0 %	$ 0	0.0 %	$ 0	0.0 %
17.03	81 to 90%	$ 0	0.0 %	$ 0	0.0 %	$ 0	0.0 %
17.04	71 to 80%	$ 0	0.0 %	$ 0	0.0 %	$ 0	0.0 %
17.05	below 70%	$ 0	0.0 %	$ 0	0.0 %	$ 0	0.0 %

18. Amounts and percentages of the reporting entity's total admitted assets held in each of the five largest investments in real estate:

18.01 Are assets held in real estate reported less than 2.5% of the reporting entity's total admitted assets? ..... Yes [X] No [ ]

If response to 18.01 above is yes, responses are not required for the remainder of Interrogatory 18.

Largest five investments in any one parcel or group of contiguous parcels of real estate.

	Description 1	2	3
18.02		$ 0	0.0 %
18.03		$ 0	0.0 %
18.04		$ 0	0.0 %
18.05		$ 0	0.0 %
18.06		$ 0	0.0 %

19. Report aggregate amounts and percentages of the reporting entity's total admitted assets held in investments held in mezzanine real estate loans:

19.01 Are assets held in investments held in mezzanine real estate loans less than 2.5% of the reporting entity's total admitted assets? ..... Yes [X] No [ ]

If response to 19.01 is yes, responses are not required for the remainder of Interrogatory 19.

	1	2	3
19.02	Aggregate statement value of investments held in mezzanine real estate loans:	$ 0	0.0 %
	Largest three investments held in mezzanine real estate loans:		
19.03		$ 0	0.0 %
19.04		$ 0	0.0 %
19.05		$ 0	0.0 %

20. Amounts and percentages of the reporting entity's total admitted assets subject to the following types of agreements:

		At Year End		At End of Each Quarter		
				1st Quarter	2nd Quarter	3rd Quarter
		1	2	3	4	5
20.01	Securities lending agreements (do not include assets held as collateral for such transactions)	$ 0	0.0 %	$ 0	$ 0	$ 0
20.02	Repurchase agreements	$ 0	0.0 %	$ 0	$ 0	$ 0
20.03	Reverse repurchase agreements	$ 0	0.0 %	$ 0	$ 0	$ 0
20.04	Dollar repurchase agreements	$ 0	0.0 %	$ 0	$ 0	$ 0
20.05	Dollar reverse repurchase agreements	$ 0	0.0 %	$ 0	$ 0	$ 0

21. Amounts and percentages of the reporting entity's total admitted assets for warrants not attached to other financial instruments, options, caps, and floors:

		Owned		Written	
		1	2	3	4
21.01	Hedging	$ 0	0.0 %	$ 0	0.0 %
21.02	Income generation	$ 0	0.0 %	$ 0	0.0 %
21.03	Other	$ 0	0.0 %	$ 0	0.0 %

22. Amounts and percentages of the reporting entity's total admitted assets of potential exposure for collars, swaps, and forwards:

		At Year End		At End of Each Quarter		
				1st Quarter	2nd Quarter	3rd Quarter
		1	2	3	4	5
22.01	Hedging	$ 0	0.0 %	$ 0	$ 0	$ 0
22.02	Income generation	$ 0	0.0 %	$ 0	$ 0	$ 0
22.03	Replications	$ 0	0.0 %	$ 0	$ 0	$ 0
22.04	Other	$ 0	0.0 %	$ 0	$ 0	$ 0

23. Amounts and percentages of the reporting entity's total admitted assets of potential exposure for futures contracts:

		At Year End		At End of Each Quarter		
				1st Quarter	2nd Quarter	3rd Quarter
		1	2	3	4	5
23.01	Hedging	$ 0	0.0 %	$ 0	$ 0	$ 0
23.02	Income generation	$ 0	0.0 %	$ 0	$ 0	$ 0
23.03	Replications	$ 0	0.0 %	$ 0	$ 0	$ 0
23.04	Other	$ 0	0.0 %	$ 0	$ 0	$ 0

EXHIBIT II:
SUMMARY INVESTMENT SCHEDULE

SUMMARY INVESTMENT SCHEDULE

	Gross Investment Holdings		Admitted Assets as Reported in the Annual Statement			
	1	2	3	4	5	6
Investment Categories	Amount	Percentage of Column 1 Line 13	Amount	Securities Lending Reinvested Collateral Amount	Total (Col. 3 + 4) Amount	Percentage of Column 5 Line 13
1. Long-Term Bonds (Schedule D, Part 1):						
1.01 U.S. governments	539,837	0.177	539,837	0	539,837	0.177
1.02 All other governments	3,879,879	1.269	3,879,879	0	3,879,879	1.269
1.03 U.S. states, territories and possessions, etc. guaranteed	1,643,166	0.537	1,643,166	0	1,643,166	0.537
1.04 U.S. political subdivisions of states, territories, and possessions, guaranteed	2,764,937	0.904	2,764,937	0	2,764,937	0.904
1.05 U.S. special revenue and special assessment obligations, etc. non-guaranteed	38,539,525	12.603	38,539,525	0	38,539,525	12.603
1.06 Industrial and miscellaneous	104,940,385	34.316	104,940,385	0	104,940,385	34.316
1.07 Hybrid securities	0	0.000	0	0	0	0.000
1.08 Parent, subsidiaries and affiliates	0	0.000	0	0	0	0.000
1.09 SVO identified funds	0	0.000	0	0	0	0.000
1.10 Unaffiliated Bank loans	0	0.000	0	0	0	0.000
1.11 Total long-term bonds	152,307,729	49.806	152,307,729	0	152,307,729	49.806
2. Preferred stocks (Schedule D, Part 2, Section 1):						
2.01 Industrial and miscellaneous (Unaffiliated)	0	0.000	0	0	0	0.000
2.02 Parent, subsidiaries and affiliates	0	0.000	0	0	0	0.000
2.03 Total preferred stocks	0	0.000	0	0	0	0.000
3. Common stocks (Schedule D, Part 2, Section 2):						
3.01 Industrial and miscellaneous Publicly traded (Unaffiliated)	0	0.000	0	0	0	0.000
3.02 Industrial and miscellaneous Other (Unaffiliated)	0	0.000	0	0	0	0.000
3.03 Parent, subsidiaries and affiliates Publicly traded	0	0.000	0	0	0	0.000
3.04 Parent, subsidiaries and affiliates Other	0	0.000	0	0	0	0.000
3.05 Mutual funds	0	0.000	0	0	0	0.000
3.06 Unit investment trusts	0	0.000	0	0	0	0.000
3.07 Closed-end funds	0	0.000	0	0	0	0.000
3.08 Total common stocks	0	0.000	0	0	0	0.000
4. Mortgage loans (Schedule B):						
4.01 Farm mortgages	0	0.000	0	0	0	0.000
4.02 Residential mortgages	0	0.000	0	0	0	0.000
4.03 Commercial mortgages	0	0.000	0	0	0	0.000
4.04 Mezzanine real estate loans	0	0.000	0	0	0	0.000
4.05 Total valuation allowance	0	0.000	0	0	0	0.000
4.06 Total mortgage loans	0	0.000	0	0	0	0.000
5. Real estate (Schedule A):						
5.01 Properties occupied by company	0	0.000	0	0	0	0.000
5.02 Properties held for production of income	0	0.000	0	0	0	0.000
5.03 Properties held for sale	0	0.000	0	0	0	0.000
5.04 Total real estate	0	0.000	0	0	0	0.000
6. Cash, cash equivalents and short-term investments:						
6.01 Cash (Schedule E, Part 1)	47,921	0.016	47,921	0	47,921	0.016
6.02 Cash equivalents (Schedule E, Part 2)	153,446,114	50.178	153,446,114	0	153,446,114	50.178
6.03 Short-term investments (Schedule DA)	0	0.000	0	0	0	0.000
6.04 Total cash, cash equivalents and short-term investments	153,494,035	50.194	153,494,035	0	153,494,035	50.194
7. Contract loans	0	0.000	0	0	0	0.000
8. Derivatives (Schedule DB)	0	0.000	0	0	0	0.000
9. Other invested assets (Schedule BA)	0	0.000	0	0	0	0.000
10. Receivables for securities	0	0.000	0	0	0	0.000
11. Securities Lending (Schedule DL, Part 1)	0	0.000	0	XXX	XXX	XXX
12. Other invested assets (Page 2, Line 11)	0	0.000	0	0	0	0.000
13. Total invested assets	305,801,764	100.000	305,801,764	0	305,801,764	100.000

EXHIBIT III:
SUPPLEMENTAL SCHEDULE
REGARDING REINSURANCE CONTRACTS
WITH RISK-LIMITING FEATURES

UNITEDHEALTHCARE OF MISSISSIPPI, INC.
FOR THE YEAR ENDED DECEMBER 31, 2020
SUPPLEMENTAL SCHEDULE OF THE ANNUAL AUDIT REPORT
SUPPLEMENTAL SCHEDULE REGARDING REINSURANCE CONTRACTS WITH RISK-LIMITING FEATURES

Reinsurance contracts subject to *Appendix A-791 — Life and Health Reinsurance Agreements* of the *NAIC Accounting Practices and Procedures Manual*:

The Company has no reinsurance contracts subject to Appendix A-791 — *Life and Health Reinsurance Agreements* ("A-791") that includes a provision which limits the reinsurer's assumption of significant risk.

Reinsurance contracts NOT subject to *Appendix A-791 — Life and Health Reinsurance Agreements* of the *NAIC Accounting Practices and Procedures Manual*:

The Company has no reinsurance contracts not subject to A-791, for which reinsurance accounting was applied and which includes provisions that limits the reinsurer's assumption of risk.

Payments to reinsurers (excluding reinsurance contracts with a federal or state facility):

The Company's reinsurance contracts do not contain features which result in delays in payment in form or in fact.

Reinsurance contracts NOT subject to *Appendix A-791 — Life and Health Reinsurance Agreements* of the *NAIC Accounting Practices and Procedures Manual* and NOT yearly-renewable term that meet the risk transfer requirements under SSAP No. 61R:

The Company has not reflected a reinsurance accounting credit for any contracts not subject to Appendix A-791 and not yearly renewable term, which meet the risk transfer requirements of SSAP No. 61R.

The Company did not cede any risk which is not subject to A-791 and not yearly renewable term reinsurance, under any reinsurance contract during the period covered by these financial statements, for which the statutory accounting treatment and GAAP accounting treatment were not the same.

The Company's ceded reinsurance contract which is not subject to A-791 and not yearly renewable term reinsurance, is treated the same for GAAP and statutory accounting principles.

OTHER ATTACHMENT

Deloitte.

Deloitte & Touche LLP
50 South 6th Street
Suite 2800
Minneapolis, MN 55402-1538
USA

Tel:+1 612 397 4000
Fax:+1 612 397 4450
www.deloitte.com

To the Audit Committee of
UnitedHealthcare of Mississippi, Inc.
795 Woodlands Parkway, Suite 301, MS010-1000
Ridgeland, MS 39157

The Management of
UnitedHealthcare of Mississippi, Inc.
795 Woodlands Parkway, Suite 301, MS010-1000
Ridgeland, MS 39157

Dear Members of the Audit Committee and Management:

We have audited, in accordance with auditing standards generally accepted in the United States of America, the statutory-basis financial statements of UnitedHealthcare of Mississippi, Inc. (the "Company") for the years ended December 31, 2020, and 2019, and have issued our report thereon dated May 26, 2021. In connection therewith, we advise you as follows:

1. We are independent certified public accountants with respect to the Company and conform to the standards of the accounting profession as contained in the *Code of Professional Conduct* and pronouncements of the American Institute of Certified Public Accountants, the rules and regulations of the Mississippi Insurance Department, and the Rules of Professional Conduct of the Minnesota State Board of Accountancy.

2. The engagement partner and engagement manager, who are certified public accountants, have 31 years and 12 years, respectively, of experience in public accounting and are experienced in auditing insurance enterprises. Members of the engagement team, most of whom have had experience in auditing insurance enterprises and 32 percent of whom are certified public accountants, were assigned to perform tasks commensurate with their training and experience.

3. We understand that the Company intends to file its audited statutory-basis financial statements and our report thereon with the Mississippi Insurance Department and other state insurance departments in states in which the Company is licensed and that the insurance commissioners of those states will be relying on that information in monitoring and regulating the statutory-basis financial condition of the Company.

   While we understand that an objective of issuing a report on the statutory-basis financial statements is to satisfy regulatory requirements, our audit was not planned to satisfy all objectives or responsibilities of insurance regulators. In this context, the Company and insurance commissioners should understand that the objective of an audit of statutory-basis financial statements in accordance with auditing standards generally accepted in the United States of America is to form an opinion and issue a report on whether the statutory-basis financial statements present fairly, in all material respects, the admitted assets, liabilities, and capital and surplus, results of operations and cash flows in accordance with accounting practices prescribed or permitted by the Mississippi Insurance Department. Consequently, under auditing standards generally accepted in the United States of America, we have the responsibility, within the inherent limitations of the auditing process, to plan and perform our audit to obtain reasonable assurance regarding whether the statutory-basis financial statements are free from material misstatement, whether due to error or fraud, and to exercise due professional care in the conduct of the audit. The Company is not required to have, nor were we engaged to perform, an audit

of internal control over financial reporting. Our audit included consideration of internal control relevant to the entity's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of internal control over financial reporting. The concept of selective testing of the data being audited, which involves judgment both as to the number of transactions to be audited and the areas to be tested, has been generally accepted as a valid and sufficient basis for an auditor to express an opinion on financial statements. Audit procedures that are effective for detecting errors, if they exist, may be ineffective for detecting misstatements resulting from fraud. Because of the characteristics of fraud, particularly those involving concealment and falsified documentation (including forgery), a properly planned and performed audit may not detect a material misstatement resulting from fraud. In addition, an audit does not address the possibility that material misstatements may occur in the future. Also, our use of professional judgment and the assessment of materiality for the purpose of our audit mean that matters may exist that would have been assessed differently by insurance commissioners.

It is the responsibility of the management of the Company to adopt sound accounting policies, to maintain an adequate and effective system of accounts, and to establish and maintain internal control that will, among other things, provide reasonable, but not absolute, assurance that assets are safeguarded against loss from unauthorized use or disposition and that transactions are executed in accordance with management's authorization and are recorded properly to permit the preparation of financial statements in conformity with accounting practices prescribed or permitted by the Mississippi Insurance Department.

The Insurance Commissioner should exercise due diligence to obtain whatever other information that may be necessary for the purpose of monitoring and regulating the statutory basis financial position of insurers and should not rely solely on the independent auditors' report.

4. We will retain the working papers (including those kept in a hard copy or electronic medium) prepared in the conduct of our audit until the Mississippi Insurance Department has filed a Report of Examination covering 2020, but no longer than seven years. After notification to the Company, we will make the working papers available for review by the Mississippi Insurance Department or its delegates, at the offices of the insurer, at our offices, at the Mississippi Insurance Department, or at any other reasonable place designated by the Insurance Commissioner. Furthermore, in the conduct of the aforementioned periodic review by the Mississippi Insurance Department, photocopies of pertinent audit working papers may be made (under the control of Deloitte & Touche LLP) and such copies may be retained by the Mississippi Insurance Department. In addition, to the extent requested, we may provide the Mississippi Insurance Department with copies of certain audit working papers (such as unlocked copies of Excel spreadsheets that do not contain password protection or encryption). As such, these audit working papers will be subject to potential modification by Mississippi Insurance Department or by others. We are not responsible for any modifications made to the copies, electronic or otherwise, after they are provided to the Mississippi Insurance Department; and we are likewise not responsible for any effect that any such modifications, whether intentional or not, might have on the process, substance, or outcome of your regulatory examination.

5. The engagement partner has served in this capacity with respect to the Company since 2017, is licensed by the Minnesota State Board of Accountancy, and is a member in good standing of the American Institute of Certified Public Accountants.

6. To the best of our knowledge and belief, we are in compliance with the requirements of section 7 of the *NAIC's Model Rule (Regulation) Requiring Annual Audited Financial Reports* regarding qualifications of independent certified public accountants.

This letter is intended solely for the information and use of the Audit Committee and management of UnitedHealthcare of Mississippi, Inc. and for filing with the Mississippi Insurance Department and other state insurance departments to whose jurisdiction the Company is subject and is not intended to be and should not be used by anyone other than these specified parties.

Deloitte & Touche LLP

May 26, 2021

United Healthcare Community Plan

Att. 4.3.2.6-4
Lines of Credit Documentation

UNITEDHEALTH GROUP

Karen Smith, Legal Services Specialist
Legal Corporate Governance (NY465-1000)
411 Theodore Fremd Avenue
Suite 206 South
Rye, NY 10580
Telephone: (763) 361-8950
Email: karen_s_smith_@uhg.com

September 27, 2018

Lauren Williams
Financial and Market Regulation Division
Mississippi Department of Insurance
Woolfolk State Office Building
501 North West Street
Jackson, MS 39201

RE: **UnitedHealthcare of Mississippi, Inc. ("Registrant")**
Form D Request for Approval
Insurance Holding Company Act: First Amendment to the Amended and Restated Subordinated Revolving Credit Agreement

Dear Ms. Williams:

Pursuant to the requirements of Miss. Dept of Ins. Reg. 92-103 § 17 and Miss. Code Ann. § 83-6-21 of the Act, enclosed for your review and approval is one executed original and one copy of the Form D- Prior Notice of a Transaction dated September 26, 2018, submitted on behalf of UnitedHealthcare of Mississippi, Inc. Also enclosed is a check to cover the cost of the filing fee in the amount of $50.

The transaction is a First Amendment to the Amended and Restated Subordinated Revolving Credit Agreement between Registrant and UnitedHealth Group, Incorporated to provide a short-term borrowing facility.

Please contact me directly if you have any further questions of the filing.

Very Truly Yours,

Karen Smith

Enclosures

United HealthCare Svs Inc
(877) 620-6192
PO Box 1459 MN008-W235
Minneapolis MN 55440-1459

CHECK DATE 03-21-2018
CHECK NUMBER 06366239

INVOICE NUMBER	INVOICE DATE	VOUCHER NUMBER	GROSS AMOUNT	DISCOUNT	NET AMOUNT
FEE031918REX003	03-20-18	24499866	50.00	.00	50.00
For questions contact Karen Smith 914-933-4625					
SPR					

VENDOR					
0000170635	TOTAL	USD	50.00	.00	50.00

000300 1064374 0001 06366239 UNW2553141-00000300 03/20/18 15:58 000017063500004 75998-0003 76239 A

THE FACE OF THIS DOCUMENT CONTAINS A MULTICOLORED BACKGROUND - THE BACK CONTAINS AN ARTIFICIAL WATERMARK (HOLD AT AN ANGLE TO VIEW) AND INK THAT RESPONDS TO TEMPERATURE.

United HealthCare Svs Inc
(877) 620-6192
PO Box 1459 MN008-W235
Minneapolis MN 55440-1459

KEYBANK NATIONAL ASSOCIATION

56-704
412

DATE 03-21-2018 CHECK NO. 06366239 150

Pay FIFTY AND 00/100 DOLLARS $50.00

To The Order of
MISSISSIPPI DEPARTMENT OF
1001 WOOLFOLK STATE OFFICE BLDG
501 N WEST ST
JACKSON MS 39201-1012

AUTHORIZED SIGNATURE

ABSENCE OF ANY OF THE FEATURES MENTIONED ABOVE MAY INDICATE A FRAUDULENT DOCUMENT - DO NOT CASH UNLESS ALL FEATURES ARE PRESENT. CHECKS CLEAR POSITIVE PAY.

[redacted]

FORM D

PRIOR NOTICE OF A TRANSACTION
Filed with the Insurance Department of the State of Mississippi

By

UnitedHealthcare of Mississippi, Inc.
Name of Registrant

On Behalf of the Following Insurance Company:

UnitedHealthcare of Mississippi, Inc.
800 Woodlands Parkway
Ridgeland, MS 39157

Date: September 26, 2018

Name, Title, Address and telephone number of Individual to Whom Notices and Correspondence Concerning This Statement Should Be Addressed:

Karen Smith
UnitedHealth Group
411 Theodore Fremd Ave.
Suite 206 South
Rye, NY 10580
Telephone: 763-361-8950
Email: karen_s_smith_@uhg.com

ITEM 1. IDENTITY OF PARTIES TO TRANSACTION

Furnish the following information for each of the parties to the transaction:

(a) Identity of parties to transaction.

(b) Home office address.

(c) Principal executive office address.

(d) The organizational structure, i.e. corporation, partnership, individual, trust, etc.

(e) A description of the nature of the parties' business operations.

(f) Relationship, if any, of other parties to the transaction to the insurer filing the notice.

(a) - (f) **UnitedHealthcare of Mississippi, Inc**. ("Registrant") whose home office and principal executive offices are located at 800 Woodlands Parkway, Suite 102, Ridgeland, MS 39157 is a Mississippi corporation licensed as a health maintenance organization. Registrant is a wholly owned direct subsidiary of UnitedHealthcare, Inc., which is a wholly owned direct subsidiary of United HealthCare Services, Inc., which is a wholly owned direct subsidiary of UnitedHealth Group Incorporated ("United"), the ultimate parent in the insurance holding company system.

UnitedHealth Group Incorporated ("United"), a Delaware corporation organized in January 1977, is the ultimate controlling person in the insurance holding company system. United is a publicly held company whose common stock is traded on the New York Stock Exchange. United has its registered and principal executive offices at UnitedHealth Group Center, 9900 Bren Road East, Minnetonka, Minnesota 55343.

Registrant is a wholly owned direct or indirect subsidiary of United, therefore affiliated within the same holding company system.

(g) Where the transaction is with a non-affiliate, the name(s) of the affiliate(s) which will receive, in whole or in substantial part, the proceeds of the transaction.

No non-affiliates are parties to the transactions contemplated by this Form D filing.

ITEM 2. DESCRIPTION OF THE TRANSACTION

Furnish the following information for each transaction for which notice is being given:

(a) Notice is being given under Miss. Code Ann. Section 83-6-21(2)(a) of the Act.

(b) The transaction is a First Amended and Restated Subordinated Revolving Credit Agreement between Registrant and United to provide a short-term borrowing facility for Registrant as describe in more detail under Item 3.

(c) We desire an effective date of November 1, 2018, however, we realize the effective date might have to be upon approval by the Commissioner of Insurance or 30 days after written notification has been provided to the Commissioner of Insurance, if the Commissioner does not disapproved of the transaction within such period. [Miss. Code Ann. § 83-6-21(2)]

ITEM 3. SALES, PURCHASES, EXCHANGES, LOANS, EXTENSIONS OF CREDIT, GUARANTEES OF INVESTMENTS

First Amendment to the Amended and Restated Subordinated Revolving Credit Agreement

The First Amendment to the Amended and Restated Subordinated Revolving Credit Agreement (the "First Amendment") is attached and is to be entered into effective November 1, 2018, by and between Registrant and United. The Amended and Restated Subordinated Revolving Credit Agreement (the "Agreement") was approved by the Mississippi Department of Insurance on October 5, 2012.

The First Amendment amends the Agreement in the following ways:

Exhibit A to the Agreement is hereby replaced in its entirety with the Exhibit A attached to this Amendment.

Pursuant to the Agreement and the First Amendment, United continues to provide a short-term borrowing facility for Registrant which shall be repaid within one year of the date on which the loan was initially made. Registrant will be able to borrow upon demand from United up to a maximum amount of $75,000,000 outstanding at any time. The interest methodology can be found in Section *4. Interest* and shall be payable at the applicable currency one month London InterBank Offered Rate ("LIBOR") plus 50 basis points in effect on last business day of the month prior to the month for which interest is being calculated and shall reset each month.

Under the Agreement and the First Amendment the advantages to Registrant remain the following: Registrant continues to have immediate access to liquidity without having to go through a bank loan application and approval process. Continues to protect the liquidity of Registrant and help cushion Registrant's investments from market fluctuation as it will allow Registrant to borrow for any unforeseen short-term cash needs without having to liquidate part of Registrant's portfolio at what may be a disadvantageous time.

The information in this filing is confidential, a trade secret, and competitively sensitive. Please hold it as confidential, protected from public disclosure in accordance with Mississippi Code Annotated Section 83-6-29 *Confidential treatment of information, document or copy* and the trade secret laws.

ITEM 4. LOANS OR EXTENSIONS OF CREDIT TO A NON-AFFILIATE

Not applicable

ITEM 5. REINSURANCE

Not applicable

ITEM 6. MANAGEMENT AGREEMENTS, SERVICE AGREEMENTS AND COST-SHARING ARRANGEMENTS

Not Applicable

EXHIBITS AND ATTACHMENTS:

Exhibit 1 - The First Amendment to the Amended and Restated Subordinated Revolving Credit Agreement

Exhibit 2 – Redline Exhibit A

ITEM 7. SIGNATURE AND CERTIFICATION

Pursuant to the requirements of Section 83-6-21 of the Act, UnitedHealthcare of Mississippi, Inc. has caused this notice to be duly signed on its behalf in the City of Minnetonka and State of Minnesota on the 26th day of September 2018.

UNITEDHEALTHCARE OF
MISSISSIPPI, INC.

THIS CORPORATION HAS
NO CORPORATE SEAL

By _____
N. Brent Cottington,
Vice President

Attest:

By _____
Heather A. Lang Jacobsen, Assistant Secretary

CERTIFICATION

The undersigned deposes and says that he has duly executed the attached notice for and on behalf of UnitedHealthcare of Mississippi, Inc., that he is a Vice President of such company and that he is authorized to execute and file such instrument. Deponent further says that he is familiar with such instrument and the contents thereof, and that the facts therein set forth are true to the best of his knowledge, information and belief.

By _____
N. Brent Cottington

EXHIBIT 1

The First Amendment to the Amended and Restated Subordinated Revolving Credit Agreement

FIRST AMENDMENT TO THE
AMENDED AND RESTATED SUBORDINATED REVOLVING CREDIT AGREEMENT

This First Amendment ("Amendment") to the Amended and Restated Subordinated Revolving Credit Agreement is entered into effective November 1, 2018 (the "Effective Date"), by and between UnitedHealth Group Incorporated, a Delaware corporation ("Lender"), and UnitedHealthcare of Mississippi, Inc., a Mississippi corporation ("Borrower"). Lender and Borrower may also be referred to in this Amendment as individually as "Party" and collectively as "the Parties."

PREMISES

A. Lender and Borrower are the Parties to that certain Amended and Restated Subordinated Revolving Credit Agreement effective October 1, 2012 (the "Agreement").

B. Lender and Borrower desire to amend the Agreement as set forth in this Amendment.

C. Capitalized terms used but not otherwise defined in this Amendment will have the meanings set forth in the Agreement.

NOW, THEREFORE, in consideration of the mutual promises set forth below, and for other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the Parties intending to be legally bound, hereby agree as follows:

1. Exhibit A to the Agreement is hereby replaced in its entirety with the Exhibit A attached to this Amendment.

2. Except as otherwise amended by this Amendment, all other terms and conditions set forth in the Agreement shall remain in full force and effect. In the event there is any inconsistency or conflict between the provisions of this Amendment and those of the Agreement, the provisions of this Amendment shall supersede and control.

3. This Amendment may be executed in one or more counterparts, including by facsimile signature, any one of which need not contain the signatures of more than one party, but all of which taken together shall constitute one and the same instrument.

[REMAINDER OF THIS PAGE INTENTIONALLY LEFT BLANK]

IN WITNESS WHEREOF, the parties have caused this Amendment to be executed by duly authorized officers as of the Effective Date.

UNITEDHEALTH GROUP INCORPORATED	UNITEDHEALTHCARE OF MISSISSIPPI, INC.
_____	_____
Name: Paul T. Runice Title: Assistant Treasurer	Name: Thomas S. McGlinch Title: Assistant Treasurer

EXHIBIT A

1. The aggregate principal amount that may be outstanding at any time shall not exceed $75,000,000.

EXHIBIT 2

REDLINE EXHIBIT A

EXHIBIT A

~~In the event of a conflict between this Addendum or any provision of this Agreement, the provisions of this Addendum shall control except as required by applicable law.~~

1. The aggregate principal amount that may be outstanding at any time shall not exceed ~~15,000,000.~~ $75,000,000.

MIKE CHANEY
Commissioner of Insurance
State Fire Marshal

MARK HAIRE
Deputy Commissioner of Insurance

MISSISSIPPI INSURANCE DEPARTMENT

501 N. WEST STREET, SUITE 1001
WOOLFOLK BUILDING
JACKSON, MISSISSIPPI 39201
www.mid.ms.gov

MAILING ADDRESS
Post Office Box 79
Jackson, MS 39205-0079
TELEPHONE: (601) 359-3569
FAX: (601) 576-2568

Delivered Via Email
Karen_s_smith_@uhg.com

October 15, 2018

Ms. Karen Smith
UnitedHealth Group
411 Theodore Fremd Avenue
Suite 206 South
Rye, NY 10580

Re: UnitedHealthcare of Mississippi, Inc. – NAIC #95716
Form D Request for Approval

Dear Ms. Smith:

This letter serves as the Mississippi Insurance Department's approval of the following transaction:

- First Amendment to the Amended and Restated Subordinated Revolving Credit Agreement between UnitedHealthcare of Mississippi, Inc. and UnitedHealth Group Incorporated

Should you have any questions, please feel free to contact us at 601-359-3569.

Sincerely,

MIKE CHANEY
COMMISSIONER OF INSURANCE

BY: Chad T. Bridges
Chad T. Bridges, CFE
Chief Examiner

MC/CB/LW

FIRST AMENDMENT TO THE
AMENDED AND RESTATED SUBORDINATED REVOLVING CREDIT AGREEMENT

This First Amendment ("Amendment") to the Amended and Restated Subordinated Revolving Credit Agreement is entered into effective November 1, 2018 (the "Effective Date"), by and between UnitedHealth Group Incorporated, a Delaware corporation ("Lender"), and UnitedHealthcare of Mississippi, Inc., a Mississippi corporation ("Borrower"). Lender and Borrower may also be referred to in this Amendment as individually as "Party" and collectively as "the Parties."

PREMISES

A. Lender and Borrower are the Parties to that certain Amended and Restated Subordinated Revolving Credit Agreement effective October 1, 2012 (the "Agreement").

B. Lender and Borrower desire to amend the Agreement as set forth in this Amendment.

C. Capitalized terms used but not otherwise defined in this Amendment will have the meanings set forth in the Agreement.

NOW, THEREFORE, in consideration of the mutual promises set forth below, and for other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the Parties intending to be legally bound, hereby agree as follows:

1. Exhibit A to the Agreement is hereby replaced in its entirety with the Exhibit A attached to this Amendment.

2. Except as otherwise amended by this Amendment, all other terms and conditions set forth in the Agreement shall remain in full force and effect. In the event there is any inconsistency or conflict between the provisions of this Amendment and those of the Agreement, the provisions of this Amendment shall supersede and control.

3. This Amendment may be executed in one or more counterparts, including by facsimile signature, any one of which need not contain the signatures of more than one party, but all of which taken together shall constitute one and the same instrument.

[REMAINDER OF THIS PAGE INTENTIONALLY LEFT BLANK]

IN WITNESS WHEREOF, the parties have caused this Amendment to be executed by duly authorized officers as of the Effective Date.

UNITEDHEALTH GROUP INCORPORATED

Name: Paul T. Runice
Title: Assistant Treasurer

UNITEDHEALTHCARE OF MISSISSIPPI, INC.

Name: Thomas S. McGlinch
Title: Assistant Treasurer

EXHIBIT A

1. The aggregate principal amount that may be outstanding at any time shall not exceed $75,000,000.

UnitedHealth Group

Effective Subordinated Credit Agreements (Domestic Regulated Entities)

19087563-Statutory Coordination-Qtr 4-2021-Reg Reporting STAT

To the Insurance Subsidiaries:

#	Ticker	BU	Legal Entity Name	State	Subordinated Credit Agreement	Effective Date	Approval Date
88	UHCMS	52400	UnitedHealthcare of Mississippi, Inc.	MS	75,000,000	11/1/2018	10/15/2018

Att. 4.3.2.6-5
Pro Forma Financial Template

Coordinated Care Procurement - 4.3.2.6 Pro Forma Finanical Template

Instructions

Balance Sheet
Please report each line item requested in the Balance Sheet on a Calendar Year Basis Enter the Plan name in B1. The plan name will flow through to the other reports. Risk-Based Capital (RBC) ratio is defined as the ratio of Total Adjusted Capital divided by Authorized Control Level RBC. RBC is calculated by applying risk factors to various assets, credits, premiums, reserves and off-balance sheet items, where the factor ishigher for those items with greater underlying risk and lower for those tiems with lower under lying risk.

Profit and Loss (P&L) Statement
Please report each line item requested in the P&L statement on a Calendar Year Basis

Cash Flow Statement
Please report each line item requested in the cash flow statement on a Calendar Year Basis

Medical Loss Ratio (MLR)
Medical Loss Ratio Rebate Calculation – MSCAN (Please report on a State Fiscal Year (SFY) basis (July 1 - June 30) **Purpose of the report:** Monitor the share of premium revenues the CCO spends on member services and quality improvement activities (MLR Rebate Calc.); calculate the MLR Pricing Percentage Calculation for each reporting period (MLR Rebate Calc.); calculate the total dollar amounts associated with the Adjusted HCQI and HIT Expenses by Reporting Categories for each reporting period (this is to track total HCQI and HIT expenditures in relation to medical expenses) [MLR Rebate Calc.]; and compare the financial impact of the Annual Medical Loss Ratio (MLR) Report to the Annual Mississippi Insurance Department Statement of Revenue and Expenses Financial Statement as filed by the CCOs (MLR Rebate Calc.).
Capitation Revenue and Tax Assessments
1. Total YTD Capitation Revenue. Sum of total capitation payments, Line 1
2. DO NOT USE THIS LINE
3. Less: Allocation for Premium Taxes
4. Less: Other taxes and other Revenue Based Assessments: Income taxes from earnings applicable to the respective Medicaid operations in the State of Mississippi (exclusive of investment activities) for the MLR reporting year. Any changes in estimates utilized should be adjusted to actual costs in subsequent MLR reporting periods. If there is a deferred tax asset generated for the year's operations, no amount should be reported for income taxes.
5. NET Current YTD Adjusted Premium Revenue (automatically calculated): Difference of Premium Tax Component of Reported Revenue and Total YTD Capitation Revenue
MLR Medical and Administrative Expenses
6a. Total Net Medical Expenses from Income Statement: Insert Total Net Medical Expenses from CCOs Income Statement
6b. DO NOT USE THIS LINE, Line 3
6c. DO NOT USE THIS LINE, Line 4
7. Incurred Claim Adjustment Additions. The additions total is the sum of incurred claim adjustment additions, as specified in Exhibit C of the MississippiCAN Contract.
8. Incurred Claim Adjustment Deductions. The additions total is the sum of incurred claim adjustment deductions, as specified in Exhibit C, of the MississippiCAN Contract
9. Incurred Claim Adjustment Exclusions. The additions total is the sum of incurred claim adjustment exclusions, as specified in Exhibit C, Of the MississippiCAN Contract
10. Adjusted Net Medical Expenses (automatically calculated): Sum of Total Net Medical Expenses from Income Statement and Incurred Claim Adjustment Additions minus Incurred Claim Adjustment Deductions minus Incurred Claim Adjustment Exclusions
HealthCare Quality Improvement (HCQI) and HealthCare Information Technology (HIT) Meaningful Use Expenses
11. HCQI and HIT Administrative Expenses from Income Statement: Insert HCQI and HIT administrative expenses from Income Statement

12. Adjustments or Exclusions to HCQI/HIT Meaningful Use Expenses: Enter detailed information in Supplemental Adjustments tab in Category 4 section. This line is the sum of adjustments or exclusions, as specified in Exhibit C of the MississippiCAN Contract
13. Adjusted HCQI/HIT Expenses: Sum of HCQI and HIT Administrative Expenses from Income Statement and Adjustments or Exclusions to HCQI/HIT Meaningful Use Expenses

14. Other Non-Claims Costs: For reporting purposes only, this is not included in the numerator
15. Program Integrity Costs: Enter detailed information in the Program Integrity Cost tab.
16. Total Adjusted Current YTD MLR Expenditures (automatically calculated): Sum of Adjusted Net Medical Expenses and Adjusted HCQI/HIT Expenses
17. Reporting MLR Percentage (automatically calculated): Total Adjusted MLR Expenses divided by Total Adjusted Current YTD MLR Expenditures
18. MLR Percentage Requirement for Rebate Calculation (automatically calculated): 87.5% as consistent with the Exhibit C of the MississippiCAN Contract

19. Percentage Below 87.5% Requirement (automatically calculated): The difference between MLR Percentage Requirement for Rebate Calculation and MLR Percentage Achieved

20. Dollar Amount of Rebate Requirement (automatically calculated): Percentage Below 87.5% Requirement multiplied by Total Adjusted Current YTD MLR Expenditures

Credibility Adjustment Applied

In alignment with MLR requirements, as defined in 42 CFR 438.8(b), the credibility adjustment is used to account for random statistical variation related to the number of enrollees in a managed care plan. The credibility adjustment categorizes managed care plans into three groups:

- Fully-credible. Managed care plans in this group, it is highly likely that the difference between the actual and target MLR is statistically significant and not due to random variation.
- Partially-credible. Managed care plans in this group, it is somewhat likely that the difference between the actual and target MLR is statistically significant but such difference could, at least in part, be due to random variation.
- Non-credible. Managed care plans with insufficient claims experience, measured in terms of member months, to calculate a reliable MLR.

The template will automatically calculate the MLR credibility adjustment required based upon the table in the template provided by CMS.

21. MLR Member Months: Enter the sum of beneficiary count for the year to date period for each reporting period.
22. MLR Member Months (Annualized)
23. Credibility Adjustment
24. Adjustment Reporting MLR Percentage
25. MLR Percentage Requirement for Rebate Calculation
26. Percentage below 87.5% Requirement
27. Dollar Amount of Rebate Required

Denials
Enter the expected denial percentage rates for each of the three (3) categories requested for each state fiscal year. The rates should be based on your projection but taking into account what you have done historically in other markets with denials. Please include any additional information to help the rates.

Assumptions
Provide any additional detail here for assumptions used in the pro forma of the financials.

Company Name: **UHC of Mississippi Inc.**

Pro Forma Statutory Balance Sheet

(In Thousands)

	2022	2023	2024
Admitted Assets			
1. Bonds	148,212	117,496	116,167
2. Stock			
3. Real Estate/Mortgage Investments			
4. Affiliated Investments			
5. Affiliated Receivables			
6. Cash/Cash Equivalents	128,808	57,034	61,853
7. Aggregate write in for assets			
8. All Other Assets	24,099	19,330	19,629
9. Total Assets(1+2+3+4+5+6+7+8)	**$ 301,120**	**$ 193,860**	**$ 197,648**
Liabilities			
10. Losses (Unpaid Claims for Accident and Health Policies)	75,014	57,998	60,068
11. Unpaid claims adjustment expenses	494	528	543
12. Reserve for Accident and Health Policies	1,795	1,388	1,438
13. Ceded Reinsurance Payable			
14. Payable to Parents, Subsidiaries & Affiliates	1,248	965	1,000
15. MLR rebates	82,882		
16. Premiums received in advanced	91	73	76
17. All other Liabilites	13,364	10,830	11,211
18. Total Liabilities (10+11+12+13+14+15+16+17)	**$ 174,888**	**$ 71,782**	**$ 74,335**
Capital and Surplus			
19. Capital Stock			
20. Gross Paid In and Contributed Surplus	119,827	119,827	119,827
21. Surplus Notes			
22. Unassigned Surplus	6,404	2,251	3,486
23. Other Items(elaborate)			
24. Total Capital and Surplus(19+20+21+22+23)	**$ 126,232**	**$ 122,078**	**$ 123,313**
25. Authorized Control Level Risk-Based Capital	38,052	29,743	30,805
26. Calculated Risk-Based Capital (24/25)	**332%**	**410%**	**400%**

Company Name: **UHC of Mississippi Inc.**

Pro Forma Statutory Profit & Loss Statement

(In Thousands, except Member Months, in Whole numbers)

	2024	2025	2026
1. Member months	2,371,777	2,373,173	2,374,753
Revenue:			
2. Net Premium Income	871,310	901,840	933,502
3. Fee for Service			
4. Risk Revenue			
5. Change in unearned premium reserves			
6. Aggregate write in for other health related revenue			
7. Aggregate write in for other non-health related revenue			
8. Total (L2+L3+L4+L5+L6+L7)	**$ 871,310**	**$ 901,840**	**$ 933,502**
Hospital and Medical Expense:			
9. Hospital/Medical Benenfits	695,284	720,173	745,992
10. Other professional Services	62,692	64,936	67,264
11. Prescription Drugs			
12. Aggregate write ins for other hospital/medical			
13. Subtotal (L9+L10+L11+L12)	**$ 757,976**	**$ 785,109**	**$ 813,255**
Less:			
14. Reinsurance recoveries			
15. Total hospital and Medical (L13 -L14)	**$ 757,976**	**$ 785,109**	**$ 813,255**
16. Non health claims			
17. Claims adjustment expenses	35,730	36,727	37,761
18. General admin expenses	66,356	68,208	70,127
19. Increase in reserves for accident and health contacts			
20. Total underwriting deductions (L15+L16+L17+L18+L19)	**$ 860,062**	**$ 890,044**	**$ 921,143**
21. Net underwriting gain or loss (L8 -L20)	**$ 11,248**	**$ 11,795**	**$ 12,359**
22. Net investment income earned	2,974	3,073	3,183
23. Aggregate write in for other income or expenses			
24. Federal Income Taxes	2,987	3,122	3,264
25. Net Realized Capital Gains (Losses)			
26. Less Capital Gains Tax			
27. Net Income (L21+L22+L23-L24+L25)	**$ 11,236**	**$ 11,746**	**$ 12,278**
28. Prior YE Surplus	122,078	123,313	130,060
29. Net Income	**$ 11,236**	**$ 11,746**	**$ 12,278**
30. Capital Increases			
31. Other Increases (Decreases)			
32. Dividends to Stockholders	10,000	5,000	5,000
33. YE Surplus (L28+L29+L30+L31-L32)	**$ 123,313**	**$ 130,060**	**$ 137,338**

***Itemize in Assumptions**

Company Name: **UHC of Mississippi Inc.**

Preliminary MLR Statement

(In Thousands)

Medical Loss Ratio (MLR) Rebate Calcuation (MSCAN)				
State Fiscal Year-to-Date Through:		2024	2025	2026
	Capitation Revenue and Tax Assessments			
1	**Total YTD Capitation Revenue**	856,611	886,575	917,671
	Tax Components of Reported Revenue			
2				
3	Less: Allocation for premium taxes	25,698	26,597	27,530
4	Less: Other taxes and other revenue-based assessments	3,173	3,334	3,501
5	**NET Current YTD Adjusted Premium Revenue**	**$ 827,740**	**$ 856,643**	**$ 886,639**
	MLR Medical and Administrative Expenses			
6a	Net Medical Expenses from Income Statement	744,914	771,542	799,182
6b				
6c				
6	**Total Net Medical Expenses**	**$ 744,914**	**$ 771,542**	**$ 799,182**
	MLR Expense Adjustments as defined in Exhibit C			
7	Incurred claims adjustment additions			
8	Incurred claims adjustment deductions	834	864	895
9	Incurred claims adjustment exclusions			
10	**Adjusted Net Medical Expenses**	**$ 744,080**	**$ 770,679**	**$ 798,288**
	Health Care Quality Improvement (HCQI) and Health Care Information Technology (HIT) Meaningful Use Expenses			
11	HCQI and HIT Administrative Expenses from Income Statement	15,300	15,712	16,137
12	Adjustments or exclusions to HCQI/HIT meaningful use expenses	2,608	2,678	2,751
13	**Adjusted HCQI/HIT Expenses**	**$ 12,692**	**$ 13,034**	**$ 13,387**
14	**Other Non-Claims Costs (FOR REPORTING PURPOSES ONLY. NOT INCLUDED IN NUMERATOR.)**	56,322	57,836	59,403
15	**Program Integrity Costs (FOR REPORTING PURPOSES ONLY. NOT INCLUDED IN NUMERATOR.)**	5,022	5,157	5,297
16	**Total Adjusted Current YTD MLR Medical Expenditures**	**$ 756,772**	**$ 783,712**	**$ 811,674**
17	**Reporting MLR Percentage**	**91.4%**	**91.5%**	**91.5%**
18	**MLR percentage requirement for rebate calculation**	**87.5%**	**87.5%**	**87.5%**
19	**Percentage below 87.5% Requirement**	**0.0%**	**0.0%**	**0.0%**
20	**Dollar Amount of Rebate Requirement**	**$ -**	**$ -**	**$ -**
	Credibility Adjustment Applied			
21	MLR Member Months	2,371,777	2,373,173	2,374,753
22	**MLR Member Months (Annualized)**	9,487,109	4,746,347	2,374,753
23	**Credibility Adjustment**	**0.0%**	**0.0%**	**0.0%**
24	**Adjusted Reporting MLR Percentage**	**91.4%**	**91.5%**	**91.5%**
25	**MLR Percentage Requirement for Rebate Calculation**	**87.5%**	**87.5%**	**87.5%**
26	**Percentage below 87.5% Requirement**	**0.0%**	**0.0%**	**0.0%**
27	**Dollar Amount of Rebate Required**	**$ -**	**$ -**	**$ -**

Company Name: **UHC of Mississippi Inc.**

Pro Forma Statutory Cash Flow Statement

(In Thousands)

	2024	2025	2026
Cash From Operations			
1. Premiums Collected Net of Reinsurance	870,922	901,437	933,084
2. Benefits Paid	755,847	782,898	810,962
3. Underwriting Expenses Paid	101,955	104,799	107,744
4. Total Cash From Underwriting (L1-L2-L3)	**$ 13,120**	**$ 13,739**	**$ 14,378**
5. Net Investment Income	2,981	3,054	3,161
6. Other Income			
7. Dividends to Policyholders			
8. Federal and Foreign Income Taxes (Paid) Recovered	(2,970)	(3,120)	(3,262)
9. Net Cash From Operations (L4+L5+L6-L7+L8)	**$ 13,130**	**$ 13,673**	**$ 14,278**
Cash From Investments			
10. Net Cash from Investments	1,329	(3,880)	(4,282)
Cash From Financing and Misc Sources			
11. Capital and paid in Surplus			
12. Surplus Notes			
13. Borrowed Funds			
14. Dividends	10,000	5,000	5,000
15. Other Cash Provided (Applied)	359	50	36
16. Net Cash from Financing and Misc Sources			
(L11+L12+L13-L14+L15)	**$ (9,641)**	**$ (4,950)**	**$ (4,964)**
17. Net Change in Cash, Cash Equivalents and Short -Term	**$ 4,819**	**$ 4,843**	**$ 5,032**

UHC of Mississippi Inc.
Statement of Assumptions

List below all of the relevant assumptions used to create the proforma statements.
Overall comment : Our 2021 Statutory Basis Balance Sheet, P&L, and Cash Flow are used as the base for our forecast. Note that by the time of this RFQ submission, our 2021 Statutory Financials were not finalized and audited. UHC of Mississippi Inc., as a legal entity, does offer comprehensive commercial products to employer groups, but the commercial products make up a very small percentage of the total business. As such, for this appendix, the forecasted information is specific to our Medicaid line of business. We believe the forecasted information appropriately represents the financial positions and operations of UHC of Mississippi Incs. in the required future years, based on the best information we had at the time this appendix was prepared.
P/L - Member months - forecasted, assuming that 3 MCOs are awarded, with the majority of the members choosing to continue with their incumbent contractor as allowed in the RFQ.
P/L - Revenue - forecasted, using SFY2022 rates provided within the State's documentation and trended forward annually by 3.5%.
P/L - Hospital and Medical Expenses - forecasted, using the service costs in the SFY2022 rates and trended forward annually by 3.5%.
P/L - Adminstrative Expenses (Claim adjustment expenses + General admin expenses) - forecasted, using our cost build up for all the different functions needed to appropriately serve our members and meet the contract requirements. Administrative Expenses include costs related to SDoH.
P/L - Net investment income earned - forecasted as a percentage of our investment balance. Our calendar year 2021 net investment income earned and 2021 investment balance were used to calculate the percentage.
P/L - Federal Income Taxes is calculated at statutory federal tax rate of 21% over Net Income.
P/L - Dividends to Stockholders - forecasted by our Treasury, based on the entity's total assets and liabilities, taken in considerations the entity's BCR and the unassigned surplus amount.
Balance Sheet line items forecasted as a percentage of Revenue: Premiums received in advance. Our calendar year 2021 revenue and the 2021 premiums received in advance line item were used to calculate the percentage.
Balance Sheet line items forecasted as a percentage of Hospital and Medical Expenses: Losses (Unpaid Claims for Accident and Health Policies) and Reserve for Accident and Health Policies. Our calendar year 2021 hospital and medical expenses and the correspondent 2021 balance sheet line items were used to calculate the percentage.
Balance Sheet line items forecasted as a percentage of Administrative Expenses: Unpaid claims adjustment expenses and Payable to Parents, Subsidiaries & Affiliates. Our calendar year 2021 administrative expenses and the correspondent 2021 balance sheet line items were used to calculate the percentage.
Balance Sheet line items not forecasted based on the P&L: MLR rebates; Bonds; All Other Assets; All other Liabilities; and Cash/Cash Equivalents. - MLR rebates forecasted, using our estimated payback to the State (both MLR and Risk Corridor) as well as estimated timing of payments based on State's historical recoupment schedule. - Bonds forecasted, using historical investment trends, adjusted for any significant payout on the liability side. Investments would be liquidated if needed to ensure the whole entity is at the appropriate RBC level. - All Other Assets and All Other Liabilities - forecasted, using the 2021 balances for these line items as a percentage of total assets or liabilities, respectively. - Cash/Cash Equivalents is the by-products of the P/L as well as the change in BS for the respective line itme.
MLR - Incurred claims adjustment deductions - forecasted using the balances included within SFY2020 final MLR filings as well SFY 2021 preliminary MLR filings, as a percentage of Net Medical Expenses. The deductions are primarily related to Rx rebates and provider bonus/ incentives.
MLR - HCQI and HIT Administrative Expenses and Adjustment or exclusions to HCQI/ HIT meaningful use expenses - forecasted using the balances included within SFY2020 final MLR filings as well SFY 2021 preliminary MLR filings, as a percentage of total admin costs. The exclusions to HCQI/ HIT meaningful use expenses are primarily related to the related-party margin, indirect, and overhead expenses.
MLR - Other Non-Claims Costs and Program Integrity Costs - forecasted using the balances included within SFY2020 final MLR filings as well SFY 2021 preliminary MLR filings, as a percentage of total admin costs.

Company Name: **UHC of Mississippi Inc.**

Denials

Claims Denial Report					
The Mississippi Division of Medicaid provides a template to report on denials requiring to be completed by each contracted managed care organization. The template includes a detail of information including In Network, Out of Network, Prior Authorizations, Claims Completions errors, etc. A detailed explanation is required if the percentages exceed a certain amount.					
Assumption: Based on your expectation or history of denials review, what do you project your denials rate would be for services covered under this contract?					
			2022	2023	2024
% Total Claims Entirely Accepted			86%	86%	86%
% Total Claims Entirely Denied			8%	8%	8%
% Total Claims Partially Accepted and Denied			6%	6%	6%
Please provide any additional information to support your projection and expectation of denied claims.					

We looked at our calendar year 2019, 2020, and 2021 percentages of total claims entirely accepted, entirely denied, or partially accepted and denied. Our percentages of total claims entirely denied or partially accepted and denied stayed quite consistent from 2019 to 2021 with a slight decrease over the years. Similarly, our percetages of total claims entirely accepted also stayed consistent from 2019 to 2021 with a slight improvement over the years. As such, our estimated percentages for 2022, 2023, and 2024 is consistent with 2021 percentages. Although UHC does not have complete control over how providers submit claims, but we are committed to continue to work with our provider partners to improve these percentages.

4.3.3 Organization and Staffing

4.3.3.1 Organization (Marked)

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 ...

UnitedHealthcare of Mississippi, Inc. has been providing Medicaid services in Mississippi since we were first awarded the Division’s CHIP contract in 2010, followed by the MississippiCAN contract in 2011. Today, we are responsible for the well-being of over 162,000 MississippiCAN and 28,000 CHIP members. We have been NCQA accredited since 2013. Currently, we are the only coordinated care organization (CCO) in the state bearing the NCQA Multicultural Health Care Distinction.

Our 214 Mississippi-based employees will remain fully engaged upon contract implementation. We commit to continuing to recruit locally based talent with direct experience supporting our members in an effort to build trust in the local health care system that addresses individual member needs and empowers our members to advocate for the culturally responsive care they need. Every employee completes cultural diversity awareness training, furthering our goal to provide culturally competent care and services that recognize members’ beliefs and customs.

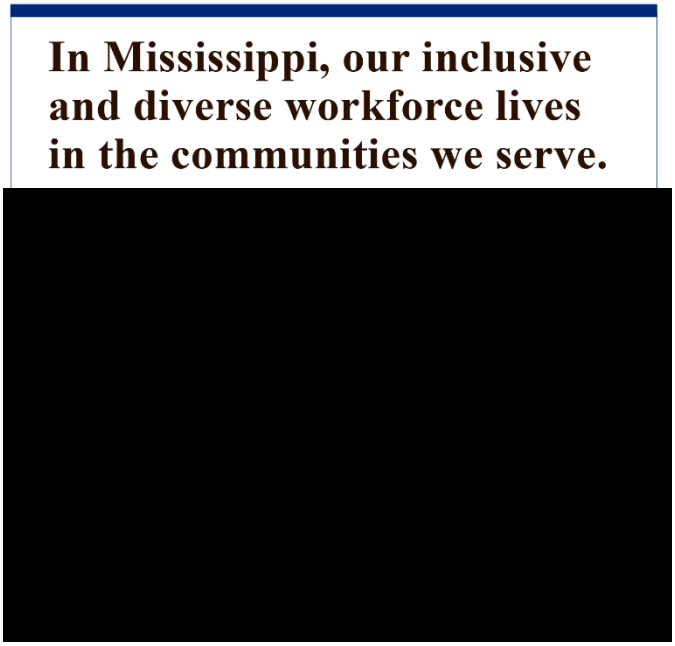


Figure 1. Our inclusive and diverse Mississippi workforce.

Our local staff is led by an established leadership team with expertise in the management of large health care delivery systems, including integrated physical and behavioral care management, population health management, service quality improvement and payer operations. Led by our chief executive officer, a native Mississippian, the executive team provides effective program oversight and monitors contract compliance.

In preparing to renew our contracts, we will continue using our local executive, administrative and clinical staff to facilitate management consistency and operational continuity from implementation through operationalization. Our chief operating officer will oversee — in concert with health plan leadership and designated operational and administrative leads — implementation of the contract requirements and sign off on all deliverables and major activities during the implementation and operationalization phases.

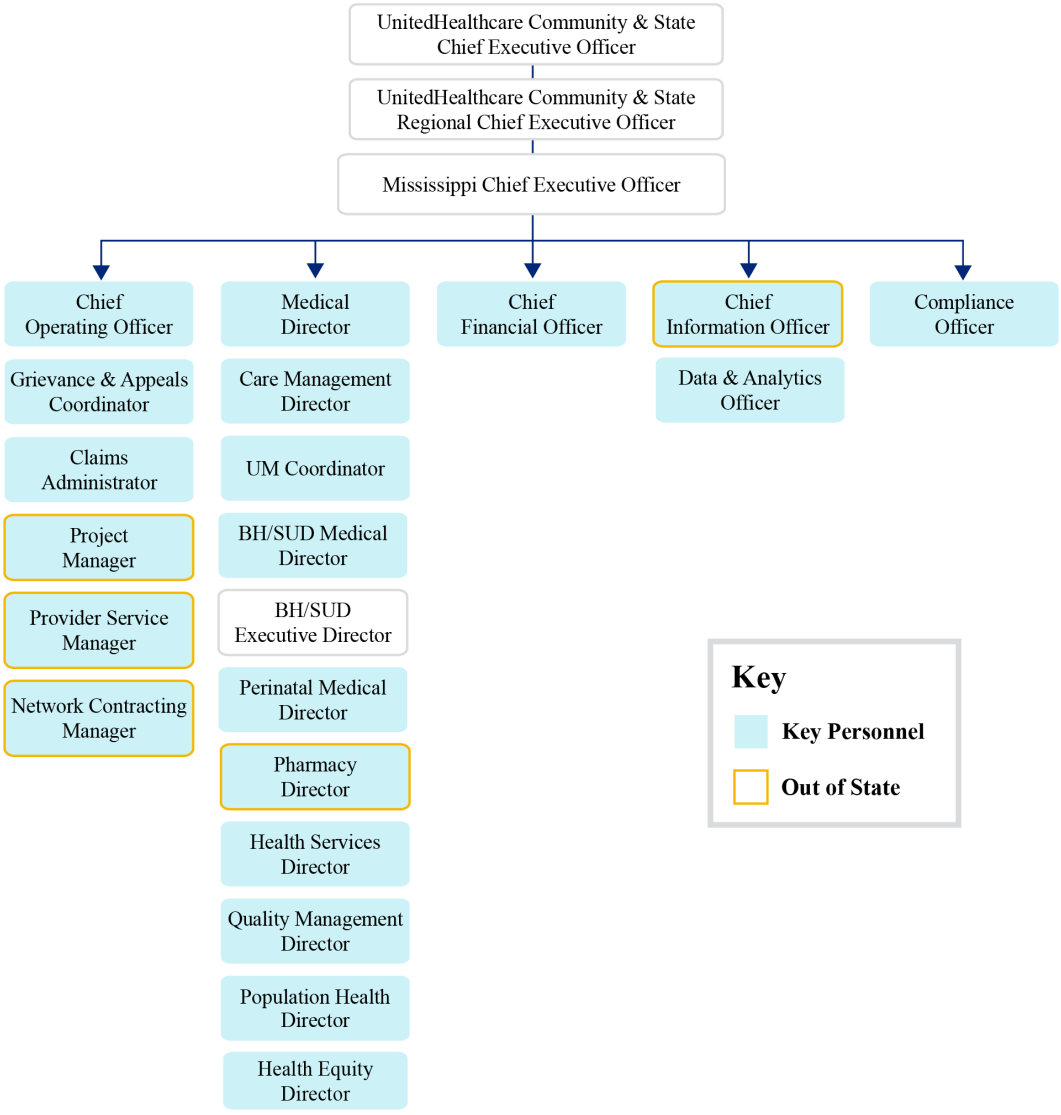
In addition, the chief operating officer has the national resources and experience of UnitedHealth Group, our parent company, at their disposal, affording us access to the efficiencies and economies of scale achieved through the centralization of certain administrative functions (e.g., IT, claims and encounters, finance and human resources support), and the expertise, innovations and best practices of health plans across the country. This allows us to minimize our administrative expenses and thereby maximize funds available for member and provider-facing activities.

Our participation in MississippiCAN and CHIP has allowed our staff to build long-standing, collaborative relationships with private, state and community-based organizations, affording members and providers the benefit of these organizations’ established community presence, efficiencies and expertise. We work with these

Nurturing Local Partnerships

organizations and invest our time and money. Our staff logged over 6,400 volunteer hours toward various Mississippi causes in 2020, and we have recently contributed $550,000 toward a Mississippi Public Health Institute initiative aimed at improving maternal health outcomes and related maternal and infant disparities.

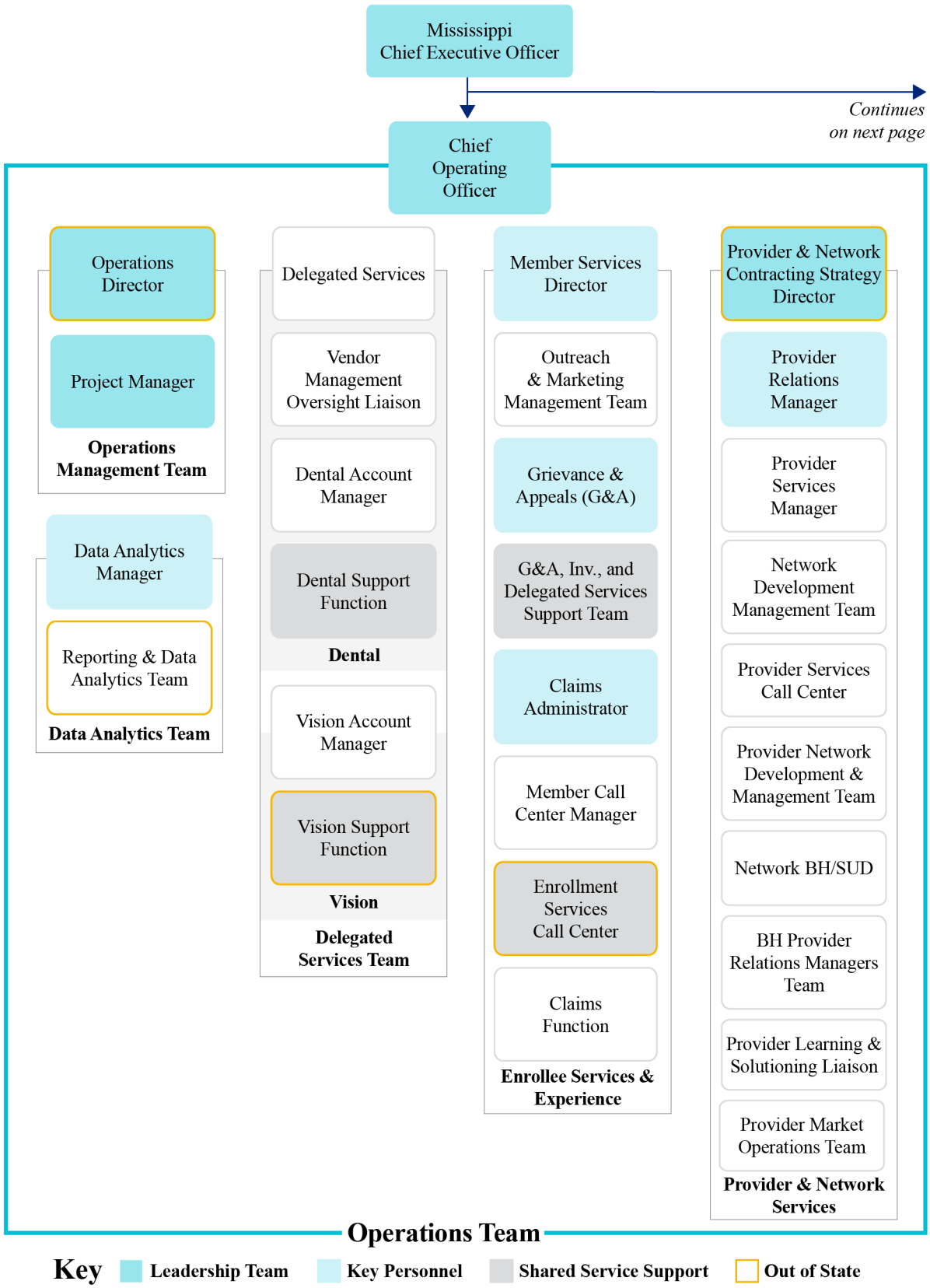
Our Mississippi leadership team is represented in the following organization chart:

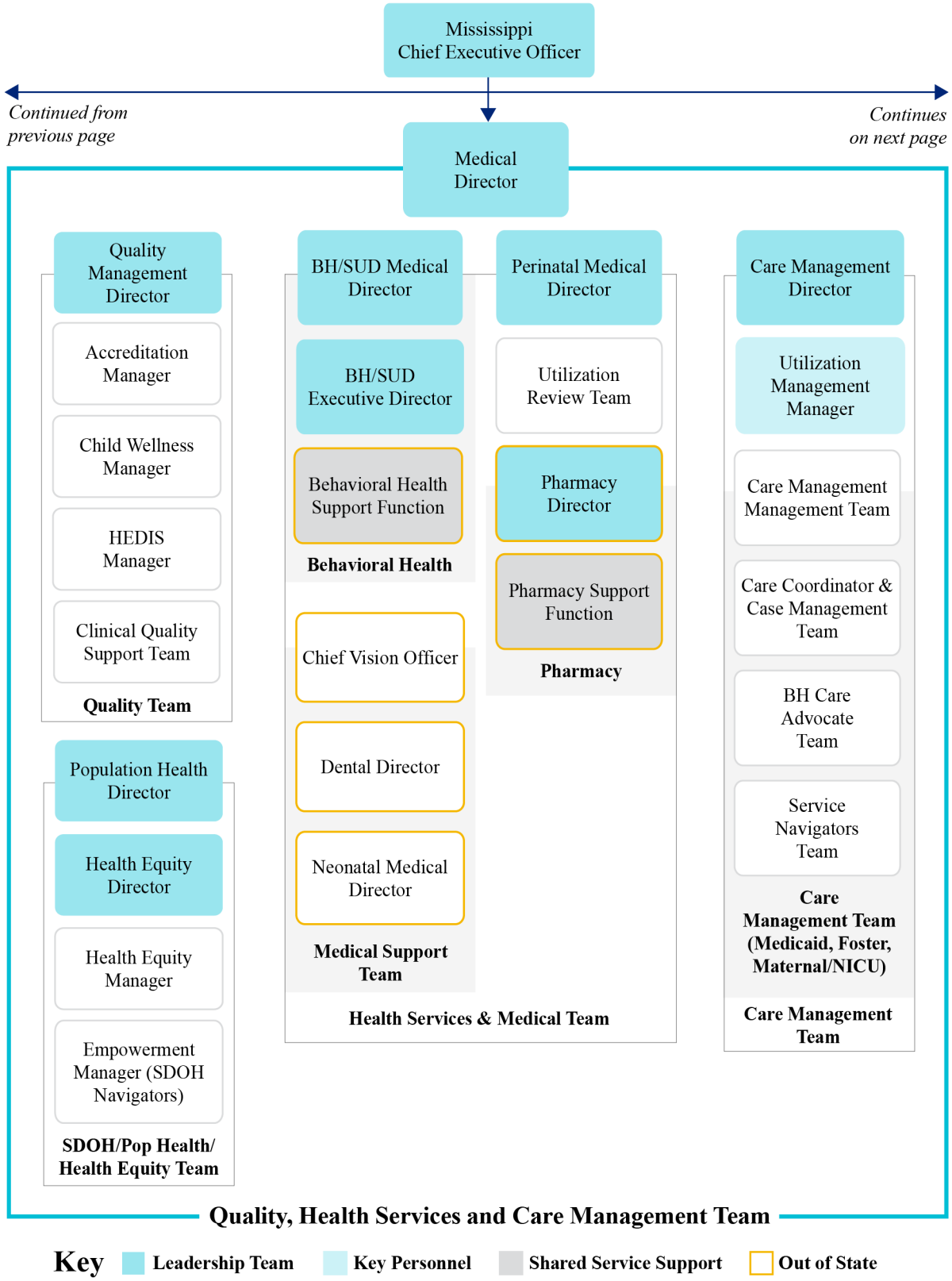


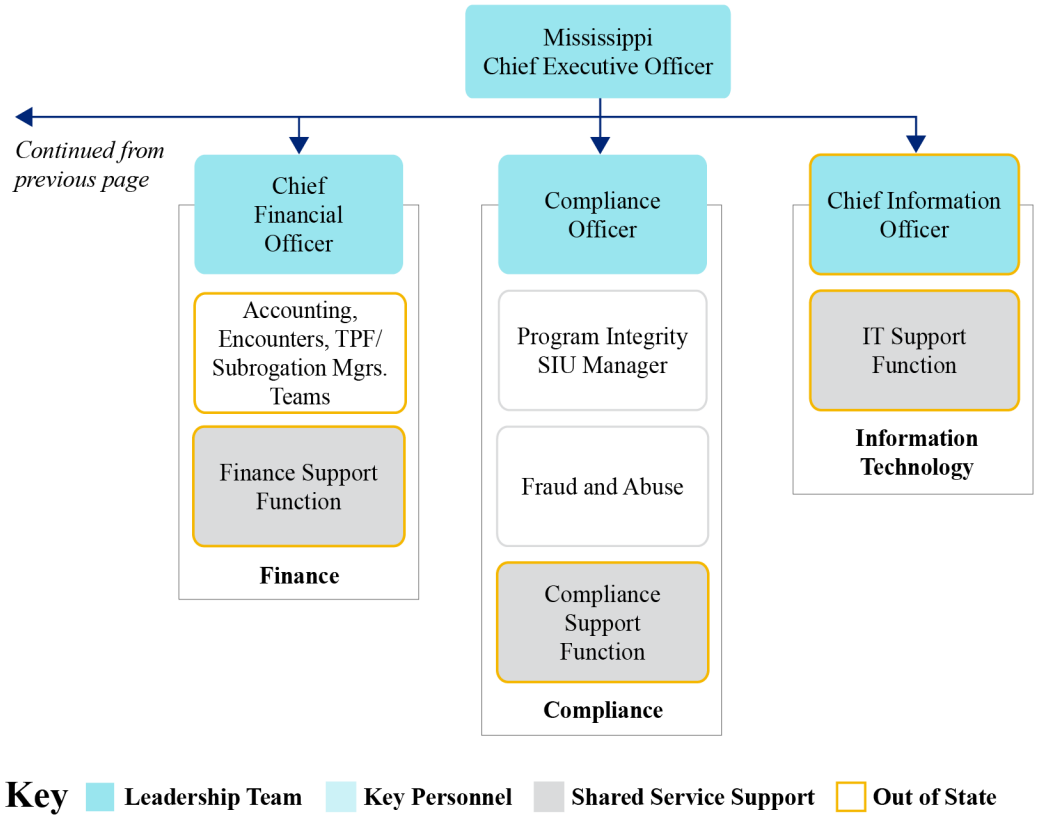
The following table provides the number of FTEs associated with each position for Key Staff as described in the Model Contract, Section 1.3.1.

Key Positions			
Executive Positions	**FTEs**	**Administrative Positions**	**FTEs**
Chief Executive Officer	1	Provider Services Manager	1
Chief Operating Officer	1	Network/Contracting Manager	1
Chief Financial Officer	1	Member Services Director	1
Medical Director	1	Quality Management Director	1
Perinatal Medical Director	1	Care Management Director	1
BH/SUD Medical Director	1	Population Health Director	1
Chief Information Officer	1	Utilization Management Coordinator	1
Compliance Officer	1	Grievance and Appeals Coordinator	1
Project Manager	1	Claims Administrator	1
		Data and Analytics Manager	1
		Clinical Pharmacist	1

The organizational charts on the following pages depict our organizational structure for the implementation and operationalization phases of MississippiCAN and CHIP. The charts indicate if staff are wholly dedicated to the associated contract or shared. All staff are full time.


Mississippi Chief Executive Officer
Continues on next page
Chief Operating Officer
Operations Director
Project Manager
Operations Management Team
Data Analytics Manager
Reporting & Data Analytics Team
Data Analytics Team
Delegated Services
Vendor Management Oversight Liaison
Dental Account Manager
Dental Support Function
Dental
Vision Account Manager
Vision Support Function
Vision
Delegated Services Team
Member Services Director
Outreach & Marketing Management Team
Grievance & Appeals (G&A)
G&A, Inv., and Delegated Services Support Team
Claims Administrator
Member Call Center Manager
Enrollment Services Call Center
Claims Function
Enrollee Services & Experience
Provider & Network Contracting Strategy Director
Provider Relations Manager
Provider Services Manager
Network Development Management Team
Provider Services Call Center
Provider Network Development & Management Team
Network BH/SUD
BH Provider Relations Managers Team
Provider Learning & Solutioning Liaison
Provider Market Operations Team
Provider & Network Services
Operations Team
Key
Leadership Team
Key Personnel
Shared Service Support
Out of State


Mississippi Chief Executive Officer
Continued from previous page
Continues on next page
Medical Director
Quality Management Director
Accreditation Manager
Child Wellness Manager
HEDIS Manager
Clinical Quality Support Team
Quality Team
Population Health Director
Health Equity Director
Health Equity Manager
Empowerment Manager (SDOH Navigators)
SDOH/Pop Health/ Health Equity Team
BH/SUD Medical Director
BH/SUD Executive Director
Behavioral Health Support Function
Behavioral Health
Chief Vision Officer
Dental Director
Neonatal Medical Director
Medical Support Team
Perinatal Medical Director
Utilization Review Team
Pharmacy Director
Pharmacy Support Function
Pharmacy
Health Services & Medical Team
Care Management Director
Utilization Management Manager
Care Management Management Team
Care Coordinator & Case Management Team
BH Care Advocate Team
Service Navigators Team
Care Management Team (Medicaid, Foster, Maternal/NICU)
Care Management Team
Quality, Health Services and Care Management Team
Key
Leadership Team
Key Personnel
Shared Service Support
Out of State



[END OF RESPONSE]

4.3.3.2 Job Descriptions and Responsibilities of Key Positions (Marked)

The Offeror must submit detailed job descriptions for each position included in Section 1.13, Administration Management, ...

The Offeror must use the appropriate form provided in Appendix H to respond to this request. The Offeror may not submit resumes ...

We provide job descriptions and responsibilities of the key executive, administrative and other positions in the following pages.

Since our inception in 2010, UnitedHealthcare has grown from covering 65,000 lives as the state's only CCO for CHIP, to now covering nearly 200,000 lives under the Division of Medicaid's MississippiCAN program and CHIP.

We attribute that success to the combined efforts of the Division and our local MississippiCAN and CHIP staff (in conjunction with our corporate resources) toward advancing health care, improving health equity and promoting economic security throughout the state. In doing so, our leadership and staff have developed long-standing relationships with our members, providers, local community leaders, in-state professional organizations and various state partners.

Our 20 key leaders (as identified in Appendix A of the Model Contract) have an average of 18 years' health care experience, including an average of 10 years serving the Division's Mississippi Medicaid programs. Some have elected to remain in the same functional area, due to their deep satisfaction with their role, while others have pursued and assumed new responsibilities in alignment with their professional growth objectives and commitment to meeting the evolving needs of our members, providers and the Division.

[END OF RESPONSE]

Key Position: Job Description

Title of Position: Chief Executive Officer (CEO)

Description of Position: Chief executive officer (CEO) is a senior executive leadership position, where the incumbent has demonstrated experience in strategic planning, organizational design, people management, and operational and technical skills. This person is accountable for the Medicaid health plan in Mississippi. They direct the strategic development, growth and operations of the health plan in providing innovative care to the populations in MississippiCAN and CHIP. The overall goal of this position is to provide executive oversight and leadership for UnitedHealthcare so the needs of the members are met and contractual compliance is achieved.

Description of Responsibilities of Position:

- Shapes and implements continuous improvement in UnitedHealthcare operational quality, efficiency and financial performance
- Key contact and liaison to the Division of Medicaid's leadership regarding the contract and other matters relating to MississippiCAN and CHIP
- Builds, maintains and manages relationships with internal and external stakeholders
- Drives industry-leading customer service and satisfaction, creating an environment that promotes consumer advocacy and delivers value beyond our consumers' expectations
- Validates applicable processes, tools, procedures and systems platforms to adhere to applicable legal, regulatory and contractual requirements
- Develops, translates and executes strategies or functional/operational objectives for UnitedHealthcare
- Provides leadership to and is accountable for the performance and results through senior level professional staff; influences goals and results through matrix relationships
- Oversees the development of policies and procedures for operational processes; verifies optimization and compliance with established standards and regulations
- Reviews medical expense drivers and creates plans to reduce waste and increase the affordability of our programs
- Provides for the appropriate coordination and delivery of covered services with the medical directors and service coordination team
- Represents UnitedHealthcare at external events and organizations; interacts with community and state leaders
- Creates and sustains a culture of employee engagement where commitment to our members and providers is paramount

Minimum Experience Required:

- 7+ years of successful leadership experience in leading and managing people
- 7+ years of P&L and/or extensive budgeting experience and strategic planning and development

Skills Required:

- Expert level of proficiency working in a fast-paced, matrix organization/environment with an enterprise focus
- Prior leadership experience in program execution

Are there any educational requirements for this position?
[X] Yes [ ] No

If yes, list below:

- Bachelor's degree or equivalent combination of education and experience
- Master's degree in business administration 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?
[X] Yes [ ] No

If yes, list below:

- Annual Compliance Training, including topics of Fraud, Waste and Abuse and Code of Conduct
- Safe and Secure with Me – Privacy and Security Annual Training
- Cultural Competency
- MississippiCAN and CHIP contract changes, when applicable
- Organizational Conflicts of Interest
- Doing Business with U.S. Governments Overview
- Special Needs Plan Model of Care Training
- SMART Goals
- Contract requirements and updates, when needed
- Specific functional training updates, when needed

Any additional information relevant to this position:

- N/A

Key Position: Job Description

Title of Position: Chief Operating Officer (COO)

Description of Position: The health plan chief operating officer (COO) is the primary point of contact for all UnitedHealthcare operational issues and is responsible for management and administration of multiple functions and general business operations, health services and the medical management team. The COO will oversee the day-to-day business activities of the MississippiCAN and CHIP contracts. They will formulate business strategies and operational plans for the optimal performance of MississippiCAN and CHIP in meeting the needs of our members, providers, the contract, regulatory requirements, growth and operating income objectives.

Description of Responsibilities of Position:

- Assigned to the day-to-day management of all operations and ensures that performance measures from the Division and CMS requirements are met
- Serves as the primary liaison with the Division for all operational issues
- Oversees all health plan critical operations to meet performance requirements
- Provides subject matter expertise in project management, project scope definition, risk identification, project methodology, resource allocation and other areas of expertise
- Responsible for the design, coordination and completion of operational improvement projects across various functional areas within UnitedHealthcare
- Develops collaborative relationships with and confirms business partners can execute day-to-day responsibility for key operations (i.e., call centers, enrollment, claims, grievances and appeals)
- Informs and advises management regarding the state's current trends, problems and activities to facilitate strategic plans to improve operational performance and enhance growth
- Confirms all operational activities conform to contract compliance for all programs
- Understands and manages the Division's requirements and relationships related to operations
- Co-leads business executive team with primary responsibility to build the organizational support and infrastructure to translate business vision and strategy into operational tactics
- Works with the compliance officer to provide interpretation and education to UnitedHealthcare on contract, rules and regulations
- Facilitates and assists the business in addressing and accommodating new legislation. Provides consultative expertise/guidance and promotes compliance with laws and regulations with business partners ensuring effective response to changing laws
- Identifies issues for resolution and works closely with compliance functional areas and cross-functional/cross-segment departments necessary to resolve issues

Minimum Experience Required:

- A minimum of 10 years' related managed care experience is required, with a minimum of 5 years' people management experience required
- Proven ability to execute to short- and long-term growth and profitability targets
- 8+ years of people management experience
- 3+ years of experience in strategic planning and development

Skills Required:

- Ability to communicate clearly with internal partners and external regulatory agencies and effectively represent UnitedHealthcare's interests
- Technical and financial understanding of health care operations
- Strong leadership and business planning skills within a matrix environment
- Adept at organizational design: ability to resolve matrix barriers and build relationships across the matrix

Are there any educational requirements for this position?
[X] Yes [ ] No

If yes, list below:

- Bachelor's or master's degree in business administration

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?
[X] Yes [ ] No

If yes, list below:

- Annual Compliance Training, including topics of Fraud, Waste and Abuse and Code of Conduct
- Safe and Secure with Me – Privacy and Security Annual Training
- Cultural Competency
- MississippiCAN and CHIP contract changes, when applicable
- Organizational Conflicts of Interest
- Doing Business with U.S. Governments Overview
- Special Needs Plan Model of Care Training
- SMART Goals
- Contract requirements/updates, when needed
- Specific functional training updates, when needed

Any additional information relevant to this position:

- N/A

Key Position: Job Description

Title of Position: Chief Financial Officer (CFO)

Description of Position: The chief financial officer (CFO) oversees all aspects of strategic financial planning, analysis and operations for the health plan. This position establishes a disciplined approach to financial performance management and oversees the budget, accounting systems, financial reporting and audit activities.

Description of Responsibilities of Position:

- Confirms compliance with MississippiCAN and CHIP regulatory requirements (e.g., quarterly/annual filings) and other program operational areas (e.g., rate changes, fee-schedule changes, revenue reconciliation, reporting) and oversees all audit activities
- Develops, performs and manages analyses of business/financial metrics and performance measures and reports financial and operational data to region/site leaders
- Develops and maintains financial reports to clearly communicate actual results, forecasted performance, and variances to plan, forecast and budget
- Works closely with health plan executives to develop, recommend and establish strategies, plans and processes to improve profitability and cost efficiencies
- Leads the financial management of capital, operating expense and develops metrics, benchmarks and analytics to guide the appropriate investment in infrastructure
- Establishes detailed budgets and identifies, quantifies and prioritizes strategic initiatives to realize these budgets
- Assists with trend analysis and forecasting
- Assists with development and operationalization of medical cost reporting
- Engages in monthly close process

Minimum Experience Required:

- 4 years' management experience within total finance/professional experience base of approximately 10 years, preferably with benefit cost and other medical analysis or medical management background
- Ability to effectively support/train and perform transactional-based finance and accounting transactions
- Strong strategic focus combined with operational, analytical and project management skills

Skills Required:

- Ability to assess problems and implement solutions based on sound financial principles
- Leadership skills, including change agent capability, working with management and analysts to identify opportunities and develop creative solutions
- Demonstrate technical and financial understanding of physician and provider claim submission and contracts, claim system operations, and the resulting generation of data into financial and incurred but not reported (IBNR) reporting information
- Ability to understand and influence the necessary and appropriate actions to ensure maximization of financial results and objectives

Are there any educational requirements for this position?
[X] Yes [ ] No

If yes, list below:

- Bachelor's degree in finance or accounting required
- Certified Public Accountant or Certified Management Accountant preferred
- Master of Business Administration 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?
[X] Yes [ ] No

If yes, list below:

- Annual Compliance Training, including topics of Fraud, Waste and Abuse and Code of Conduct
- Safe and Secure with Me – Privacy and Security Annual Training
- Cultural Competency
- MississippiCAN and CHIP contract changes, when applicable
- Organizational Conflicts of Interest
- Doing Business with U.S. Governments Overview
- Special Needs Plan Model of Care Training
- SMART Goals
- Contract requirements and updates, when needed
- Specific functional training updates, when needed

Any additional information relevant to this position:

- N/A

Key Position: Job Description

Title of Position: Medical Director

Description of Position: Our medical director is responsible for all clinical decisions and provides medical oversight, expertise, leadership and direction for the administration of MississippiCAN and CHIP. The medical director is actively involved in all major clinical and quality management components of the health plan's operations. They oversee clinical operations initiatives that focus on clinical excellence, affordability and performance improvement. They are responsible for developing and implementing utilization management (UM), disease management (DM) and quality management (QM) strategies to serve MississippiCAN and CHIP members. They are a physician licensed to practice medicine who resides in Mississippi.

Description of Responsibilities of Position:

- Oversees clinical decisions related to the provision of care and educates others on clinical and operational topics and programs
- Leads local clinical operations initiatives and manages communications of clinical decisions, programs, cases and results
- Assesses and manages clinical operational capability of UM and prior authorizations
- Responsible for implementation and oversight of the UM, DM and QM programs, and executes clinical quality initiatives in collaboration with team leads
- Performs medical expense management activities, including sharing data with hospitals and physicians, working with clinical staff to ensure cost-effectiveness
- Conducts peer-to-peer communications; monitors results of interventions to achieve utilization goals; collaborates with care coordinators to keep focus on achieving targets
- Communicates to providers new focus and HEDIS® measure changes
- Oversees quality initiatives and provider communication campaigns
- Supports clinical quality initiatives and peer review processes including quality-of-care and quality-of-service issues
- Maintains relationships with Division and regulatory authorities and medical societies and actively participates in joint operating, QM, UM and medical management committees
- Develops, implements and provides medical interpretation of medical policies and procedures, including, but not limited to, service authorization, claims review, discharge planning, credentialing, referrals and medical review included in the grievance system

Minimum Experience Required:

- Strong knowledge of managed care industry and the Medicaid line of business
- Quality management experience
- Background in primary care medicine with demonstrated ability to work with peers and other health care providers to resolve DM, QM, UM and complex care issues

Skills Required:

- Expert level of proficiency working in a fast-paced matrix organization/environment with an enterprise focus
- Prior leadership experience in program execution
- Familiarity with current medical issues and practices
- Solid data analysis and interpretation skills; ability to focus on key metrics
- Excellent interpersonal communication skills
- Solid negotiation and conflict management skills

Are there any educational requirements for this position?
[X] Yes [ ] No

If yes, list below:

- 3 years of training in a medical specialty
- 5 years of experience post-training clinical experience

Are any professional licenses or certifications required for this position?
[X] Yes [ ] No

If yes, list below:
- A physician with an active license in Mississippi
- Board-certification in specialty

Are there any continuing education requirements for this position?
[X] Yes [ ] No

If yes, list below:
- Annual Compliance Training (includes the topics of Fraud, Waste and Abuse and Code of Conduct)
- Safe and Secure with Me – Privacy and Security Annual Training
- Cultural Competency
- MississippiCAN and CHIP contract changes, when applicable
- Organizational Conflicts of Interest
- Doing Business with U.S. Governments Overview
- Special Needs Plan Model of Care Training
- SMART Goals
- Contract requirements/updates, when needed
- Specific functional training updates, when needed

Any additional information relevant to this position:
- N/A

Key Position: Job Description
Title of Position: Perinatal Medical Director
Description of Position: Perinatal medical director provides strategic leadership and is accountable for all clinical programs for perinatal and infant vitality products and membership served by the health plan to ensure contractual compliance and achievement of clinical and utilization management goals. Responsible for the development and implementation of perinatal health policy through covered services to members.
Description of Responsibilities of Position: ▪ Serves as the primary point of contact and is accountable for all aspects of health plan maternity and infant vitality clinical and utilization management performance. Because of the unique structure and alignment of clinical programs within UnitedHealthcare, this role requires a high degree of coordination with external and internal business partners, including, but not limited to, the UnitedHealthcare clinical services inpatient and intake/prior authorizations, appeals and grievance, quality, Optum case and disease management, Healthy First Steps, NICU, Optum behavioral health, state Medicaid partners and other clinical specialty, external vendors or national programs. Creates and sustains a culture of employee engagement where commitment to our members and providers is paramount ▪ Serves as a liaison between contractor and providers ▪ Provides consultation to the contractor's staff on referrals, denials, grievances and appeals; reviews potential quality of care problems and participates in the development and implementation of corrective action plans ▪ Serves on quality work groups as required by the Division ▪ Works collaboratively with the health plan director of quality and medical director to support achievement of state infant mortality, quality initiatives, HEDIS measures and to ensure compliance with relevant requirements of the state's annual performance review(s) conducted by the external quality review organization (EQRO), state or other oversight body and meeting NCQA requirements ▪ Works collaboratively with the plan medical director, business partners and finance to develop, implement/execute the Healthcare Affordability Plan, monitor outcomes of the planned initiatives and adjust the plan as needed to meet targets
Minimum Experience Required: ▪ 5+ years of experience providing direct care or care coordination to at-risk pregnant individuals receiving Medicaid services ▪ Solid knowledge base working in managed care or working in coordination with managed care ▪ Significant experience working with community-based partners to increase pregnancy compliance programs, engaging individuals in need of specialty services to support them through difficult pregnancies, birth experiences and parental support after birth ▪ Significant experience in development and execution of clinical programs in public sector managed care environment ▪ Clinical experience with Medicaid/Medicare populations ▪ Demonstrated track record of clinical program compliance, functional collaboration and meeting program goals
Skills Required: ▪ Demonstrated track record of leadership development ▪ Intermediate computer skills – MS Office Suite: PowerPoint, Excel, Word

Are there any educational requirements for this position?
[ ] Yes [X] No

If yes, list below:
Preferred qualifications:

- Obstetrical and/or NICU advanced certifications
- Managed care and/or health plan experience
- Certified Case Manager (CCM) certified

Are any professional licenses or certifications required for this position?
[X] Yes [ ] No

If yes, list below:

- Mississippi-licensed 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

Are there any continuing education requirements for this position?
[X] Yes [ ] No

If yes, list below:

- Annual Compliance Training (includes the topics of Fraud, Waste and Abuse and Code of Conduct)
- Safe and Secure with Me – Privacy and Security Annual Training
- Cultural Competency
- MississippiCAN and CHIP contract changes, when applicable
- Organizational Conflicts of Interest
- Doing Business with U.S. Governments Overview
- Special Needs Plan Model of Care Training
- SMART Goals
- Contract requirements/updates, when needed
- Specific functional training updates, when needed

Any additional information relevant to this position:

- N/A

Key Position: Job Description
Title of Position: Behavioral Health/SUD Executive Director
Description of Position: The behavioral health/SUD executive director is a member of the health plan executive leadership team managing development and implementation of affordable, evidence-based treatments and regional action planning within a large, matrixed managed care organization. They are accountable for the strategic approach to executing our annual business objectives in alignment with the larger organization. They work collaboratively with other functional partners such as care advocacy, quality improvement, utilization management, division and legal compliance, and matrixed operational and clinical finance leaders to provide medical subject matter expertise to execute our goals.
Description of Responsibilities of Position: ▪ Oversees and is responsible for the development and implementation of behavioral health policy through covered services to members ▪ Maintain the clinical integrity of the program ▪ Serve as a liaison between the health plan and providers ▪ Consult on referrals, denials, grievances and appeals ▪ Reviews potential quality of care concerns ▪ Participates in the development and implementation of corrective action plans ▪ Acts as a liaison to medical and behavioral health provider and community stakeholders ▪ Provides consultation regarding issues such as clinical standards, policies, procedures, recovery and resiliency best practices ▪ Participates in quality assurance activities and quality work groups as required by the Mississippi Division of Medicaid ▪ Collaborates with matrixed clinical, operational and financial leaders to identify opportunities for market innovation ▪ Supports clinical care management activities providing medical expertise to support the receipt of the appropriate level of care according to evidence-based practices and best practice clinical guidelines
Minimum Experience 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 ▪ Master of Business Administration, Master of Public Health, Master of Healthcare Administration or Ph.D. preferred ▪ Knowledge of public sector care in Mississippi preferred ▪ Prior medical director leadership experience preferred
Skills Required: ▪ Minimum of 5 years of experience providing and supervising treatment service for mental illness and substance use disorders ▪ Demonstrated ability to lead and teach others ▪ Demonstrated ability to proactively engage colleagues and manage adversarial situations ▪ Personal computer (PC) proficiency, data analysis and strong organizational skills ▪ Excellent communication, negotiation and customer service skills
Are there any educational requirements for this position? **[X] Yes [ ] No** **If yes, list below:** ▪ Licensed Mississippi M.D.

Are any professional licenses or certifications required for this position?
[X] Yes [ ] No

If yes, list below:

- Active, unrestricted medical license with the Mississippi State Board of Medical Licensure

Are there any continuing education requirements for this position?
[X] Yes [ ] No

If yes, list below:

- Annual Compliance Training (includes the topics of Fraud, Waste and Abuse and Code of Conduct)
- Safe and Secure with Me – Privacy and Security Annual Training
- Cultural Competency
- MississippiCAN and CHIP contract changes, when applicable
- Organizational Conflicts of Interest
- Doing Business with U.S. Governments Overview
- Special Needs Plan Model of Care Training
- SMART Goals
- Contract requirements/updates, when needed
- Specific functional training updates, when needed

Any additional information relevant to this position:

- N/A

Key Position: Job Description
Title of Position: Chief Information Officer (CIO)
Description of Position: This position is responsible for overseeing and maintaining information systems that enable data validation, correct claims payment, and timely and accurate reporting. Builds key collaborative relationships with state partners, health plan business units, IT delivery teams, and project management teams to understand the Division's IT requirements. This position will drive implementation plans and work collaboratively to remediate obstacles to ensure a successful deployment and compliance with the needs of the Division. The incumbent will leverage their business knowledge in the health care industry to support daily efforts, innovative IT efforts, and must excel in high-impact and escalated crisis situations. This position will be a key contact for IT efforts and will work with the appropriate delivery areas for UnitedHealthcare's IT projects for MississippiCAN and CHIP. The overall goal of this position is to provide executive oversight and leadership in UnitedHealthcare's strong matrix environment, so the IT needs of the business and state partners are met, and contractual compliance is achieved.
Description of Responsibilities of Position: ▪ Builds and improves state, health plan, IT and service unit partnerships to create long-lasting transparent and trusting relationships ▪ Represents UnitedHealthcare at meetings with the Division; interacts with senior health plan and shared services leaders ▪ Influences, negotiates effectively and provides recommendations to arrive at win-win solutions with our state partner, health plan, IT and business service partners related to IT initiatives ▪ Leads change and innovation by demonstrating emotional resilience, managing change by proactively communicating the case for change and promoting a culture that thrives on change ▪ Influences health plan, business service units, Division partners, and IT teams employees by fostering teamwork and collaboration, driving employee engagement and leveraging diversity and inclusion ▪ Provides oversight and direction to ensure that the IT applications and operations are working effectively, through high levels of engagement with health plan leaders and service units ▪ Provides subject matter expertise (SME) on business capabilities, such as claims, member, clinical, provider, X12 transactions, etc., to provide a translation of business need into technical requirements for both growth and regulatory IT initiatives ▪ Works with business leaders to identify and frame their IT needs, mapping them to strategic plans and prioritizing them ▪ Drives high-quality execution and operational excellence by communicating clear directions and expectations ▪ Drives sound and disciplined decisions that drive action while effectively using IT and health care business knowledge ▪ Provides leadership to and is accountable for the Division and health plan satisfaction as it relates to IT initiatives and performance ▪ Partners with leaders to determine funding and budget requirements, timing and resources for projects ▪ Introduces and aligns enterprise business and technology innovations to our markets to advance retention and growth across members and providers ▪ Provides designs, options and executable solutions to existing UnitedHealthcare problems requiring innovative solutions ▪ Facilitates implementation readiness and creates/enhances operational processes to increase efficiencies ▪ Continually drives innovation and creative solutions to business opportunities and applies industry standard methodologies and technology best practices ▪ Continually leads technology integration and simplification initiatives

Minimum Experience Required:

- Proven skills driving implementation of IT initiatives
- Strategic planning in the health care industry
- 10+ years of professional IT experience
- 7+ years of professional IT management experience in a large, enterprise environment
- 5+ years of experience leading teams and/or managing workloads for IT team members
- 3+ years of professional director-level experience in a large, enterprise environment
- Medicare/Medicaid experience
- Health care industry experience

Skills Required:

- Expert level of proficiency working in a fast-paced matrix organization/environment with an enterprise focus
- Prior leadership experience in program execution
- Ability to navigate and influence a complex, matrixed environment across UnitedHealthcare, Optum and other delegated entities and drive to resolution
- Demonstrated ability to be adept at understanding and resolving complex concepts and situations presented by the business environment; ability to assess complex problems and recommend the appropriate IT solutions

Are there any educational requirements for this position?
[X] Yes [ ] No

If yes, list below:

- Bachelor's degree or higher level of education

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?
[X] Yes [ ] No

If yes, list below:

- Annual Compliance Training (includes the topics of Fraud, Waste and Abuse and Code of Conduct)
- Safe and Secure with Me – Privacy and Security Annual Training
- Cultural Competency
- MississippiCAN and CHIP contract changes, when applicable
- Organizational Conflicts of Interest
- Doing Business with U.S. Governments Overview
- Special Needs Plan Model of Care Training
- SMART Goals
- Contract requirements/updates, when needed
- Specific functional training updates, when needed

Any additional information relevant to this position:

- N/A

Key Position: Job Description

Title of Position: Compliance Officer

Description of Position: The compliance officer has accountability for monitoring changes to laws and regulations to ensure compliance with state and federal laws, regulations and mandates. This role establishes and implements standard policies, procedures, processes and best practices across UnitedHealthcare to promote compliance with applicable laws and contractual obligations. The compliance officer is responsible for and has authority to take all reasonable and necessary measures to implement the compliance program. The compliance officer collaborates with our legal counsel to conduct Division-specific legal research and monitors changes to requirements to mitigate risks and achieve compliance. In addition, this position supports the collection of data for regulatory filings and coordinates and develops reports, projects and assessment tools to verify compliance. This position may also develop compliance communications and drive problem resolution.

Description of Responsibilities of Position:

- Establishes, implements and drives adherence to compliance programs
- Identifies compliance issues, manages risk and reports compliance status and issues
- Develops and manages site compliance committee meetings
- Coordinates and supports implementation of compliance training and educational programs with the appropriate business areas. Verifies that procedures are in place to review, and reports possible violations in accordance with reporting requirements
- Oversees monitoring and enforcement of the fraud, waste and abuse compliance program pursuant to state and federal rules and regulations, implementing any corrective actions as needed
- Assumes authority to assess records and independently refer suspected fraud and abuse cases to the Division and other duly authorized enforcement agencies
- Coordinates with legal counsel, government programs investigators and others as needed to conduct investigations
- Collaborates with staff to develop and implement monitoring and auditing procedures as appropriate to determine the level of compliance with key regulatory requirements
- Works with operational leaders to ensure understanding and communication of plan-level regulatory contract requirements
- Validates standards and processes are in place to confirm subcontractors meet regulatory and contract requirements for effective pre-contracting evaluation and service level requirements, ongoing monitoring and contract management activities
- Coordinates privacy-related activities with the government programs privacy team to verify training and education is provided to plan employees and others as required
- Serves as key point of contact for regulatory agencies interfacing with UnitedHealthcare

Minimum Experience Required:

- 3+ years of experience in direct management of a health plan compliance program
- Experience leading government program audits and compliance initiatives
- Experience developing relationships with regulatory agencies
- Experience leading audits and major program initiatives

Skills Required:

- Ability to navigate and influence a complex, matrixed environment across UnitedHealthcare, Optum and other delegated entities and drive to resolution
- Solid skills in goal(s) setting and works independently to achieve them; pushes self and others to reach milestones
- Excellent skills in verbal and written communication; problem solving
- Demonstrates advanced writing/presentation skills; easily shifts style based on audience
- Demonstrated ability to make decisions even when information is limited or unclear
- Adept at understanding and resolving complex concepts and situations presented by the business environment; ability to assess complex problems and recommend the appropriate compliance solutions
- Ability to effectively deal with ambiguity - can effectively cope with change, can shift gears

comfortably, can decide and act without having the total picture, comfortably handles risk and uncertainty in a manner consistent with UnitedHealth Group's core values, culture and common language of leadership

Are there any educational requirements for this position?
[X] Yes [ ] No

If yes, list below:
- Bachelor's degree or appropriate 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?
[X] Yes [ ] No

If yes, list below:
- Annual Compliance Training (includes the topics of Fraud, Waste and Abuse and Code of Conduct)
- Safe and Secure with Me – Privacy and Security Annual Training
- Cultural Competency
- MississippiCAN and CHIP contract changes, when applicable
- Organizational Conflicts of Interest
- Doing Business with U.S. Governments Overview
- Special Needs Plan Model of Care Training
- SMART Goals
- Contract requirements/updates, when needed
- Specific functional training updates, when needed

Any additional information relevant to this position:
- N/A

Key Position: Job Description
Title of Position: Project Manager
Description of Position: The project manager oversees the implementation of the contract requirements during all phases of the contract.
Description of Responsibilities of Position: ▪ As an in-house business project manager, works closely with leadership on all aspects of the health plan across the business ▪ Responsible for leading and overseeing the implementation of the contract requirements across all functional areas to ensure a successful contract implementation ▪ Will be involved with all aspects of the health plan business, including clinical, marketing, employee engagement and provider engagement. ▪ Solves moderately complex problems and conducts moderately complex analyses ▪ Develops and implements contract implementation projects for the success of the health plan ▪ Tracks and monitors contract implementation projects with action strategy development based on identified opportunities ▪ Prepares weekly reports
Minimum Experience Required: ▪ Knowledge of Medicaid programs, particularly with Medicaid managed care programs, with relevant experience navigating similar complex projects ▪ 3+ years of business project management experience ▪ 3+ years of experience in a deadline-driven environment ▪ Process improvement related experience preferred
Skills Required: ▪ 3+ years of proficiency in MS Office Suite, including Word, Excel, Outlook, Visio and PowerPoint ▪ 3+ years of experience demonstrating organizational skills ▪ Able to be flexible and work with ambiguity ▪ 3+ years of experience managing and prioritizing multiple deliverables ▪ 3+ years of experience influencing and collaborating with others ▪ Able to take complex information and synthesize it into clear strategies ▪ Able to create and refine strategic plans based on needs of the health plan Project Management Professional (PMP) certification preferred
Are there any educational requirements for this position? **[X] Yes [ ] No** **If yes, list below:** ▪ Bachelor's degree or equivalent combination of education and experience
Are any professional licenses or certifications required for this position? **[ ] Yes [X] No** **If yes, list below:** ▪
Are there any continuing education requirements for this position? **[X] Yes [ ] No** **If yes, list below:** ▪ Annual Compliance Training (includes the topics of Fraud, Waste and Abuse and Code of Conduct) ▪ Safe and Secure with Me – Privacy and Security Annual Training ▪ Cultural Competency ▪ MississippiCAN and CHIP contract changes, when applicable ▪ Organizational Conflicts of Interest

- Doing Business with U.S. Governments Overview
- Special Needs Plan Model of Care Training
- SMART Goals
- Contract requirements/updates, when needed
- Specific functional training updates, when needed

Any additional information relevant to this position:

- This position must be based in Mississippi during the implementation phase of the contract

Key Position: Job Description

Title of Position: Provider Services Manager

Description of Position: Our provider services manager develops the provider network through retention activities. This role implements and manages provider orientation, education, training and serving activities for our provider network. The provider services manager interacts with local plan leadership and functional teams and regional and national resources in developing and supporting the provider network.

Description of Responsibilities of Position:

- Oversees the development and maintenance of contracts, forms, materials and other tools related to the provider services team activities
- Monitors provider network for adequate access for member populations
- Monitors providers for contract compliance, provides orientation, training and support, as needed
- Researches and develops provider agreements and other contracts and establishes regular contract review
- Performs contract and reimbursement support analysis in support of contract negotiations
- Participates in the development and preparation of network provider listings and services materials; reviews and analyzes fee schedules
- Helps obtain required credentialing documents from providers, as needed

Minimum Experience Required:

- 5+ years working in managed health care plan setting
- 2+ years of experience working with physicians and other providers
- Proven success in provider contracting and servicing

Skills Required:

- Exceptional interpersonal skills
- Passionate about resolving issues; delivering WOW through service
- Demonstrated ability to drive positive outcomes and balance multiple activities
- Dynamic and highly engaged independent thinker
- Ability to collaborate, influence and facilitate successful outcomes within a cross-functional environment
- Ability to prioritize and organize work to meet deadlines
- Ability to work across organizational levels to resolve problems
- Exceptional written and verbal communication, presentation, problem-solving and analytical skills
- Ability to multitask, approaching each new direction with a sense of urgency and following through to completion
- Ability to work as a team member, understanding individual efforts will combine to determine the overall success of the model
- Not afraid to challenge processes/procedures to develop more efficient outcomes for providers
- Ability to persevere and overcome barriers

Are there any educational requirements for this position?
[X] Yes [ ] No

If yes, list below:

- Bachelor's degree required, in business or health care preferred
- 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?
[X] Yes [ ] No

If yes, list below:

- Annual Compliance Training (includes the topics of Fraud, Waste and Abuse and Code of Conduct)
- Safe and Secure with Me – Privacy and Security Annual Training
- Cultural Competency
- MississippiCAN and CHIP contract changes, when applicable
- Organizational Conflicts of Interest
- Doing Business with U.S. Governments Overview
- Special Needs Plan Model of Care Training
- SMART Goals
- Contract requirements/updates, when needed
- Specific functional training updates, when needed

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 network development. Partners with the national network program management team for successful program design, compliance with network requirements, network assessment and selection, and program/product implementation.

Description of Responsibilities of Position:

- Sets team direction, resolves problems and provides guidance to members of own team
- Adapts departmental plans and priorities to address business and operational challenges
- Directs cross-functional and cross-segment teams to develop enterprisewide clinically integrated networks focused on specific clinical areas/service lines such as oncology or cardiology
- Oversees network analysis and strategy development and implementation
- Drives program design and implementation to improve quality and affordability through improvements in appropriateness and effectiveness
- Ensures teams are obtaining, validating and analyzing network availability and access data
- Meets with key Medicaid managed care providers to drive collaboration and partnerships
- Pursues value-based purchasing opportunities with provider community

Minimum Experience Required:

- 3+ years of experience working with a managed care organization or health insurer; or as a consultant in a network/contract management role, such as contracting, provider services, etc.
- 3+ years of experience in data analysis
- 3+ years of experience managing staff
- 3+ years of project management or project lead experience

Skills Required:

- Experience with contract submission, validation and maintenance with strong knowledge of business processes that impact facility/ancillary contact loading and auditing

Are there any educational requirements for this position?
[X] Yes [ ] No

If yes, list below:

- Undergraduate degree or equivalent work 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?
[X] Yes [ ] No

If yes, list below:

- Annual Compliance Training (includes the topics of Fraud, Waste and Abuse and Code of Conduct)
- Safe and Secure with Me – Privacy and Security Annual Training
- Cultural Competency
- MississippiCAN and CHIP contract changes, when applicable
- Organizational Conflicts of Interest
- Doing Business with U.S. Governments Overview
- Special Needs Plan Model of Care Training
- SMART Goals
- Contract requirements/updates, as needed
- Specific functional training updates, as needed

Any additional information relevant to this position:

- N/A

Key Position: Job Description

Title of Position: Member Services Director

Description of Position: Our member services director is responsible for providing expertise and customer service support to members, customers and providers. Develops and executes growth and marketing strategies to drive continued growth and innovation in Mississippi and has accountability for the strategic growth and retention efforts in the state.

Description of Responsibilities of Position:

- Develops and executes and continually updates overall strategies for Medicaid product offering to maximize product growth, member retention, innovation and member and provider experience
- Leads, develops and upholds accountability of Medicaid product forecasting models with complete understanding of auto-assignment algorithms, eligibility requirements, self-select and involuntary versus voluntary term ratios
- Oversees the Medicaid community agenda and field-based outreach teams to develop market-leading provider and community engagement to forge strong external relationships
- Manages and upholds accountability for marketing, sponsorship and outreach budgets
- Oversees member services functions, including member help line telephone performance, member email communications, member education, the member website, member outreach programs and development, approval and distribution of member materials
- Oversees the interface with the Division regarding such issues as member enrollment and disenrollment
- Plans, develops and manages the quality and productivity of customer service teams
- Verifies accurate staffing and service levels
- Manages inbound customer service call center and daily inventories
- Oversees operational metrics, contract compliance and key performance indicators

Minimum Experience Required:

- 5+ years of people management experience
- 3+ years of managed care or Medicaid experience
- Experience building analytical skills including experience generating return on investment (ROI), business case forecasting and growth opportunities
- Familiarity with health adviser model preferred
- Experience developing and deploying market strategies

Skills Required:

- Strong analytical and problem-solving skills
- Ability to evaluate outcomes based upon qualitative and quantitative measures and adjusts accordingly
- Personal computer (PC) proficiency, data analysis and strong organizational skills
- Excellent communication, negotiation and customer service skills

Are there any educational requirements for this position?
[X] Yes [ ] No

If yes, list below:

- Bachelor's degree or equivalent combination of education and experience

Are any professional licenses or certifications required for this position?
[ ] Yes [X] No

If yes, list below:

Are there any continuing education requirements for this position?
[X] Yes [ ] No

If yes, list below:

- Annual Compliance Training (includes the topics of Fraud, Waste and Abuse and Code of Conduct)
- Safe and Secure with Me – Privacy and Security Annual Training
- Cultural Competency
- MississippiCAN and CHIP contract changes, when applicable
- Organizational Conflicts of Interest
- Doing Business with U.S. Governments Overview
- Special Needs Plan Model of Care Training
- SMART Goals
- Contract requirements/updates, when needed
- Specific functional training updates, when needed

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 provides strategic leadership and direction for the quality improvement and management program(s) as a core service to UnitedHealthcare health plans. The director works within highly matrixed relationships to lead and develop the overall quality strategy for the plan, ensuring the quality program is proactive, continuously improving, applies to all product and programs within the state, and includes both quality management/regulatory adherence and quality improvement. Serves as the Division contact for quality performance measures.
Description of Responsibilities of Position: ▪ Develops and manages the health plan's quality improvement projects. Oversees and directs, as applicable, quality improvement activities and interventions to close gaps in care and improve outcomes for identified critical quality measures while meeting contractual requirements ▪ Oversees the development and implementation of plan quality program ▪ Focuses organizational efforts on the improvement of clinical quality performance measures ▪ Identifies population-based member barriers to care and works with the Quality Management and Improvement Committee (QMIC) team to identify local-level strategies to overcome barriers and close clinical gaps in care ▪ Uses data to develop intervention strategies to improve outcomes ▪ Supports quality improvement program studies ranging from accessing and analyzing provider records, maintaining databases, and researching to identify members' encounter history ▪ Designs practice-level quality transformation through targeted clinical education and approved materials related to HEDIS®/Division-specific quality measures for provider and staff education ▪ Engages providers in strategies to improve outcomes through collaborative partnerships ▪ Develops and implements PIPs, both internal and across our health plans ▪ Collaborates across business segments to attain or maintain the plan's compliance with accreditation standards and contractual requirements as they apply to quality ▪ Ensures and oversees health plan quality management/committee structure and integrated quality oversight processes ▪ Oversees and directs, as applicable, process improvement plans and corrective action plans for surveys, accreditations, EQROs and state audits, for quality management and improvement
Minimum Experience Required: ▪ 5+ years of clinical or field related experience ▪ 2+ years of experience in quality improvement or related field such as Six Sigma ▪ 8+ years of significant leadership and managerial experience ▪ Experience working in Medicaid or Medicare, including regulatory and compliance preferred ▪ Knowledge of one or more of clinical standards of care, preventive health standards, CMS standards, HEDIS, NCQA, governing and regulatory agency requirements ▪ Experience managing and coordinating regulatory audits including documentation, on-site preparation and responsive corrective action plans
Skills Required: ▪ Strong demonstrated ability to lead business initiatives to a successful result ▪ Strong communicator; capable of effectively presenting ideas and selling concepts and tactics; excellent writer, proven ability to communicate effectively with executive-levels; ability to quickly understand needs and act on those needs; ability to conceptualize and effectuate change management and "out-of-the-box" thinking ▪ Proven ability to build relationships cross-functionally and lead toward common goals ▪ Strong influencing and negotiation skills ▪ Strong, independent decision maker and risk taker ▪ Strong change management experience and demonstrated skills ▪ Strong process and project management skills

Are there any educational requirements for this position?
[X] Yes [ ] No

If yes, list below:
- Bachelor of Science in nursing or equivalent work experience
- 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?
[X] Yes [ ] No

If yes, list below:
- Annual Compliance Training (includes the topics of Fraud, Waste and Abuse and Code of Conduct)
- Safe and Secure with Me – Privacy and Security Annual Training
- Cultural Competency
- MississippiCAN and CHIP contract changes, when applicable
- Organizational Conflicts of Interest
- Doing Business with U.S. Governments Overview
- Special Needs Plan Model of Care Training
- SMART Goals
- Contract requirements/updates, when needed
- Specific functional training updates, when needed

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 provides strategic leadership and is accountable for all clinical programs for all products and membership served by the health plan to ensure contractual compliance and achievement of clinical and utilization management goals. Serves as the primary point of contact and is accountable for all aspects of health plan clinical and utilization management performance.
Description of Responsibilities of Position: ▪ Accountable for overall local market health plan clinical operations for all products including achievement of annual clinical, quality/affordability and utilization management goals ▪ Local market subject matter expert for all clinical/medical management programs and contractual requirements ▪ Leads, coaches/develops, trains (in conjunction with clinical learning team) and supports health-plan-based clinical team. Ensures effective, compliant, clinical program delivery, and monitors performance and clinical outcomes ▪ Responsible for designing, administering and evaluating a unique program of care management for MississippiCAN and CHIP ▪ Oversees the provision of a range of targeted, clinical services and benefits following MississippiCAN and CHIP contract ▪ Ensures compliance with the Division requirements such as timely completion of assessments, appropriate submission for determination of level of care, notification to the Division ▪ Oversees delegated service coordination activities that the case management agencies provide ▪ Monitors for adequate staffing during hours of operations, assisting staff as needed with process issues and walk-in enrollees, providers, prospective members, community members and addressing other issues as they arise ▪ Maintains compliance with utilization review activities for members enrolled with UnitedHealthcare ▪ Interacts and communicates with the external patient community to provide information (e.g., health fairs; lunch and learn sessions) ▪ Interacts and communicates with potential and existing customers to educate and inform them of company value and services ▪ Presents to external stakeholders (e.g., conferences; industry professionals) on industry-related issues to provide visibility for and understanding of company products and services
Minimum Experience Required: ▪ Significant experience in development and execution of clinical programs in public sector managed care environment ▪ Clinical experience with Medicaid/Medicare populations
Skills Required: ▪ Demonstrated track record of clinical program compliance, functional collaboration and meeting program goals ▪ Demonstrated track record of leadership development ▪ Intermediate computer skills – MS Office Suite – PowerPoint, Excel, Word
Are there any educational requirements for this position? **[X] Yes [ ] No** **If yes, list below:** ▪ Associate degree or higher

Are any professional licenses or certifications required for this position?
[X] Yes [ ] No

If yes, list below:

- Licensed clinical social worker, registered nurse, nurse practitioner, and/or physician licensed to practice in Mississippi
- Undergraduate degree in nursing

Are there any continuing education requirements for this position?
[X] Yes [ ] No

If yes, list below:

- Annual Compliance Training (includes the topics of Fraud, Waste and Abuse and Code of Conduct)
- Safe and Secure with Me – Privacy and Security Annual Training
- Cultural Competency
- MississippiCAN and CHIP contract changes, when applicable
- Organizational Conflicts of Interest
- Doing Business with U.S. Governments Overview
- Special Needs Plan Model of Care Training
- SMART Goals
- Contract requirements/updates, when needed
- Specific functional training updates, when needed

Any additional information relevant to this position:

- N/A

Key Position: Job Description
Title of Position: Population Health Director
Description of Position: The population health director provides visionary leadership and contributes to the successful advancement of culture, health equity and social responsibility principles. This senior level Mississippi-based position has accountability for building and deploying initiatives that address SDOH needs of members and communities, advance health equity, reduce disparities and reduce implicit, explicit and institutional bias experienced by people of color. This leader will work with internal and external partners to build solutions to reduce those disparities.
Description of Responsibilities of Position: ▪ Coordinates and oversees the population health management and equity program and services ▪ Strategizes, develops and directs operations of the health services department to ensure provision of high-quality, cost-effective services ▪ Drives engagement and identifies and seeks opportunities to celebrate and communicate culture, health equity and social responsibility to enable active change agents throughout the organization, especially within the care delivery organizations ▪ Conducts the Clinical Oversight Committee, which reports out to the Quality Oversight Committee, developing and managing budgets and directing actions to control targeted costs for inpatient and outpatient services in conjunction with the site medical expense team ▪ Maintains compliance with state and federal regulations and contracts, and complies with company policies and procedures ▪ Reports to the medical director and supports in driving affordability, health care policy, appeals and grievance review (State Fair Hearing), support HEDIS and EPSDT rate achievement, direct oversight of the Maternal Child program, Private Duty nursing and support of the clinical nursing team ▪ Leads the population health initiatives for the Mississippi health plan, including the development and administration of procedures, protocols and standards regarding the efficiency, cost and quality of the health care delivered to our members ▪ Identifies and owns the development of population health management consulting solutions that will be brought to market, leveraging research and internal resources ▪ Provides organizational leadership and oversight of population health tools, workflow design, outcome metrics, along with financial and quality performance ▪ Defines and develops analytic and population health strategies that align with organizational strategic priorities; implements data-driven programs that assist in the identification and risk stratification of high-risk populations with the goal of improving quality and outcomes, while reducing costs; and develops analytics and programs to address care gaps in patients while also evaluating the socioeconomic needs of patients ▪ Partners with the quality management director, care management director, health equity director and our national teams to define and drive the proper population health solutions for Mississippi
Minimum Experience Required: ▪ 5+ years of management experience with 2 or more years of experience in care management or home health ▪ Experience with Medicaid and D-SNP (strongly preferred) managed care ▪ Previous successful experience in disease management/QM/care management managed care programs ▪ Previous work with service coordinators, including review of care plans ▪ Experience addressing health disparity and/or health equity concerns ▪ Experience and knowledge of change management principles, methodologies and tools

Skills Required:

- Demonstrated successful leadership skills in program execution and people management in both internal and external environments
- Must have experience managing in the matrix environment
- Excellent communication skills – verbal, interpersonal, presentation and facilitation, along with written message development
- Proven track record of effectively managing conflict, resolving issues, mitigating risks and influencing leaders
- Master's degree in public health administration, public policy or related fields preferred
- Undergraduate degree in nursing, social work or similar preferred
- Evidential experience of trauma-informed care philosophy preferred
- Medicare/Medicaid knowledge and experience preferred

Are there any educational requirements for this position?
[X] Yes [ ] No

If yes, list below:

- Bachelor's degree in nursing or health-related field

Are any professional licenses or certifications required for this position?
[X] Yes [ ] No

If yes, list below:

- Current RN license in Mississippi

Are there any continuing education requirements for this position?
[X] Yes [ ] No

If yes, list below:

- Annual Compliance Training (includes the topics of Fraud, Waste and Abuse and Code of Conduct)
- Safe and Secure with Me – Privacy and Security Annual Training
- Cultural Competency
- MississippiCAN and CHIP contract changes, when applicable
- Organizational Conflicts of Interest
- Doing Business with U.S. Governments Overview
- Special Needs Plan Model of Care Training
- SMART Goals
- Contract requirements/updates, when needed
- Specific functional training updates, when needed

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 (UM) coordinator is responsible for the supervisory oversight and direction of UM department activities to include prior authorization (PA) for post-acute services, medical necessity determinations, concurrent and retrospective reviews, and discharge planning functions. The UM coordinator actively participates in management decision making to verify compliance with all reporting requirements.
Description of Responsibilities of Position: ▪ Responsible for designing, administering and evaluating a program of utilization management ▪ Oversees the utilization management (authorization, notice of action and appeals) of the provision of services and benefits from multiple network providers ▪ Oversees all efforts related to the identification, delivery, installation, operation and regular maintenance of DME and assistive technologies in collaboration with a biomedical engineer ▪ Aids, approves and intervenes as needed to determine medical necessity, appropriateness and extended length-of-stay decisions ▪ Assists inpatient care manager in UM of enrollees with complex medical care involving numerous providers or frequent intervention ▪ Participates in the district- or plan-required audits and complies with all reporting requirements by area of responsibility ▪ Oversees the reporting process; monitors potential high-cost cases, readmissions, UM statistics to include admits per thousand, bed days per thousand, length-of-stay and readmissions per thousand within 30 days of discharge; develops and implements action plans for improvement as needed ▪ Integrates a collaborative process which assesses, plans, implements, coordinates, monitors, and evaluates the options and services to meet the enrollee's health needs using education, communication, and all available resources to promote quality, cost-effective outcomes ▪ Discharge planning or management of transitions between care settings to ensure the appropriate services/resources are in place for quality outcomes ▪ Applies professional judgment, takes initiative to follow up, and manages conversations to make sound conclusions/recommendations regarding patient care or coverage ▪ Works collaboratively with peers/team members and other levels or segments within Optum, UnitedHealthcare or United Behavioral Health (e.g., case managers, field care advocates) to identify appropriate course of action (e.g., appropriate care, follow-up course of action, make referral)
Minimum Experience Required: ▪ 5+ years of relevant experience, including 3 years in a supervisory role in UM in a managed care environment ▪ Demonstrate knowledge of specific software applications associated with the job function (e.g., navigation of relevant computer applications or systems, intranet databases, records management or claims databases) ▪ Demonstrate knowledge of process flow of UM including prior authorization, concurrent authorization and/or clinical appeal and grievance reviews ▪ Previous experience analyzing and make recommendation for process improvement ▪ Bachelor of Science in Nursing (BSN) preferred ▪ Medicare and/or Medicaid managed care experience preferred ▪ Case Management experience preferred ▪ Certified Case Manager (CCM) preferred ▪ Experience / exposure with discharge planning preferred ▪ Experience in utilization review, concurrent review and/or risk management preferred

Skills Required:

- Demonstrate knowledge of computer functionality, navigation, and software applications (e.g., Windows, Microsoft Office applications, phone applications, fax server)
- Solid data analysis and interpretation skills; ability to focus on key metrics
- Influence others
- Listen actively

Are there any educational requirements for this position?
[X] Yes [ ] No

If yes, list below:

- Unrestricted RN license in the state of Mississippi

Are any professional licenses or certifications required for this position?
[X] Yes [ ] No

If yes, list below:

- Must be an independently licensed master's-level mental health professional, licensed Ph.D. or registered nurse in the state of Mississippi
- Must have a current, independent unrestricted license

Are there any continuing education requirements for this position?
[X] Yes [ ] No

If yes, list below:

- Annual Compliance Training (includes the topics of Fraud, Waste and Abuse and Code of Conduct)
- Safe and Secure with Me – Privacy and Security Annual Training
- Cultural Competency
- MississippiCAN and CHIP contract changes, when applicable
- Organizational Conflicts of Interest
- Doing Business with U.S. Governments Overview
- Special Needs Plan Model of Care Training
- SMART Goals
- Contract requirements/updates, when needed
- Specific functional training updates, when needed

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 (G&A) coordinator adjudicates member grievances and appeals, including coordination of requests for state fair hearings. The G&A coordinator is qualified by training and experience to process and resolve grievances and appeals and is responsible for the grievance system.
Description of Responsibilities of Position: ▪ Completes member, provider and regulatory grievances and appeals cases within the specified time frame ▪ Prepares grievance and appeals cases for presentation to triage and resolution teams ▪ Works with internal departments to resolve grievances and appeals ▪ Analyzes, researches and understands how a service, procedure or authorization was processed and why it was denied/modified ▪ Obtains relevant medical records to submit appeals or grievance for additional review, as needed ▪ Leverages appropriate resources to obtain all information relevant to the claim modified or denied service ▪ Identifies and obtains additional information needed to make an appropriate determination ▪ Determines whether additional appeal or grievance reviews are required (e.g., medical necessity), and whether additional appeal rights are applicable ▪ Determines where specific appeals or grievances should be reviewed/handled, and routes to other departments as appropriate ▪ Completes member, provider and regulatory grievances and appeals cases within the specified time frame ▪ Acts as liaison with regulatory agencies regarding member grievances and appeals
Minimum Experience Required: ▪ 2+ years of experience with appeals, grievances and member complaints ▪ Experience with Medicare, Medicaid and managed care in a variety of health care settings ▪ Experience gathering documentation and presenting case facts to administrative law judge at state fair hearings
Skills Required: ▪ Familiarity and fluency with computer and Windows PC applications, which includes the ability to learn new and complex computer system applications ▪ Experience with Microsoft Excel (ability filter, sort, create and edit spreadsheets) ▪ Ability to compose written correspondence free of grammatical errors while also translating medical and insurance expressions into simple terms that members can easily understand ▪ Ability to remain focused and productive each day though tasks may be repetitive ▪ Ability to multitask, including the ability to understand multiple products and multiple levels of benefits within each product ▪ Consistent attendance with ability to meet work schedule including the required training period ▪ Ability to make fact-based decisions ▪ Ability to work effectively in a changing environment
Are there any educational requirements for this position? **[X] Yes [ ] No** **If yes, list below:** ▪ Bachelor's degree 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?
[X] Yes [ ] No

If yes, list below:

- Annual Compliance Training (includes the topics of Fraud, Waste and Abuse and Code of Conduct)
- Safe and Secure with Me – Privacy and Security Annual Training
- Cultural Competency
- MississippiCAN and CHIP contract changes, when applicable
- Organizational Conflicts of Interest
- Doing Business with U.S. Governments Overview
- Special Needs Plan Model of Care Training
- SMART Goals
- Contract requirements/updates, when needed
- Specific functional training updates, when needed

Any additional information relevant to this position:

- N/A

Key Position: Job Description
Title of Position: Claims Administrator
Description of Position: Handles interactions with providers and claims management staff regarding provider claims inquiries or requests for assistance with claims issues, including working on end-to-end provider claim and call quality, ease of use of physician portal and future service enhancements, and training and development of external provider education programs regarding claims submission processes.
Description of Responsibilities of Position: ▪ Oversees first pass claim adjudication and adjustments for UnitedHealthcare Medicaid health plans in assigned states ▪ Manages or has oversight responsibility for large claims adjudication teams ▪ Oversees end-to-end adjudication of claims ▪ Leads operational strategy to reduce costs while improving the customer experience ▪ Primary liaison between UnitedHealthcare Medicaid health plan operations team and IT division, with responsibility for vetting and validating IT products and processes, including cost-benefit analysis to drive market-specific performance and strategy ▪ Adheres to applicable policies and procedures regarding claims adjudication (e.g., reimbursement; claims; appeals; credentialing; complaints; medical policies; benefits design; regulatory requirements; client business rules) ▪ Uses company branding, service, tools and outreach activities to address provider claims issues ▪ Stays current on industry-related trends and/or events (e.g., regulations; health care reform) ▪ Complies with and uses relevant computer and software applications (e.g., MS Office; storage)
Minimum Experience Required: ▪ Demonstrates understanding of internal claims and payment policies and procedures ▪ Demonstrates understanding of claims IT systems to provide services to providers ▪ Demonstrates understanding of provider contracting (e.g., language; terminology; processes; methodology) ▪ Demonstrates understanding of coding and billing, and how those apply to reimbursement policies
Skills Required: ▪ Ability to remain focused and productive each day though tasks may be repetitive ▪ Ability to multitask, including the ability to understand multiple products and multiple levels of benefits within each product ▪ Consistent attendance with ability to meet work schedule including the required training period ▪ Ability to make fact-based decisions ▪ Ability to work effectively in a changing environment
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? **[ ] Yes [X] No** **If yes, list below:**

Are there any continuing education requirements for this position?
[X] Yes [ ] No

If yes, list below:

- Annual Compliance Training (includes the topics of Fraud, Waste and Abuse and Code of Conduct)
- Safe and Secure with Me – Privacy and Security Annual Training
- Cultural Competency
- MississippiCAN and CHIP contract changes, when applicable
- Organizational Conflicts of Interest
- Doing Business with U.S. Governments Overview
- Special Needs Plan Model of Care Training
- SMART Goals
- Contract requirements/updates, when needed
- Specific functional training updates, when needed

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 partners with stakeholders to understand data requirements and develop tools and models such as segmentation, dashboards, data visualizations, decision aids and business case analysis to support the organization. Other responsibilities include producing and managing the delivery of activity and value analytics to share with external stakeholders and internal customers. This role focuses on descriptive and regression-based analytics and leverages subject matter expert views in the design of data analytics and algorithms.
Description of Responsibilities of Position: ▪ Provides leadership to and is accountable for the performance and results through multiple layers of management and senior level professional staff ▪ Develops, translates and executes strategies or functional/operational objectives for a region, line of business, or major portion of a business segment functional area ▪ Directs others to resolve highly complex or unusual business problems that affect major functions or disciplines ▪ Drives programs that impact markets of customers and consumers
Minimum Experience Required: ▪ 3+ years of business or systems analysis experience ▪ Proven understanding of database modeling concepts: entities/tables, relations/constraints, attribute data types and column data times
Skills Required: ▪ Intermediate MS access proficiency ▪ Proficiency with all UnitedHealthcare provider data systems (NDB) and claims platforms (UNET, PULSE, CSP Facets, COSMOS, Impact, FICAS) used in the region ▪ Proficiency with multiple auditing tools, such as Examiner and Danner ▪ High attention to details ▪ Proven organization skills and able to work independently ▪ Excellent verbal and written communication skills; ability to speak clearly and concisely, conveying complex or technical information in a manner that others can understand; ability to understand and interpret complex information from others, including, but not limited to, reimbursement policy standards ▪ Proven interpersonal skills, establishing rapport and working well with others
Are there any educational requirements for this position? **[X] Yes [ ] No** **If yes, list below:** ▪ Bachelor's degree 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?
[X] Yes [ ] No

If yes, list below:

- Annual Compliance Training (includes the topics of Fraud, Waste and Abuse and Code of Conduct)
- Safe and Secure with Me – Privacy and Security Annual Training
- Cultural Competency
- MississippiCAN and CHIP contract changes, when applicable
- Organizational Conflicts of Interest
- Doing Business with U.S. Governments Overview
- Special Needs Plan Model of Care Training
- SMART Goals
- Contract requirements/updates, when needed
- Specific functional training updates, when needed

Any additional information relevant to this position:

- N/A

Key Position: Job Description
Title of Position: Clinical Pharmacist
Description of Position: The clinical pharmacist has overall responsibility for instituting and coordinating all components of the pharmacy program for the health plan. This includes formulary development and consultation, drug rebates, drug UM activities, member and provider pharmacy issue resolution management, pharmacy network support, adherence to health plan policies and procedures and regulatory requirements, assisting with integrated care activities, and attendance at all relevant meetings with health plan and external meetings.
Description of Responsibilities of Position: ▪ Institutes and coordinates management of the pharmacy program benefit, working with local leadership and regional/national pharmacy teams, including our pharmacy benefit manager (PBM) ▪ Attends the Agency's Pharmacy Committee and Drug Utilization meetings ▪ Coordinates with clinical teams (including behavioral health) for an interdisciplinary approach to health care delivery, quality and management of care ▪ Ensures all contractual and regulatory requirements are met for the health plan's pharmacy benefit programs ▪ Manages high-cost specialty drug use; helps coordinate and manage the pharmacy portion of care for chronic/high-risk/high-cost members
Minimum Experience Required: ▪ Experience in pharmacy managed care and/or pharmacy UM preferred ▪ Expertise in pharmacy coding, claims and reimbursement, medication management and formulary development preferred
Skills Required: ▪ Completion of a managed care pharmacy residency ▪ Experience with writing/developing utilization management criteria for physician administered medications ▪ Proven analytical skills with an ability to sift through data and identify solutions to solve problems ▪ Project management skills ▪ Solid organizational skills with the ability to balance multiple tasks and both accept direction, and self-manage daily activities ▪ Ability to build internal and external relationships with key stakeholders ▪ Skilled communicator with an ability to adapt written and verbal communications to needs of audience ▪ Ability to work both independently and within a matrixed team environment to deliver objectives within an established timeline
Are there any educational requirements for this position? **[X] Yes [ ] No** **If yes, list below:** ▪ Bachelor of Science or Pharm.D. from an accredited college or university required ▪ Master's degree preferred
Are any professional licenses or certifications required for this position? **[X] Yes [ ] No** **If yes, list below:** ▪ Mississippi-licensed pharmacist with at least 5 years of experience in pharmacy (any setting)

Are there any continuing education requirements for this position?
[X] Yes [ ] No

If yes, list below:

- Annual Compliance Training (includes the topics of Fraud, Waste and Abuse and Code of Conduct)
- Safe and Secure with Me – Privacy and Security Annual Training
- Cultural Competency
- MississippiCAN and CHIP contract changes, when applicable
- Organizational Conflicts of Interest
- Doing Business with U.S. Governments Overview
- Special Needs Plan Model of Care Training
- SMART Goals
- Contract requirements/updates, when needed
- Specific functional training updates, when needed

Any additional information relevant to this position:

- N/A

Additional Staff Requirements: Job Description
Title of Position: Health Equity Director
Description of Position: The health equity director is responsible for providing visionary leadership and contributes to the successful advancement of culture, health equity and social responsibility principles. This senior level Mississippi-based position has accountability for building and deploying initiatives that address SDOH needs of members and communities, advance health equity, reduce disparities and reduce implicit, explicit and institutional bias experienced by people of color. This leader will work with internal and external partners to build solutions to reduce those disparities.
Description of Responsibilities of Position: ▪ Builds and deploys strategies and initiatives that identify and reduce implicit, explicit and institutional bias experienced by people of color ▪ Consults and aligns with Division partners and constituents serving as Community & State Mississippi health plan link to established enterprise communities (such as Culture Ambassadors and I&D Councils and other emerging groups) and deploys those efforts within Mississippi health plan, as appropriate, to enhance culture, health equity and social responsibility ▪ Identifies health disparities experienced by MississippiCAN and CHIP populations, and works with internal and external partners to build solutions that address and reduce those disparities ▪ Demonstrates organizational agility and understands how the business operates and can identify and interpret business levers. Creates experiences that shape and grow the organizations' culture programs and capabilities ▪ Develops emerging capabilities and keeps pace with the changing nature of Culture and Health Equity within and outside of UnitedHealth Group. Develops and deploys a Culture and Health Equity success profile, and a transfer of competence skill and competency building model to equip people to make a positive impact on Culture and Health Equity ▪ Drives engagement and identifies and seeks opportunities to celebrate and communicate Culture, Health Equity and Social Responsibility to enable active change agents throughout the organization, especially within the care delivery organizations
Minimum Experience Required: ▪ 5+ years of experience leading and developing broad scale organizational/enterprise diversity, inclusion and equity strategies ▪ 5+ years of experience interfacing with senior leadership team ▪ Experience addressing health disparity and/or health equity concerns ▪ Experience and knowledge of change management principles, methodologies and tools ▪ Experience working with Medicaid and/or Medicare programs preferred ▪ Experience working in a matrix environment preferred ▪ Experience working with and influencing all levels of employees; inspiring others to engage, participate and act preferred ▪ Excellent communication skills — verbal, interpersonal, presentation, and facilitation along with written message development preferred ▪ Proven track record of effectively managing conflict, resolving issues, mitigating risks and influencing leaders preferred
Skills Required: ▪ Proficiency in MS Office Suite ▪ Excellent communication skills, both written and verbal ▪ Solid data analysis and interpretation skills; ability to focus on key metrics ▪ Ability to prioritize and meet deadlines ▪ Ability to work independently and remain on task ▪ Good organization and planning skills
Are there any educational requirements for this position? **[X] Yes [ ] No** **If yes, list below:** ▪ Bachelor's degree or equivalent years of experience ▪ Master's degree in business/healthcare administration, public health or related field 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?
[X] Yes [ ] No

If yes, list below:

- Annual Compliance Training (includes the topics of Fraud, Waste and Abuse and Code of Conduct)
- Safe and Secure with Me – Privacy and Security Annual Training
- Cultural Competency
- MississippiCAN and CHIP contract changes, when applicable
- Organizational Conflicts of Interest
- Doing Business with U.S. Governments Overview
- Special Needs Plan Model of Care Training
- SMART Goals
- Contract requirements/updates, when needed
- Specific functional training updates, as needed

Any additional information relevant to this position:

- **N/A**

Additional Staff Requirements: Job Description

Title of Position: Operations Director

Description of Position: The operations director drives solid operational performance by using an account management approach. Responsibilities include, but are not limited to achieving and maintaining of a reference account, promoting operational excellence, developing collaborative relationships across the enterprise and with the Division and providing thought leadership/innovation. This role reports to the regional operations, performance and alignment leader with matrix accountability to the health plan CEO.

Description of Responsibilities of Position:

- Learns the Division Contractual/Market/Member Benefit Requirements in partnership with Compliance to drive understanding and accountability
- Builds strong relationships with matrix partners (including Claims, Member/Provider Call, Provider Operations, Appeals and Grievances, Enrollment/Eligibility, Encounters, IT, Provider/ Member Experience, Clinical, Quality) to build an account team manages key health plan strategic initiatives, goals and activities
- Ensures that our processes meet both contract requirements and UnitedHealth Group processes, resolving conflicts as they arise
- Analyzes metrics and trends to ensure contractual requirements are met
- Drives performance excellence and accountability by eliminating barriers to improve performance
- Identifies opportunities for innovation, productivity improvement and affordability
- Performs special projects as assigned

Minimum Experience Required:

- 5+ years' in-depth managed care health plan operations experience, including, but not limited to, claims, member/provider call center, enrollment and/or eligibility, and provider operations
- 5+ years of experience managing multiple projects/tasks to meet contractual deadlines or other time-sensitive commitments
- 5+ years' demonstrated experience working in a highly matrixed environment
- 5+ years' demonstrated experience managing and driving team performance
- Experience with project management preferred

Skills Required:

- Proficiency in MS Office Suite
- Excellent communication skills, both written and verbal
- Solid data analysis and interpretation skills; ability to focus on key metrics
- Ability to prioritize and meet deadlines
- High attention to details
- Ability to work independently and remain on task
- Good organization and planning skills

Are there any educational requirements for this position?
[X] Yes [ ] No

If yes, list below:

- Bachelor's degree 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?
[X] Yes [ ] No

If yes, list below:

- Annual Compliance Training (includes the topics of Fraud, Waste and Abuse and Code of Conduct)
- Safe and Secure with Me – Privacy and Security Annual Training
- Cultural Competency
- MississippiCAN and CHIP contract changes, when applicable
- Organizational Conflicts of Interest
- Doing Business with U.S. Governments Overview
- Special Needs Plan Model of Care Training
- SMART Goals
- Contract requirements/updates, when needed
- Specific functional training updates, as needed

Any additional information relevant to this position:

- N/A

Additional Staff Requirements: Job Description

Title of Position: Associate Director of Claims and Business Process

Description of Position: The associate director of claims and business process ensures we meet or exceed Medicaid encounter requirements and internal goals for Mississippi. Time is split between both detailed encounter analysis work and the work of leading a team, including developing the team, identifying risks to goals and commitments, and escalating those to break down barriers and drive resolution. Communication is a key focus at this position and includes modifying to suit the audience. This position is empowered to make independent business decisions.

Description of Responsibilities of Position:

- Manages overall business direction for a team with the mission of achieving encounter contractual compliance and internal business goals
- Manages direct reports, setting direction of training and mentoring for team and providing training and mentoring to individuals
- Identifies risks to compliance and/or internal goal achievement and escalating effectively to break down barriers and drive resolution, adapting business plans and priorities as needed to address business and operational challenges
- Owns end-to-end business process activities, creating, controlling and improving business processes
- Develops and demonstrates advanced encounter knowledge across three or more states, advising team on encounter bypasses and rejects and encounter issue root causes as needed (not performing day-to-day corrections)
- Manage the implementation of encounter requirements and ensures expected results are achieved
- Manages operational participation in encounter technology projects, prioritizing and making business decisions
- Manages encounter corrections with information technology team
- Owns collaborative relationships with internal partners impacting encounters, with health plan customers and with state customers
- Use deep communication and storytelling skills and manages relationships to achieve desired outcomes; includes summarizing for leaders
- Uses status reporting (includes contractual requirement measurements, financial completeness reports and financial completeness plans) to identify new issues, for prioritizing work, and for communicating status to health plan leadership
- Leads or participates in regular meetings with health plans; includes providing clear issue analysis with examples to get assistance on resolution from internal partners or the state, knowing which data is relevant for the audience

Minimum Experience Required:

- Experience leading and developing team, including 1+ year leading direct reports
- 5+ years of project/program management, managing multiple work streams
- Health care operations/health insurance experience preferred
- Experience with Medicaid encounters and/or Medicaid claims preferred
- Experience analyzing data, including experience working with and analyzing large quantities of data preferred
- Working knowledge of relational databases and experience using at least one data query language (e.g., PL/SQL) preferred
- Prior experience with continuous process evaluation and improvement preferred

Skills Required:

- Demonstrated experience managing team through changing priorities and ambiguity
- Demonstrated ability to communicate effectively across internal functional leaders and teams and with external stakeholders
- Intermediate level of proficiency working with MS Excel (creating pivot tables, formulas and functions, V-lookups, manipulating large data sets)

Are there any educational requirements for this position?
[X] Yes [ ] No

If yes, list below:
- Bachelor's degree

Are any professional licenses or certifications required for this position?
[ ] Yes [X] No

If yes, list below:

Are there any continuing education requirements for this position?
[X] Yes [ ] No

If yes, list below:
- Annual Compliance Training (includes the topics of Fraud, Waste and Abuse and Code of Conduct)
- Safe and Secure with Me – Privacy and Security Annual Training
- Cultural Competency
- MississippiCAN and CHIP contract changes, when applicable
- Organizational Conflicts of Interest
- Doing Business with U.S. Governments Overview
- Special Needs Plan Model of Care Training
- SMART Goals
- Contract requirements/updates, when needed
- Specific functional training updates, when needed

Any additional information relevant to this position:
- N/A

Additional Staff Requirements: Job Description
Title of Position: Care Management Manager
Description of Position: Care management managers lead a team of health and social services coordinators, while overseeing day-to-day clinical operations and participating in business development activities. Care managers manage a program or region, including team and performance management, process improvement, and standardized execution of clinical decision processes, and implementation of new program initiatives. Complying with contractual requirements and ensuring member needs are met.
Description of Responsibilities of Position: ▪ Selects, manages, develops, mentors and supports staff in designated department or region ▪ Develops clear goals and objectives for performance management and effectively communicates expectations, and holds the team accountable for results ▪ To meet the unique needs of our members, has an intimate understanding of the contractual requirements ▪ Identifies, selects, structures and prioritizes process improvement projects, ultimately implementing changes to meet program requirements ▪ Ensures standardized execution of workflow processes, including conducting performance audits, quality reviews and compliance adherence ▪ Acts as regional interface with other departments to coordinate workflow processes and implementation plans ▪ Resolves inpatient and outpatient provider authorizations and collaborates with provider relations to assist in provider resolutions ▪ Participates in training and coaching of direct reports, as needed ▪ Conducts bi-annual field visits with direct reports to observe, provide areas of teaching, address issues and concerns, and foster a good working relationship ▪ Collaborates across Optum and UnitedHealth Group and interacts with medical directors, site directors, senior leaders, network, marketing, account management, quality, product and other stakeholders ▪ Reviews and disseminates inpatient census report for nursing facility case
Minimum Experience Required: ▪ 3+ years of clinical case management experience commensurate with the MississippiCAN and CHIP populations ▪ 5+ years of experience working in a health care environment ▪ 3+ years of experience in case management within the health care industry ▪ Demonstrated management experience with responsibility for team performance management ▪ Previous experience analyzing and making recommendations for process improvement ▪ 3+ years of case management leadership experience within a health care industry
Skills Required: ▪ Demonstrated management experience with responsibility for team performance management ▪ Intermediate skills with MS Office, including Word, Excel and Outlook, with proficient ability to navigate in a Windows environment ▪ Ability to prioritize and meet deadlines ▪ High attention to details ▪ Exceptional presentation, written and verbal communication skills ▪ Ability to work independently and remain on task ▪ Good organization and planning skills ▪ Proven interpersonal skills, establishing rapport and working well with others

Are there any educational requirements for this position?
[X] Yes [ ] No

If yes, list below:
- Bachelor's degree in nursing
- Registered nurse or licensed social worker in the state of Mississippi

Are any professional licenses or certifications required for this position?
[X] Yes [ ] No

If yes, list below:
- Must have a current and unrestricted RN license in the state of Mississippi
- Commensurate with the population they serve, care managers must have education, certification or licensure in addition to or in place of an RN, such as Bachelor of Social Work, Master of Social Work, therapist or occupational therapist. The license or certification must be from an active, in-state accreditation organization

Are there any continuing education requirements for this position?
[X] Yes [ ] No

If yes, list below:
- Annual Compliance Training (includes the topics of Fraud, Waste and Abuse and Code of Conduct)
- Safe and Secure with Me – Privacy and Security Annual Training
- Cultural Competency
- MississippiCAN and CHIP contract changes, when applicable
- Organizational Conflicts of Interest
- Doing Business with U.S. Governments Overview
- Special Needs Plan Model of Care Training
- SMART Goals
- Contract requirements/updates, when needed
- Specific functional training updates, as needed

Any additional information relevant to this position:
- N/A

Additional Staff Requirements: Job Description
Title of Position: Community Health Worker
Description of Position: Community health workers (CHWs) are the liaisons with Medicaid members to ensure appropriate care is accessed and to provide home and social assessments and member education. CHWs work in a team-based structure and spend the majority of their time in the community engaging directly with members. Interest in learning to work with medically complex patients who may be experiencing significant addiction and/or behavioral health conditions is important for this role.
Description of Responsibilities of Position: ▪ Creates a positive experience and relationship with the member ▪ Helps member set goals and develops a care plan to achieve those goals ▪ Proactively engages the member to manage their own health and health care ▪ Supports the member to improve their well-being by staying out of the hospital, and attend regular visits to their primary physician ▪ As needed, helps the member engage with mental health and substance use treatment ▪ Supports the member to ensure pickup of their prescriptions ▪ Provides member education on community resources and benefits ▪ Conducts post-discharge activities from hospital facility and support connection to social services ▪ Supports member to engage in work or volunteer activities, if desired, and develop stronger social supports through deeper connections with friends, family and their community ▪ Partners with care team (community, providers, internal staff) ▪ Knowledge and continued learning of community cultures and values ▪ May conduct initial Health Risk Screening and Comprehensive Health Assessment, if needed
Minimum Experience Required: ▪ 2+ years working in a case management role ▪ Previous care management experience ▪ Experience working in managed care preferred ▪ Knowledge of Medicaid and/or Medicare population preferred
Skills Required: ▪ Ability to navigate a PC to open applications, send emails and conduct data entry ▪ Basic proficiency with MS Word, Excel, PowerPoint and Access ▪ Proven interpersonal skills, establishing rapport and working well with others ▪ Ability to work independently and remain on task ▪ Good organization and planning skills
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:** ▪ CHW Accreditation preferred

Are there any continuing education requirements for this position?
[X] Yes [ ] No

If yes, list below:

- Annual Compliance Training (includes the topics of Fraud, Waste and Abuse and Code of Conduct)
- Safe and Secure with Me – Privacy and Security Annual Training
- Cultural Competency
- MississippiCAN and CHIP contract changes, when applicable
- Organizational Conflicts of Interest
- Doing Business with U.S. Governments Overview
- Special Needs Plan Model of Care Training
- SMART Goals
- Contract requirements/updates, when needed
- Specific functional training updates, as needed

Any additional information relevant to this position:

- Ability to travel locally up to 70% of the time

Additional Staff Requirements: Job Description
Title of Position: Spiritual Support
Description of Position: The spiritual support staff will be responsible for providing spiritual care and chaplaincy services and informing members about our spiritual care program, acknowledging this important component of overall well-being.
Description of Responsibilities of Position: ▪ Actively participates in the delivery of spiritual care adhering to the Standards of Practice of a nationally recognized certifying body and the principles and practices of Outcome-Oriented Chaplaincy ▪ Responds to requests for spiritual care in a timely manner ▪ Creates processes and plans to respond with support when members are in crisis ▪ Participates in regular professional development activities and supervision ▪ Advocates for spiritual care/person-centeredness in each professional interaction ▪ Maintains accurate and confidential records of spiritual care activity to consistently communicate concrete efforts, metrics and outcomes ▪ Coordinates with health plan leaders to ensure consistent communication and process ▪ Creates didactic content as a subject matter expert in chaplaincy-related arenas
Minimum Experience Required: ▪ Have a strong background in serving a complex health population (medical/behavioral/learning), as well as work with serious illness and end of life (preferred) ▪ 5 years of experience in professional chaplaincy ▪ Experience dealing with patients diagnosed with complex conditions, including mental and behavioral health conditions, end of life and serious illness
Skills Required: ▪ Performance driven: sets and takes accountability for achievement of development objectives ▪ Solid organization, management, administrative and human relation skills, and a style, which exhibits maturity, leadership, sensitivity and teamwork ▪ Communicates and leads in a manner that fosters collaboration, greater understanding, employee experience and commitment to results ▪ Proven interpersonal skills, establishing rapport and working well with others ▪ High attention to details ▪ Ability to manage multiple priorities ▪ Ability to work independently and collaboratively in a complex, demanding environment ▪ Ability to establish trust, rapport and relationship ▪ Maintain confidentiality of spiritual care provided to staff, while still advocating, educating and communicating the unique impact of chaplaincy care
Are there any educational requirements for this position? **[X] Yes [ ] No** **If yes, list below:** ▪ Master's degree in chaplaincy-related studies ▪ A minimum of 1,600 hours of Clinical Pastoral Education (accredited by the United States Department of Education) ▪ More than 200 hours of additional continuing education relevant to chaplaincy
Are any professional licenses or certifications required for this position? **[X] Yes [ ] No** **If yes, list below:** ▪ Board-certified as a chaplain through a nationally recognized chaplaincy certification body

Are there any continuing education requirements for this position?
[X] Yes [ ] No

If yes, list below:

- Annual Compliance Training, including Fraud, Waste and Abuse and Code of Conduct
- Safe and Secure with Me – Privacy and Security Annual Training
- Cultural Competency
- MississippiCAN and CHIP contract changes, when applicable
- Organizational Conflicts of Interest
- Doing Business with U.S. Governments Overview
- Special Needs Plan Model of Care Training
- SMART Goals
- Contract requirements/updates, when needed
- Specific functional training updates, as needed

Any additional information relevant to this position:

- N/A

Additional Staff Requirements: Job Description
Title of Position: Clinical Coordinator-RN
Description of Position: The clinical coordinator-RN is an essential element of an Integrated Care Model by relaying the pertinent information about the member needs and advocating for the best possible care available, and ensuring they have the right services to meet their needs.
Description of Responsibilities of Position: ▪ Assesses, plans and implements care strategies that are individualized by patient and directed toward the most appropriate, lease restrictive level of care ▪ Identifies and initiates referrals for social service programs; including financial, psychosocial, community and state supportive services ▪ Manages the care plan throughout the continuum of care as a single point of contact ▪ Communicates with all stakeholders the required health-related information to ensure quality coordinated care and services are provided expeditiously to all members ▪ Advocates for patients and families, as needed, to ensure the patient's needs and choices are fully represented and supported by the health care team
Minimum Experience Required: ▪ 4+ years of experience working within the community health setting in a health care role ▪ Experience in long-term care, home health, hospice, public health or assisted living ▪ Proficient working with MS Word, Excel and Outlook ▪ Ability to travel in assigned region to visit Medicaid members in their homes and/or other settings, including community centers, hospitals or providers' offices ▪ Prior field-based work experience
Skills Required: ▪ Proficiency with MS Word, Excel, PowerPoint and Access ▪ Ability to prioritize and meet deadlines ▪ Proven interpersonal skills, establishing rapport and working well with others ▪ High attention to details ▪ Exceptional presentation, written and verbal communication skills ▪ Ability to work independently and remain on task ▪ Good organization and planning skills
Are there any educational requirements for this position? **[X] Yes [ ] No** **If yes, list below:** ▪ Associate degree
Are any professional licenses or certifications required for this position? **[ ] Yes [X] No** **If yes, list below:** ▪ Licensed Practical Nurse (LPN), Certified Nursing Assistant/Home Health Aide, Certified Medical Assistant ▪ Commensurate with the population they serve, clinical coordinators must have education, certification or licensure in addition to or in place of an RN, such as Bachelor of Social Work, Master of Social Work, Respiratory Therapist, Dietician, Nutritionist or Occupational Therapist. If licensed or certified, the license or certification must be from an active, in-state accreditation organization

Are there any continuing education requirements for this position?
[X] Yes [ ] No

If yes, list below:

- Annual Compliance Training (includes the topics of Fraud, Waste and Abuse and Code of Conduct)
- Safe and Secure with Me – Privacy and Security Annual Training
- Cultural Competency
- MississippiCAN and CHIP contract changes, when applicable
- Organizational Conflicts of Interest
- Doing Business with U.S. Governments Overview
- Special Needs Plan Model of Care Training
- SMART Goals
- Contract requirements/updates, when needed
- Specific functional training updates, as needed

Any additional information relevant to this position:

- N/A

Additional Staff Requirements: Job Description

Title of Position: Clinical Administrative Coordinator (CAC)

Description of Position: The clinical administrative coordinator (CAC) is a key component in customer satisfaction and has a responsibility to make every contact informative, productive and positive for our members and providers. The CACs do live outreach, educating members about program benefits and services while also helping to manage member cases.

Description of Responsibilities of Position:

- Calls members and verifies medical services that have been performed
- Calls providers to start services for the members
- Files all medical paperwork and faxes electronically
- Responds to incoming service coordinator calls/emails and resolves inquiries
- Mails out documents to the member
- Other duties as assigned

Minimum Experience Required:

- 2+ years of customer service experience
- Experience working within the health care industry preferred
- Experience working with health care insurance preferred
- Experience working with Medicare and/or Medicaid Services preferred
- Experience working in a call center environment preferred
- Professional experience in a clerical or administrative support related role preferred
- Triage experience preferred
- Working knowledge of medical terminology to communicate with members and providers preferred

Skills Required:

- Experience navigating a PC and utilizing Microsoft Office (Word, Excel, and Outlook) in a professional setting
- Bilingual English/Spanish-preferred

Are there any educational requirements for this position?
[X] Yes [ ] No

If yes, list below:

- High School Diploma/GED

Are any professional licenses or certifications required for this position?
[X] Yes [ ] No

If yes, list below:

-

Are there any continuing education requirements for this position?
[X] Yes [ ] No

If yes, list below:

- Annual Compliance Training, including Fraud, Waste and Abuse and Code of Conduct
- Safe and Secure with Me – Privacy and Security Annual Training
- Cultural Competency
- MississippiCAN and CHIP contract changes, when applicable
- Organizational Conflicts of Interest
- Doing Business with U.S. Governments Overview
- Special Needs Plan Model of Care Training
- SMART Goals
- Contract requirements/updates, when needed
- Specific functional training updates, as needed

Any additional information relevant to this position:

- N/A

Additional Staff Requirements: Job Description

Title of Position: Peer Support Specialist

Description of Position: The peer support specialist is specifically charged with assisting consumers and families daily, communicating with families and consumers to encourage their engagement, recruiting family members and consumers to serve on committees and task forces, and maintaining excellent relationships with all consumer- and family-run services and programs.

Description of Responsibilities of Position:

- Uses their own recovery experience and training to assist families and consumers with defining their recovery goals, and developing the skills and knowledge needed for the consumer's healing
- Supports the creation and assists with the implementation of a comprehensive training and education program with peers, families, providers and staff
- Establishes and maintains strong collaborative relationships with existing consumer and family organizations, so members of those organizations become actively involved with the health plan
- Communicates plan information to consumers and consumer-operated organizations and with families and family organizations
- Identifies and outreaches to community and leaders of ethnic minority groups to identify and develop programs that are both culturally competent and that use recovery and resiliency
- As directed, serves as a designated member of internal subcommittees
- Assists and supports consumers and family members with grievance processes
- Collaborates with care managers, providers, and community agencies and organizations to facilitate access to and transition between services
- Collaborates with care managers, providers, and community agencies and organizations to identify consumers who may benefit from peer support
- Provides feedback about treatment planning development based on their interactions with other consumers and families
- Advocates on behalf of the consumers and families
- Provides peer support to consumers and family members at critical points in their treatment

Minimum Experience Required:

- 1+ year of working knowledge of community resources
- Completed the Mississippi Certified Peer Support training and certification process
- Demonstrated understanding of the principles of recovery and resiliency
- Reliable transportation, with a current and nonrestricted driver's license and state-required insurance

Skills Required:

- Background in managing populations with complex medical or behavioral health needs
- Experience with electronic charting
- Experience with arranging community resources

Are there any educational requirements for this position?
[X] Yes [ ] No

If yes, list below:

- High School Diploma/GED
- Bachelor's degree in psychology, social work, counseling or a related field; or registered psychiatric nurse is preferred

Are any professional licenses or certifications required for this position?
[X] Yes [ ] No

If yes, list below:

- Registered nurse, licensed social worker and/or behavioral health or clinical degree preferred

Are there any continuing education requirements for this position?
[X] Yes [ ] No

If yes, list below:

- Annual Compliance Training (includes the topics of Fraud, Waste and Abuse and Code of Conduct)
- Safe and Secure with Me – Privacy and Security Annual Training
- Cultural Competency
- MississippiCAN and CHIP contract changes, when applicable
- Organizational Conflicts of Interest
- Doing Business with U.S. Governments Overview
- Special Needs Plan Model of Care Training
- SMART Goals
- Contract requirements/updates, when needed
- Specific functional training updates, as needed

Any additional information relevant to this position:

- N/A

Additional Staff Requirements: Job Description

Title of Position: Recovery and Resiliency Manager

Description of Position: The recovery and resiliency (R&R) manager has direct oversight and accountability for the supervision of the R&R unit, which includes the on-staff peer support specialists. The R&R unit is responsible for developing peer-based programs and services that enhance the consumer engagement and help the consumer reach their recovery goals. The R&R manager ensures all recovery markets adhere and execute to contractual requirements, such as development and delivery of contractual recovery trainings, ensuring community integration, market performance and development, conducting training needs analysis across multiple platforms and implementing changes and modifications as necessary.

Description of Responsibilities of Position:

- Supervises on-staff peer support specialists
- Facilitates, monitors and/or evaluates market-specific training programs
- Assesses and interprets market gaps and opportunities
- Evaluates, assesses and reports on staff performance
- Creates and implements a comprehensive training and education program for peers, families, providers and staff
- Establishes strong collaborative relationships with existing consumer and family organizations, such as local NAMI and Mental Health American chapters. Promotes and facilitates active engagement with these organizations at state and national level
- Adapts departmental plans and priorities to address business and operational challenges
- Acts in advisory capacity to support departmental collaboration with product and sales partners as it relates to recovery initiatives
- Performs new hire onboarding for on-staff peer support specialists
- Recruits consumers and families to participate in the ongoing identification of best and promising practices to be used as the foundation for system change initiatives as required
- Expands opportunities for the provision of peer support, including assisting providers to expand their current Medicaid-reimbursable responsibilities and identifying community-based services to fill existing needs while simultaneously offering new opportunities for peer support services

Minimum Experience Required:

- 3+ years' experience organizing leading educational programs and events
- 3+ years' experience in community health/SUD programs
- 3+ years' supervisory/leadership experience

Skills Required:

- Proficient with Microsoft Office (Word, Excel and Outlook)
- Proven interpersonal skills, establishing rapport and working well with others
- High attention to details

Are there any educational requirements for this position?
[X] Yes [ ] No

If yes, list below:

- College degree or equivalent employment and life experience

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?
[X] Yes [ ] No

If yes, list below:

- Annual Compliance Training, including Fraud, Waste and Abuse and Code of Conduct
- Safe and Secure with Me – Privacy and Security Annual Training
- Cultural Competency
- MississippiCAN and CHIP contract changes, when applicable
- Organizational Conflicts of Interest
- Doing Business with U.S. Governments Overview
- Special Needs Plan Model of Care Training
- SMART Goals
- Contract requirements/updates, when needed
- Specific functional training updates, as needed

Any additional information relevant to this position:

- N/A

Additional Staff Requirements: Job Description
Title of Position: Clinical Coordinator – Behavioral Health (BH)
Description of Position: The clinical coordinator – behavioral health helps individuals live their lives to the fullest by promoting recovery and resiliency via coordination and collaboration with multiple internal and external partners including consumers and their families/caregivers, medical, behavioral health and clinical network teams. They work with complex and high-risk needs with a goal of engaging the consumer in the treatment process, decreasing their reliance on higher levels of care, helping them to access appropriate community services, and assisting them in improving community tenure.
Description of Responsibilities of Position: ▪ Uses advanced clinical skills to engage and motivate consumers via a recovery, health and wellness-oriented approach ▪ Assists consumers and their families/caregivers with connections to appropriate psychiatric, medical, and psychosocial referrals and services ▪ Identifies and removes barriers to procurement, delivery, participation in and success of services ▪ Provides supportive follow-up, monitoring and education as indicated, in-person and telephonically ▪ Meets with consumers in-person at facilities, provider offices and in homes, as appropriate ▪ Partners with designated external providers, programs, entities to address the needs, gaps in care, and recovery goals of complex and high-risk consumers ▪ Identifies and addresses the needs of members who are consistently high utilizers of services through case conferences and informal communications ▪ Establishes and fosters positive relationships with medical team and participates in medical-behavioral integration activities and discussions ▪ Identifies high-risk, comorbid needs of consumers
Minimum Experience Required: ▪ 2+ years of experience in a related behavioral health setting ▪ Computer/typing proficiency to enter/retrieve data in electronic clinical records; experience with email, internet research, use of online calendars and other software applications ▪ Access to high-speed internet from home ▪ Reliable transportation and the ability to travel as needed, up to 50% ▪ Experience in an inpatient setting preferred ▪ Dual diagnosis experience with mental health and substance abuse preferred ▪ Experience in a community mental health setting preferred ▪ Experience working in an environment that required coordination of benefits and utilization of multiple groups and resources for patients preferred ▪ Previous experience in a managed care environment preferred ▪ Experience with the Medicaid/Medicare population preferred ▪ Bilingual skills (fluency in Spanish/English) preferred
Skills Required: ▪ Proficiency in MS Office Suite ▪ Proven interpersonal skills, establishing rapport and working well with others ▪ Excellent communication skills, both written and verbal
Are there any educational requirements for this position? **[X] Yes [ ] No** **If yes, list below:** ▪ Licensed master's degree in psychology, social work, counseling or marriage or family counseling, or licensed Ph.D., or an RN with 2 or more years of experience in behavioral health

Are any professional licenses or certifications required for this position?
[X] Yes [ ] No

If yes, list below:

- Current, unrestricted license to practice in the state of residence

Are there any continuing education requirements for this position?
[X] Yes [ ] No

If yes, list below:

- Annual Compliance Training, including topics of Fraud, Waste and Abuse and Code of Conduct
- Safe and Secure with Me – Privacy and Security Annual Training
- Cultural Competency
- MississippiCAN and CHIP contract changes, when applicable
- Organizational Conflicts of Interest
- Doing Business with U.S. Governments Overview
- Special Needs Plan Model of Care Training
- SMART Goals
- Contract requirements/updates, when needed
- Specific functional training updates, as needed

Any additional information relevant to this position:

- N/A

Additional Staff Requirements: Job Description
Title of Position: Network Provider Services Team
Description of Position: The network provider services team is accountable for the full range of provider relations and service interactions within UnitedHealthcare, including working on end-to-end provider claim and call quality, ease-of-use of provider portal and future service enhancements, and training and development of external provider education programs.
Description of Responsibilities of Position: ▪ Designs and implements programs to build and nurture positive relationships between the health plan, providers (physician, hospital, ancillary, etc.) and practice managers ▪ Identifies gaps in network composition and services to assist the network contracting and development staff in prioritizing contracting needs ▪ Conducts activities related to contracting, credentialing and setup of new providers ▪ Validates correct payments through claims testing procedures prior to release to production ▪ Develops and executes provider communications ▪ Develops and executes provider education sessions and training ▪ May be involved in identifying and remediating operational shortfalls and researching and remediating claims
Minimum Experience Required: ▪ Past experience in working with physician practices in administrative management, support, service, consulting or similar role ▪ Extensive knowledge of medical practice administration and operations ▪ Familiarity with medical practice diagnosis and procedure coding ▪ Ability to interpret and use financial and utilization analysis reports in development of network performance optimization plans
Skills Required: ▪ Intermediate proficiency with MS Word, Excel, PowerPoint and Access ▪ Ability to prioritize and meet deadlines from multiple provider groups ▪ Proven interpersonal skills, establishing rapport and working well with others ▪ High attention to details ▪ Exceptional presentation, written and verbal communication skills ▪ Ability to work independently and remain on task ▪ Good organization and planning skills
Are there any educational requirements for this position? **[X] Yes [ ] No** **If yes, list below:** ▪ Undergraduate degree 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?
[X] Yes [ ] No

If yes, list below:

- Annual Compliance Training (includes the topics of Fraud, Waste and Abuse and Code of Conduct)
- Safe and Secure with Me – Privacy and Security Annual Training
- Cultural Competency
- MississippiCAN and CHIP contract changes, when applicable
- Organizational Conflicts of Interest
- Doing Business with U.S. Governments Overview
- Special Needs Plan Model of Care Training
- SMART Goals
- Contract requirements/updates, when needed
- Specific functional training updates, when needed

Any additional information relevant to this position:

- N/A

Additional Staff Requirements: Job Description

Title of Position: Outreach Coordinator

Description of Position: The outreach coordinator oversees the development of market strategies to support outreach initiatives and drive membership retention. They raise public awareness of benefits and services. They do this by developing relationships with key stakeholders including community-based organizations (CBOs), providers, faith-based organization, small businesses and educational institutions, leveraging those relationships to engage individuals in need of services. The coordinator will direct the health plan's community relations and member outreach activities specific to MississippiCAN and CHIP and in compliance with contractual requirements. The coordinator develops member marketing and outreach initiatives and collaborates with internal and local community partners to carry out member marketing and outreach activities.

Description of Responsibilities of Position:

- Identifies stakeholders in service areas who may be viable partners in efforts to identify persons eligible for Medicaid
- Introduces the community to wellness programs that bring added value to the community and our partners
- Identifies and coordinates participation in community events where we can provide information to persons needing health insurance
- Works collaboratively with partners on special projects, such as closing gaps in care, flu prevention, immunizations, well-child visits and health awareness campaigns
- Works with members and providers to ensure consistent communication to Division-specific recertification processes
- Conducts outreach to the provider community to educate them on quality programs and incentives
- Develops relationships and partners with local charitable groups and organizations to support various causes in our community including community walks, coat/food drives and volunteer opportunities
- Develops presentations and materials for stakeholder meetings

Minimum Experience Required:

- 2+ years of managed care/outreach experience
- Experience in event planning and execution
- Must have a dependable vehicle and current driver's license

Skills Required:

- Proficiency with MS Word, Excel, PowerPoint and Access
- Ability to prioritize and meet deadlines
- High attention to details
- Exceptional presentation, written and verbal communication skills
- Ability to work independently and remain on task
- Good organization and planning skills
- Proven interpersonal skills, establishing rapport and working well with others

Are there any educational requirements for this position?
[X] Yes [ ] No

If yes, list below:

- Undergraduate degree 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?
[X] Yes [ ] No

If yes, list below:

- Annual Compliance Training, including topics of Fraud, Waste and Abuse and Code of Conduct
- Safe and Secure with Me – Privacy and Security Annual Training
- Cultural Competency
- MississippiCAN and CHIP contract changes, when applicable
- Organizational Conflicts of Interest
- Doing Business with U.S. Governments Overview
- Special Needs Plan Model of Care Training
- SMART Goals
- Contract requirements/updates, when needed
- Specific functional training updates, when needed

Any additional information relevant to this position:

- N/A

Additional Staff Requirements: Job Description

Title of Position: Service Navigator (Navigate4Me)

Description of Position: Service Navigators serve as the primary point of contact for all customer service issues. Day-to-day functions include inbound and outbound calls with assigned members and member account research with focus on issue resolution. Service navigators will assist with end-to-end issue identification and resolution, including completing any necessary follow-ups with third parties and/or the member to ensure issues are fully resolved. This role is expected to anticipate and help eliminate member hassles, facilitate next best actions, assist with resolution of cost and financial barriers, and help ensure access to care/providers.

Description of Responsibilities of Position:

- Best-in-class dedicated customer service agent who provides concierge and white-glove level service, removing burdens and providing end-to-end resolution for members. This includes, but is not limited to, clinical, financial decision support, behavioral health support and claims inquiries
- Agent provides a single point of contact for the customer. This gives customers the opportunity to form a relationship with their own concierge
- Responds to and owns consumer inquiries and issues by identifying the topic and type of assistance the caller needs such as benefits, eligibility, claims, financial spending accounts, correspondence, OptumRx Pharmacy, Optum Behavioral Health and self-service options
- Conducts proactive research on assigned member accounts to identify service issues and informs member plan of navigation in coordination with clinical and/or nonclinical staff outreach
- Communicates with assigned clinical and/or nonclinical staff with the health plan regarding member service issues that are proactively identified, member identified and closes the loop on the resolution of service issues to inform the plan of navigation for assigned members
- Navigators are trained to listen beyond the initial request of the member to anticipate and solve for root cause needs beyond the initial member question. This includes verbal cues that indicate the consumer may need to be connected with a clinician to discuss a live health event

Minimum Experience Required:

- 1+ years of experience in an advocate role supporting one or more of the following products: Medicare Advantage, employer-sponsored insurance or Medicaid

Skills Required:

- Proficiency with MS Word, Excel, PowerPoint and Access
- Demonstrated ability to quickly build rapport and respond to customers in a compassionate manner by identifying and exceeding customer expectations (responding in respectful, timely manner and delivering on commitments)
- Demonstrated ability to listen skillfully, collect relevant information, determine immediate requests and identify the current and future needs of the member
- Ability to use analytical thought process to dissect complex claim issues, and complete appropriate steps to resolve identified issues/or partner with others to resolve escalated issues
- Ability to use critical thinking skills to negotiate complex health scenarios
- Demonstrated ability to listen skillfully, collect relevant information, determine immediate requests and identify the current and future needs of the member
- Ability to provide necessary feedback and identify root cause to other call center agents, departments and leaders to ensure process improvement
- Ability to use multiple systems/platforms while on a call with a member — strong computer skills and technical aptitude

Are there any educational requirements for this position?
[X] Yes [ ] No

If yes, list below:

- High School Diploma or GED and 4+ years of work or volunteer experience in coaching and guiding internal or external customers (customer service), or

- Associate degree and 2+ years of work or volunteer experience in coaching and guiding internal or external customers (customer service), or
- Bachelor's degree and 6+ months of work or volunteer experience in coaching and guiding internal or external customers (customer service)

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?
[X] Yes [ ] No

If yes, list below:

- Employees will be provided training to gain proficiency in member tools, benefit interpretation and complex issue management to interpret situations and proactively address complex member issues
- Annual Compliance Training, including topics of Fraud, Waste and Abuse and Code of Conduct
- Safe and Secure with Me – Privacy and Security Annual Training
- Cultural Competency
- MississippiCAN and CHIP contract changes, when applicable
- Organizational Conflicts of Interest
- Doing Business with U.S. Governments Overview
- Special Needs Plan Model of Care Training
- SMART Goals
- Contract requirements/updates, when needed
- Specific functional training updates, as needed

Any additional information relevant to this position:

- N/A

[END OF RESPONSE]

4.3.3.3 Administrative Requirements (Marked)

The Offeror will verify and answer the following:

1. The Offeror will have an Administrative Office within fifteen (15) miles of the Mississippi Division of Medicaid's Central Office ...

Please see below for our attestation that we maintain an administrative office within 15 miles of the Division's central office, as required.

4.3.3.3 Administrative Requirements (Marked) – 5 points

Offeror attests to the following:

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

United Healthcare of Mississippi, Inc.

Name of Offeror

J. Michael Parnell

Printed name of person attesting for Offeror

Chief Executive Officer

Title of person attesting for Offeror

Signature of person attesting for Offeror

03/03/2022

Date

2. In a narrative no longer than two (2) pages, the Offeror will Describe how and where administrative records and data will be ...

Administrative Records and Data: Retention and Retrieval

UnitedHealthcare maintains administrative records and data within our corporate-owned and managed data center in the Mississippi metro area, with management on-site. We protect against hardware and software failures and human error through administrative, technical and physical safeguards, committing significant financial and staff resources to maintain compliance and responsiveness. We retain and maintain sole custody of a primary copy of data locally and a second copy at an off-site location. Within each data center, we implement critical systems with a redundant approach, with hardware replicated for seamless cutover to secondary devices to support high availability. Our network meets or exceeds ANSI/TIA 942-Data Center Tier 1-3 standards, significantly mitigates risks from data center disabling events and supports availability of key production systems and data 24 hours a day, seven days a week.

Our local operations department, led by our chief operating officer with our local compliance officer and general legal counsel, make certain we maintain records and data in accordance with Appendix A, Mississippi Medicaid Coordinated Care Contract, Section 16.1 of the Model Contract. Records will be available for review by authorized federal and state agencies during the term of this contract and for 10 years thereafter unless an audit or legal action is in progress. If an audit or pending litigation is not completed by the end of the 10-year period, we retain records until issues are resolved. We maintain strict data retention policies and standards.

- **Operational:** We retain daily backups used for file and database restoration resulting from a near-term operational loss for a period of 28 to 90 days.
- **Regulatory:** Legal and risk management establishes policies and standards for data retention to meet regulatory requirements. These retention periods range from three to over 10 years depending on content, risk and regulatory requirements.
- **Legal holds:** Legal holds supersede all other retention specifications when initiated, including the suspension of all data destruction.

Records and Data Confidentiality

Our information security program is HIPAA compliant, leveraging protocols based on industry practices, applicable regulatory requirements and customer considerations. Employees receive HIPAA training upon hire and at least annually thereafter. Our policies and standards address the specific requirements of audit and security controls. Our parent company, UnitedHealth Group, takes reasonable precautions to secure company data and data entrusted to us from unauthorized use or disclosure. Information owners are required to classify and label data as protected, confidential or public information. We treat all confidential information as privileged communication for use only as necessary for proper discharge of our obligations and rights. We will provide the Division, state attorney general, authorized federal and state personnel or authorized representatives of these parties access to confidential information per contract requirements, state and federal law and regulations.

Backup, Recoverability and Security

We regularly back up information to support availability and limit data loss if there is an outage. System and information owners determine what assets are backed up per corporate classification levels, including master files, databases, transactions files, system programs or utilities, application software, parameter settings and system documentation. We transmit over secured channels, are the sole entity in the chain of custody for the data and we encrypt the data, at the time the media is written, for risk mitigation purposes using industry accepted encryption algorithms (256-Bit Advanced Encryption Standard).

Physical, Personnel, Procedural and Technical Controls to Secure Records and Data
■ Formal information security policies and standards, reviewed and updated at least annually

Physical, Personnel, Procedural and Technical Controls to Secure Records and Data
■ Standard operating system/database/application baseline configurations, to satisfy security requirements
■ Mandatory ongoing security-related training for all employees and contractors
■ Access control mechanisms and regular access and entitlement reviews to enforce least privilege and access on an as-needed basis to resources and access
■ Physical controls for sensitive areas (e.g., data centers, user processing areas)
■ Monitoring of the environment for security-related events of interest
■ Formal security incident response to quickly assess potential incidents and appropriate actions
■ Periodic internal and external vulnerability scans, audits and other assessments to verify controls are operating effectively
■ Contingency procedures for responding to damage of systems containing electronic protected health information (ePHI)
■ In-sourcing of tape management facilities
■ A rapid recovery solution to protect data and make it available should there be a situation requiring data recovery
■ On-site process for data eradication of disk drives replaced during maintenance and on decommissioned storage arrays to Department of Defense standards before leaving our facilities

Our enterprise information security and privacy program protocols are based on industry practices (National Institute of Standards and Technology, ISO) and applicable regulatory obligations, including those imposed by federal and state entities and the European Union (EU 95/46EC).

Our business continuity and disaster recovery plans focus on critical business functions and planning for worst-case scenario including disasters lasting a minimum of 90 days. For business functions classified as critical, we maintain a recovery time objective of 72 hours or less by using geographically dispersed, redundant operations. We assess the effect of the operational loss as part of an original business impact analysis and annually thereafter. We update the business continuity plans a minimum of twice annually and test annually.

Process and Timeline for Retrieving Records

Our compliance officer handles records requests from the Division or other external review representatives as specified in the model contract, using the following steps:

1. We receive the records request from the Division or other state or external review representative. Our compliance officer triages the request to the appropriate department(s) to extract the information. We use existing Transition Data File layout to format the data.
2. We extract data and apply data release governance for review against HIPAA compliancy regulations.
3. Once our compliance officer approves the request, we submit data to the requesting entity using secure email functionality (size permitting) or secure File Transfer Protocol (SFTP).

All records and data, including training records, will be retrievable within three business days for review at the request of the Division or its authorized representatives. We will produce records requested for desk audits immediately for on-site review or mail delivery to the requesting authority within 14 calendar days.

[END OF RESPONSE]

4.3.3.4 Staffing (Marked)

The Offeror will describe the following:

1. Describe the entity's staffing ratios per enrolled Member, including the number of Member services call center employees and ...

Our member services call center, staffed by Mississippians, uses a person-centered approach to enhance the member and family experience, providing accurate first-call resolution to member inquiries and concerns in a timely manner. All members are assigned a primary point of contact, their service navigator, upon enrollment. Service navigators — who are part of the member's care management team — provide a single, integrated point of contact, resulting in straightforward, one-stop access to information and support for inquiries or issues regarding medical, behavioral and dental health and community-based services and transportation. While typical member services calls involve multiple transfers, our member services model provides members with a single point of contact for the duration of their inquiry or issue. For example, in instances where advanced clinical knowledge is necessary, the service navigator will bring other care management team members (e.g., community health worker, behavioral health specialist or registered nurse) onto the call as necessary, thus sparing the member the frustration that can result from multiple transfers.

Call Center Performance Excellence
Year after year, our member services call center performance exceeds the Division's requirements. Here are our 2021 outcomes:

- Abandonment rate must be 4% or less — our average was 0.04%
- Average speed to answer must be 120 seconds or less — our average was under 10 seconds
- Hold time must be under two minutes — our average was about 1.5 minutes

Service navigators are expert in our various program offerings and appreciative of our members' cultural background, enabling them to better relate to members and address their needs. As part of normal business operations, we track and trend common themes associated with member calls, then use these to implement performance improvement activities to improve the member experience. The objective is to resolve a wide range of issues and concerns in a single call and proactively engage members with information and support tailored to their situation.

Member Services Staffing Ratios

Our member services center employees include more than 40 trained service navigators, two supervisors and one manager, all of whom live in Mississippi. Member services center managers use our membership numbers, in conjunction with industry staffing tools, such as Workforce Management Projection Model (WMPM) software, to project the number of personnel required to support our members, address expected workload fluctuations and meet or exceed the Division's call center performance metrics. We expect that our service navigator to member ratio will be 1:4000 with a supervisor to staff ratio of 1:18.

Nurse Advice Line Staffing and Ratios

For additional call center assistance, we provide our members with access to our nurse advice line. This line is fully staffed and operational 24 hours a day, seven days a week. Our nurse advice line is staffed with 300 full-time trained and experienced RNs dedicated to addressing member questions and triaging immediate health concerns. **Last year, our nurse advice line staff successfully completed an average of 4,400 calls a day for a total resolution of 1.6 million nurse advice line calls**. Given Mississippi's population, we expect that the ratio will be 1:100,000 for members with a staffing ratio of 1:18 for nurse advice line supervisor to staff. We consistently monitor nurse advice line call volumes and make real-time staffing adjustments to make certain that every member connects with a nurse advice line staff member in a timely manner.

Plans and Resources for Adapting to Additional Staffing Needs

We use workforce management tools to adjust daily staffing levels. In addition, our National Operations Center (NOC) monitors weather, natural disasters and incidents across the United States. If the NOC identifies a threat

to local member, provider or employee safety or operational capacity, they will communicate and coordinate with our Mississippi call center managers to proactively manage call routing and backup staffing to maintain services and performance excellence and business continuity. Using call forecasting technology, we shift overflow calls quickly and seamlessly to alternate locations when needed, facilitating top performance and uninterrupted call center service.

We will provide cross-training to designated backup resources in a nearby state, allowing us to increase staffing levels as needed when call volumes exceed normal daily activity or we experience a local site emergency. Our designated backup resources receive the same training for MississippiCAN and CHIP that the Mississippi service navigators receive.

Member Services Qualifications

Staff	Job Qualifications
Member Services Representative Manager	Required: Bachelor's degree; minimum 5 years of call-center management experience; minimum of 3 years managed care supervisory experience and knowledge of human resource policies and procedures. Preferred: bilingual; familiar with Rapid Resolution Experts model; claims adjustment process experience and health adviser model; knowledge of call center systems; project management experience; basic knowledge and experience in finance and cost accounting.
Member Services Representative Supervisor	Required: High school diploma or GED, more than 5 years of previous supervisory experience and more than 1 year of experience as a supervisor in a professional work environment. Preferred: Associate degree or higher, health care experience or experience as a subject matter expert, trainer or conflict-resolution group analyst.
Member Services Representative	Required: High school diploma or GED; experience in health care or insurance environment. Preferred: 1 year of customer service experience or professional call center environment; demonstrated ability to quickly build rapport, respond to members in a compassionate manner and exceed member expectations; strong computer skills and technical aptitude; excellent verbal and written skills.

Nurse Advice Line Qualifications

Staff	Job Qualifications
Nurse Advice Line Director	Required: Medical director who is a licensed physician, board-certified by the American Board of Medical Specialties, with an active unrestricted license and more than 5 years of clinical practice experience and experience in managed care and medical policy development. On-call physicians and a lead RN with extensive experience in ER and urgent care.
Nurse Advice Line Nurses	Required: RNs with active licensure, 3 years of recent clinical experience in areas such as ER, pediatrics, geriatrics, obstetrics, critical care, urgent care or surgery; must maintain 30 hours of continuing education credits every 2 years.

Member Services Call Center Training and Education

Our local staff within our call center will be experienced with MississippiCAN and CHIP and will receive ongoing training, at least quarterly, to confirm they effectively respond to a broad range of inquiries with sensitivity to members with disabilities, language differences, need for assistive technology and various cultural backgrounds. We will submit quarterly reports to the Division that detail the trainings, topics covered and the staff who complete the training.

Education for our local service navigators will begin with 11 weeks of rigorous training on subjects, including, but not limited to, Medicaid, MississippiCAN and CHIP, benefits and eligibility, searching for providers, handling urgent calls and our core customer care philosophy. Service navigators receive training on referrals, escalations and warm transfers to care management for clinical staff assistance for members with complex needs. They receive training on the enhanced capabilities of our member services model, including the Community Services Referral Module, to refer members to food banks, job placement and other local resources; Prevention and Wellness Module to resolve barriers from closing gaps in care; and Provider Processes Module

that trains the service navigator to offer to schedule appointments. We assess all service navigators on their training to ensure comprehension and retention.

We will provide service navigators with ongoing training inclusive of the very latest in Medicaid changes and requirements that include “Late Breaking News” articles, Provider Bulletins, State Plan Amendments, Administrative Code Filings, the Division’s Provider Reference Guide and MississippiCAN and CHIP updates. We will deliver ongoing multimodal training, including ad hoc training sessions led by supervisors, team meetings, one-on-one coaching and web-based training. Other ongoing trainings include general refresher courses on important topics such as member experience, ethics and confidentiality; quality analyst monitoring and formal feedback; supervisor monitoring of calls followed by one-on-one coaching; and weekly newsletters to all service navigators that include reminders regarding policies and procedures.

Our service navigators will be local residents who understand the cultural elements of Mississippi. We will provide ongoing cultural competency training on the cultural, linguistic characteristics and special health care needs of the members they serve. Training focuses on awareness-building activities, including:

- Communication protocols for members with limited English proficiency
- Cultural awareness and understanding of health disparities among different cultural groups
- Cultural beliefs related to health, illness, medical care and end-of-life issues
- The need to treat each person with dignity and respect
- Barriers facing individuals with special health care needs
- Overcoming barriers to communicating with individuals with disabilities
- Cultural sensitivity training via role-play and teaching modules
- Social determinants of health and effect on member care needs

The service navigators are comprehensively trained to recognize when a member calls with an urgent need, situation or behavioral health crisis. Service navigators are trained to recognize the symptoms of a medical crisis (such as slurred speech, shallow breathing) and symptoms of a behavioral health or substance use disorder (SUD) crisis. Trained and experienced RNs on staff triage callers with life-threatening emergencies to 911 and warm transfer callers to a licensed behavioral health clinician when the RN presumes the member is experiencing a non-life-threatening emergency or urgent behavioral health crisis. All service navigators complete training on long-term services and supports, inclusive of the roles of care managers. Inside of that course, they will review supporting standard operating procedures and job aids for Mississippi.

Training Management

LearnSource, our companywide, web-based learning management system, offers our employees classes, including, but not limited to, professional development, cultural competency, company policies, state and federal regulations and compliance. This web-based tool allows employees to register for training (classroom and web-based), take web-based training and track required and completed training. Supervisors can track registration and course completion using automated tools and reports. We will submit quarterly reports to the Division that detail the trainings, topics covered and the staff who complete the training. Our member services call center training program complies with all standards set forth in Appendix A, CCO Contract, Section 5.1.5.

2. Describe the entity’s staffing ratios per enrolled Provider, including the number of Provider services call center employees, ...

Provider Services Staffing and Ratios

Our ratio of provider phone representatives (PPRs) to enrolled provider is 1:565, with a supervisor to staff ratio of 1:20. However, when determining staffing ratios, we have found membership information to be a stronger predictor of provider call volume — and thus staffing levels — than the number of providers. We determine our provider services call center staffing levels by taking existing membership information and applying a contact

rate (number of calls received per 1,000 members per month) based on historical data (either from the existing program or a program similar to it). The result is a projected call volume to which we then we apply planned (average handle time [AHT]), availability and occupancy rates to determine the FTEs needed to handle calls in a timely manner. Our provider call abandonment rate averaged 1.37% in 2021, significantly below the 4% mark required by the Division.

We maintain a minimum staff of 28 PPRs, 100% of whom are in Mississippi and specifically trained in MississippiCAN and CHIP. These representatives have many resources at their disposal and can resolve most questions with the first call and without escalation or handoff.

Our business continuity location for our provider services center is in a bordering state. These PPRs receive the same training for MississippiCAN and CHIP that the Mississippi-based PPRs receive. These individuals receive Mississippi calls if there is a power outage or unexpectedly high call volumes. The operations center maintains real-time reports on call metrics, enabling us to shift the resources as needed for optimal provider service and to meet or exceed Mississippi performance standards.

Staff	Job Qualifications
Provider Phone Representative Supervisor	Required: High school diploma or GED, more than 2 years of previous supervisory experience, including coaching and development, more than 2 years of customer service experience and more than 1 year of health care experience in an insurance environment.
Provider Phone Representatives	Required: One year of experience in either customer service or 1 year of front-line customer experience in an office environment; high school diploma or GED or 10 years of equivalent work experience.

Provider Services Call Center Training and Education

The contractor's provider services call center staff must receive trainings at least quarterly. Staff must receive updates about continued Medicaid 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 MississippiCAN and CHIP updates.

We facilitate initial and ongoing training to foster high provider satisfaction. Our provider services call center team members, PPRs, play a key role in delivering prompt and high-quality service support to providers. PPRs receive extensive MississippiCAN- and CHIP-specific training to handle a broad range of complex topics. We conduct on-site trainings for our provider services call center team and their backup counterpart teams. Claims supervisors, call center supervisors and PPRs participate in monthly (and ad hoc) calls to discuss updates, issues, concerns and changes that occur in the network that may affect how we respond and resolve provider inquiries. Our PPR training program complies with all standards set forth in Appendix A, CCO Contract, Section 6.9.1.1.

In concert with our standard new employee training and onboarding activities, initial training for our PPRs includes segments that align with our member services call center training; plus a six-week provider services session covering benefits, eligibility, claims and two weeks of on-the-job training. We use methods such as facilitated lectures, role-playing and simulation, question-and-answer sessions and computer-based training. Seasoned staffs receive ongoing monitoring and training. Training topics and educational information cover all aspects of MississippiCAN and CHIP, including:

Provider Services Call Center Training and Education		
UnitedHealthcare Onboarding	**Functional Onboarding**	**Annual**
MississippiCAN and CHIP Contract Training	Introduction to Medicaid and Medicaid Calls	Privacy and Security: Safe and Secure with Me

Provider Services Call Center Training and Education		
UnitedHealthcare Onboarding	**Functional Onboarding**	**Annual**
Required Courses on LearnSource	Call Handling	Annual Compliance Training (includes the topics of Fraud, Waste and Abuse and Code of Conduct)
Fraud, Waste and Abuse	Handling Complex Member Inquiries	
Privacy and Security	Introduction to the Company's Medicaid Operations	
Cultural Competency	Net Promoter Score System	
Code of Conduct	Pharmacy and Prior Authorization Systems	

Before placement in the provider services call center occurs, trainees must demonstrate their ability to respond to provider inquiries, including complaints, grievances and appeals and claims during their training period. Provider services staff receive annual refresher and ad hoc training. Once provider services staff begin working independently, we continue to monitor their performance and provide feedback for continuous quality improvement. Our call center supervisors routinely monitor provider services staff calls and provide coaching, as applicable. The PPRs work collaboratively with the provider services manager, who meets on weekly with call center supervisors.

Cultural Competency Training

Our cultural competency training will bring awareness and sensitivity to individuals who come from varied economic, social, religious or ethnic backgrounds. Trainers present an overview of several major cultural groups and explore the cultural dimensions of each group to increase staff understanding and appreciation of differences and similarities. Ongoing training will address the cultural competency and special health care management needs of our MississippiCAN and CHIP population, including use of our member-first language; cultural awareness and understanding of health disparities among cultural groups; treating each person with dignity and respect; communication protocols for members with limited English proficiency; and characteristics of and barriers facing individuals with special health care needs.

Training Management

LearnSource, our companywide, web-based learning management system, offers our employees classes, including, but not limited to, professional development, cultural competency, company policies, state and federal regulations, and compliance. This web-based tool allows employees to register for training (classroom and web-based), take web-based training, and track required and completed training. Supervisors can track registration and course completion using automated tools and reports. We will submit quarterly reports to the Division that detail the trainings, topics covered and the staff who complete the training.

3. Describe staff who will be assigned to the quality management program and their qualifications.

We have a strong Quality Management (QM) program in place that will fulfill the requirements of this contract. We have a dedicated team supporting our QM program, as shown in the following table.

Position (FTEs)	Qualifications
Medical Director (1)	**Minimum Education and Experience Required:** ■ A Mississippi-licensed physician ■ Located in Mississippi, board-certified and either an actively practicing physician in Mississippi or have been an actively practicing physician in Mississippi in the past five (5) years ■ 5 years' post-training clinical experience ■ 3 years' training in a medical specialty ■ Strong knowledge of the managed care industry, Medicaid and quality management ■ Background in primary care medicine with demonstrated ability to work with peers and other health care providers to resolve DM, QM, UM and complex care issues **Preferred Qualifications/Experience:** ■ Solid data analysis and interpretation skills; ability to focus on key metrics ■ Solid negotiation and conflict management skills
Behavioral Health/SUD Medical Director (1)	**Minimum Education and Experience Required:** ■ Active, unrestricted medical license with the Mississippi State Board of Medical Licensure ■ 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. ■ Minimum of 5 years of experience providing and supervising treatment service for mental illness and substance use disorders **Preferred Qualifications/Experience:** ■ Leadership expertise such as MBA, MPH, MHA or Ph.D. ■ Knowledge of public sector care in Mississippi ■ Prior medical director leadership experience ■ Excellent project management skills
Quality Management Director (1)	**Minimum Education and Experience Required:** ■ B.S. in nursing or equivalent work experience required; master's degree preferred ■ More than 5 years of clinical- or field-related experience ■ More than 2 years of experience in quality improvement or related field such as Six Sigma ■ 8+ years of significant leadership and managerial experience ■ Experience working in Medicaid or Medicare ■ Health care and insurance industry experience, including regulatory and compliance preferred ■ Knowledge of one or more of clinical standards of care, preventive health standards, CMS standards, HEDIS®, NCQA, governing and regulatory agency requirements ■ Experience managing and coordinating regulatory audits, including documentation, on-site preparation and responsive corrective action plans **Preferred Qualifications/Experience:** ■ Experience and familiarity with audit processes including External Quality Review Organizations ■ Experience working as an executive-level health plan quality leader ■ Experience working on health equity through collaboration with community-based organizations, analyzing and using health care disparities data

Position (FTEs)	Qualifications
Population Health Director (1)	**Minimum Education and Experience Required:** ■ Current RN license in Mississippi ■ Bachelor's degree in nursing or health-related field ■ 5+ years of management experience with 2+ years of experience in care management or home health ■ Experience with Medicaid and D-SNP (strongly preferred) MCO/CCO ■ Previous successful experience in disease management, QM, or care management programs ■ Previous work with service coordinators, including review of treatment plans ■ Experience addressing health disparity and/or health equity concerns ■ Experience and knowledge of change management principles, methods and tools **Preferred Qualifications/Experience:** ■ Demonstrated successful leadership skills in program execution and people management ■ Experience managing in the matrix environment
Health Equity Director (1)	**Minimum Education and Experience Required:** ■ Bachelor's degree or equivalent years of experience ■ 5+ years of experience leading and developing broad scale organizational/enterprise diversity, inclusion and equity strategies ■ 5+ years of experience interfacing with senior leadership team ■ Experience addressing health disparity and/or health equity concerns ■ Experience and knowledge of change management principles, methods and tools **Preferred Qualifications/Experience:** ■ Master's degree in business/healthcare administration, public health or related field ■ Experience working with Medicaid and/or Medicare programs ■ Experience working with and influencing all levels of employees; inspiring others to engage and act ■ Proven track record of managing conflict, resolving issues, mitigating risks and influencing leaders
Behavioral Health Quality Improvement Director (1)	**Minimum Education and Experience Required:** ■ Bachelor's degree or RN with 3+ years' management experience ■ 5+ years QM experience, in clinical or managed behavioral health care industry ■ Broad analytic expertise, knowledge of Continuous Quality Improvement (CQI) tools and methodology ■ Experience completing independent NCQA accreditation surveys ■ Knowledge of HEDIS® and demonstrated project management experience ■ Demonstrated leadership and presentation skills ■ Proven ability to communicate effectively and interface with diverse audiences **Preferred Qualifications/Experience:** ■ Six Sigma, CPHQ or other Quality Certification ■ Educational background in behavioral health field and master's degree or Ph.D. in behavioral health field ■ Licensed in a behavioral health discipline
Behavioral Health Quality Improvement Specialist (1)	**Minimum Education and Experience Required:** ■ Bachelor's degree ■ 3+ years of experience in a health care setting ■ Demonstrated ability to manage multiple projects simultaneously ■ Intermediate computer and presentation skills with the ability to navigate a Windows environment. **Preferred Qualifications/Experience:** ■ Six Sigma, CPHQ or other Quality Certification ■ Managed care experience and/or prior work with providers ■ Knowledge and previous experience with national QI standards (NCQA, HEDIS®, URAC) ■ 2+ years' experience developing and implementing performance improvement projects or using data to develop intervention strategies to improve outcomes

Position (FTEs)	Qualifications
Clinical Transformation Consultants (2)	**Minimum Education and Experience Required:** ■ Bachelor's degree or equivalent relevant experience ■ 4+ years of combined experience with improving clinical quality, health care analytics, or driving clinical transformation initiatives with population health programs, Patient Centered Medical Homes or in Accountable Care Organizations ■ Experience in interpreting and utilizing clinical data analytics, outcomes measurement in healthcare and use of that data to drive change ■ Experience working with and collaborating successfully with senior level leadership ■ Demonstrated experience leading groups and strong presentation skills ■ Strong Microsoft Office Skills with Word, Excel, Outlook and PowerPoint ■ Strong relationship-building skills with internal and practice teams to drive goal alignment ■ Must have access to high speed internet for home office setup ■ Willingness to travel between 25% and 75% for face-to-face meetings ■ Access to reliable transportation that will enable you to travel to client and/or patient sites within a designated area **Preferred Qualifications/Experience:** ■ Master's degree ■ Active, unrestricted RN license in the state of Mississippi ■ Demonstrated experience implementing Clinical Practice Transformation initiatives designed to help provider or hospital groups achieve large-scale health transformation goals ■ Experience preparing and presenting information to clinical and executive level leadership ■ Physician practice experience
RN Quality Managers (3)	**Minimum Education and Experience Required:** ■ Bachelor's degree OR RN licensure in the state of Mississippi ■ Experience with HEDIS and NCQA including audit and project management of submissions to the state and NCQA ■ QI project experience with QIP and PIPs (quality improvement projects) ■ Experience with outside audit organizations such as EQROs ■ Leadership experience ■ Experience with managed care and insurance industry ■ Experience in writing reports and analyzing performance data ■ Experience creating detailed reports and project management **Preferred Qualifications/Experience:** ■ 2+ years of demonstrated Management experience with responsibility for team performance management ■ Performance driven ■ Quality improvement experience within a health plan ■ Clinical experience/background ■ Experience with corrective action plans ■ Ability to make independent decisions ■ Change management experience and demonstrated skills ■ Demonstrated staff development skills ■ Strong team building, collaboration and motivational skills ■ Results-oriented ■ Ability to work in a fast-paced environment ■ Experience with Excel (working with pivot tables) and creating PowerPoint presentations

Position (FTEs)	Qualifications
RN Quality Practice Consultants (3)	**Minimum Education and Experience Required:** ■ Current, unrestricted RN license in the state of Mississippi or bachelor's level degree or higher ■ 2+ years of health care experience ■ 2+ years of Medicare/Medicaid experience ■ Intermediate level proficiency in Microsoft Excel ■ Reliable transportation to travel to physician offices locally up to 75% of the time **Preferred Qualifications/Experience:** ■ 2+ years of quality improvement experience ■ 3+ years of clinical experience in a physician practice, outpatient facility ■ 2+ years of HEDIS experience ■ Health insurance industry experience, including regulatory and compliance ■ Knowledge of one or more of: clinical standards of care, preventive health standards, HEDIS, governing and regulatory agency requirements and the managed care industry ■ Ability to handle multiple tasks and competing priorities
EPSDT Clinical Administration Coordinators (2)	**Minimum Education and Experience Required:** ■ 3+ years of clinical experience ■ Experience presenting to others ■ Proficient within a Windows environment, utilizing Outlook and advanced skills with Microsoft Excel ■ Ability to create spreadsheets in Excel **Preferred Qualifications/Experience:** ■ Bachelor of Science in Nursing (BSN) ■ Current, unrestricted Registered Nurse (RN) licensure in the state of Mississippi or a compact license allowing you to practice in Mississippi ■ Pediatric nursing experience ■ Experience with wellness quality metrics related to childhood health screenings ■ Experience working with provider offices ■ Clinical nursing experience in managed care environment ■ Experience working with the Medicaid/Medicare Population ■ Comfort with reading and writing reports and analyzing data ■ Experience with EPSDT ■ Experience working with providers and members to increase compliance with screenings ■ Strong written and verbal communication skills
Outreach Coordinators (2)	**Minimum Education and Experience Required:** ■ 2+ years of managed care/outreach experience ■ Experience in event planning and execution ■ Must have a dependable vehicle and current driver's license ■ Proficiency with MS Word, Excel, PowerPoint and Access ■ Ability to prioritize and meet deadlines ■ Proven interpersonal skills, establishing rapport, and working well with others ■ High attention to details ■ Exceptional presentation, written and verbal communication skills ■ Ability to work independently and remain on task ■ Good organization and planning skills

Position (FTEs)	Qualifications
	Preferred Qualifications/Experience: ■ Bachelor's or master's degree ■ Bilingual Spanish ■ Previous Medicaid or Medicare work experience ■ Public relations experience ■ Have established professional relationships with nonprofits, community sources, religious/faith-based organizations (FBOs) in designated sales territory ■ Experience working with communities of all different ethnicities, cultural backgrounds, diverse populations and/or underserved communities
Grand Total 19	

4. Describe the role of the Care Manager and Care Management Team. Describe the minimum level of education, training, and ...

Care Management Team Leadership and Staffing Model

Our care management director oversees our integrated clinical team, seeing to it that our care management services align with our population health and health equity goals, provider and facility engagement strategy and operational excellence.

Care Management Team

Our highly trained, skilled and experienced Mississippi-based care management team is prepared to work collaboratively with the Division, providers and members to achieve Mississippi's goals of increasing access to high-quality care, connecting individuals to needed services and improving population health outcomes. Team members work together to mitigate system fragmentation, activate the right level of support for the right goal and make sure that all components of the member's social-environmental ecosystem are operating in tandem to support the member.

Using information gathered from Health Risk Screenings (HRSs), Comprehensive Health Assessments (CHAs), referrals (providers, partners, family) and our risk stratification tools, we align the identified needs of the member with a primary point of contact who is appropriately equipped to serve the member. The comprehensive view allows us to customize the care management team makeup, level and intensity of engagement and intervention based on condition profile, severity of illness, unmet needs and existing connection with care. Central to this approach is a care management team and a sophisticated set of analytics, risk stratifications and a central care management platform.

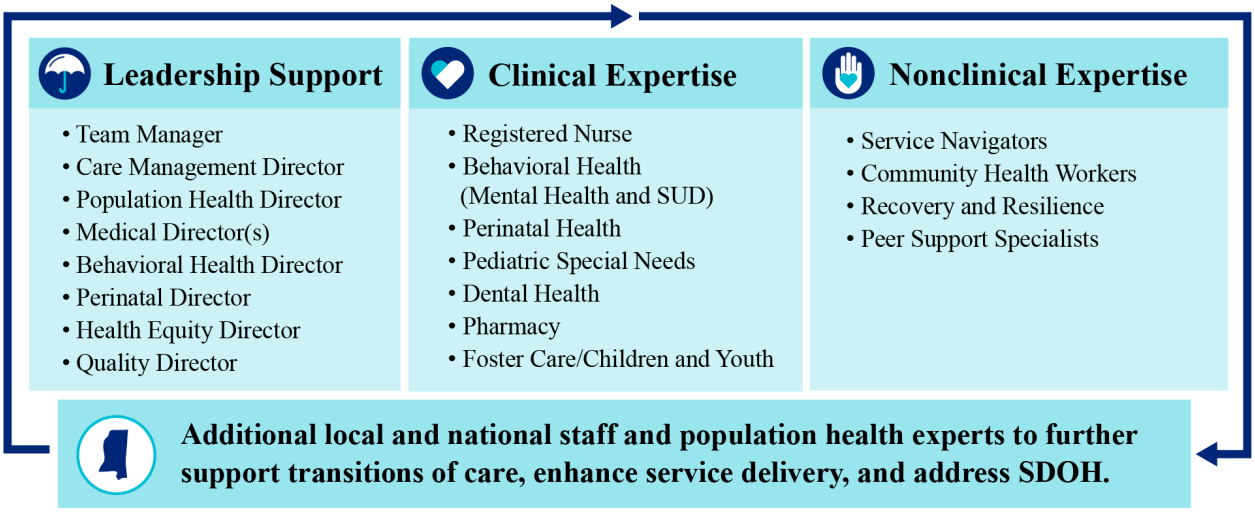


Figure 1. Our Care Management Team. We customize the makeup of the team based on the needs of the member.

The care management team includes clinicians with physical health, behavioral health and pharmacy experience. It includes nonclinicians, including peers and community health workers, and individuals with deep understanding of housing and other social support programs. The care management team includes health plan leaders, provider engagement staff, service navigators and clinical program partners.

Role of the Care Manager and Care Management Team

All members are assigned a primary point of contact, their service navigator, upon enrollment. The service navigator is part of the member's care management team, bringing greater flexibility to the care management model, as it permits service navigators to help low-risk members navigate the health care system, while helping moderate and higher risk members move — or navigate — to more intensive services, such as care management, when necessary.

Service navigators are available to members at each of our three risk levels (low, medium and high), serving as the member's primary point of contact for low-risk members and providing complementary support for the care manager for medium and high-risk members. The service navigator and care managers are empowered to support the member in all matters related to accessing needed health care, including assessing medical, behavioral health and SDOH needs, connecting members to PCPs, behavioral health providers, specialists and community-based organizations (CBOs). They monitor and follow up with members and providers to confirm continuity and quality of care. Our care management model will meet all requirements as outlined in Section 7.5 Care Management Services of the Contract.

Our low-risk care management approach focuses on prevention and wellness by addressing and resolving barriers to accessing preventive and specialty services, using targeted education based on condition, connecting to community and natural supports and enhancing self-management. Members who are connected with care do not have chronic conditions and may need occasional general health information or support connecting with services are assigned a service navigator to serve as their primary point of contact and conduct the activities outlined above to provide a supported health journey. The service navigator can access transition specialists, housing navigators and other members of the care management team, as needed, to support the members they serve. As a member may move in and out of more intensive care management, the service navigator remains available to the member to complement care manager engagement.

Members who meet the criteria for medium or high-risk are assigned care managers who are supported by an interdisciplinary treatment team (ITT) who can handle complex behavioral health, physical or SDOH needs. Our Mississippi-based care managers are trained and equipped to address the unique needs of medium- and high-risk members. Members who are part of Mississippi's Native American community will be assigned to a care manager trained and equipped to address their needs. Care managers meet with the members they serve at least monthly to facilitate progress on individualized treatment plans.

Minimum Level of Education, Experience and Training for Care Managers

We have established minimum education/formal training and certification/licensure requirements for the disciplines that can occupy a care manager role: community health workers (CHWs), registered and licensed practical nurses, behavioral health specialists and social workers. This includes current, active licensure for RNs and licensed practical nurses (LPN), and clinical licensure as an independent practitioner for behavioral health clinicians (e.g., LCSW, LPC, LMFT). Care managers working with specific populations must have experience in that area. Examples include maternal-child health, foster care or case management in an ambulatory or inpatient setting.

Consistent with the contract, all care managers will be local to Mississippi. We will hire regionally across the state to make sure our team is diverse, representing the communities served, and familiar with individual community resources and support networks. At least one of our care managers will have special training and

knowledge of care management practices relevant to Mississippi's Native American community, though all care managers will receive training on the unique considerations for supporting Native American communities.

Service navigators and other roles on the care management team augment the care manager's skill sets and expertise. Roles include certified peer support specialist, housing navigator, pharmacist and dental care coordinator.

Cultural Competency Among Care Managers

Delivering care that is sensitive and responsive to one's culture and cultural experiences is the bedrock of person-centered, trauma-informed care management. In addition to our data-driven processes that help identify gaps in care and claims-based medical, behavioral and dental needs, we will train care managers to **deeply understand how an individual's self-reported identity, experiences and cultural trauma(s) impact their perception of and engagement with the health care system.** We understand that individuals may have had their own experiences with systemic racism, resulting in mistrust of formal systems. As a result, we have committed to embracing practices that help advance our effort of being an anti-racist organization and delivering anti-racist care management.

In 2021, we piloted a staff-level curriculum that brought deeper awareness of implicit bias and how to become an ally in eradicating racism and discrimination. In 2022, we committed to developing and delivering a comprehensive baseline health equity curriculum for all staff, from front line to leadership levels. The curriculum will establish a unified understanding of key concepts that impact our members while providing our staff with actionable recommendations to develop a greater level of personal awareness and provide culturally responsive care for our members. This curriculum is slated to include a blend of both concept and practice topics, such as:

- Health equity and health disparities
- Implicit and unconscious bias
- Inclusion and diversity
- Cultural humility
- Trauma-informed care
- Motivational interviewing

To confirm our nondiscriminatory efforts are embedded in the fabric of our organization, we are evolving our internal infrastructure to support this goal. For instance, our comprehensive assessment, used for all members in care management, has been carefully reconfigured to include a thorough list of responses to key questions about an individual's sexual orientation and ethnic, racial and gender identities. We have leveraged internal experts and diversity groups to provide response options that are inclusive beyond binary definitions or the minimum federally established demographic groups. Further, our assessment prompts care managers to ask members what impact their identity has had on engaging the formal health system. These actions align with requirements of the NCQA Health Equity Accreditation standard and the National Institute of Health race and ethnicity standard.

We are enhancing our clinical information technology platform to integrate demographic data to drive alignment between our members' self-reported identities and our internal systems that retain the information. Aligning our system platforms mitigates the risk of traumatizing or retraumatizing a member and enables staff to address members in a way that preserves their dignity. Through data alignment, we will ascertain our effectiveness with unique populations and invest in intervention approaches for populations where we may be having a lesser impact.

We are an organization that prides itself on our rapid-cycle, continuous quality improvement; our anti-racist care management initiatives will receive that same level of rigorous evaluation. We will track key initiatives

and create action plans when performance falls below expectations. We will consult with affinity employee groups who serve as subject matter experts on specialty population groups to continuously inform our programs with up-to-date information.

Using a Member's Initial Risk Level to Inform Care Manager Assignment

Our care management model is tailored to the unique program design articulated by the Division and augmented by our own observed trends. In alignment with the service requirements outlined in the model contract, we will implement a three-level care management framework aimed at meeting members where they are on their personal health journey. Regardless of risk level, our care management teams focus on engaging members to drive their health, connecting them with appropriate care and removing barriers that affect their ability to access the services they need to lead healthier lives.

Support for All Members

All members enrolled in our plan will have outreach from our plan encouraging completion of an HRS within 90 days of contract implementation or within 30 days after health plan enrollment, self-referral or provider referral for those enrolling after the initial contract implementation period. For members for whom the HRS reveals medium or high-risk, the member will work with a care management team member to complete a Comprehensive Health Assessment (CHA). During the CHA, the member will be asked to share about their physical, behavioral health, social and environmental needs. The member will be supported through the screening process by team members trained in motivational interviewing and trauma-informed care to make sure preference, identity and health care experiences are honored and respected. If the member shares a need or goal that could be supported by a connection with a community partner, state agency or provider, the care management team member will facilitate a warm connection to appropriate resources. The timely, efficient and personal connection to these services, followed by monitoring that confirms the services were provided (closed loop), is of critical importance to the member and their health.

Our predictive analytics tool analyzes membership using data at the individual (conditions, inpatient and ER use, pharmacy use, SDOH needs) and community-level (environmental, ZIP code) to produce a risk score. This risk scoring, combined with the details from the member's responses to screenings and assessments, will be used to create a comprehensive view of the member's risk profile, applicable programs and actionable opportunities for care management. Members' files will be updated in our care management platform to reflect the clinical program referrals and recommended assignment to care management team members.

All members will be assigned to a care management team and have access to our member services call center. We will meet all contractual requirements as outlined in Table 7.1 of the model contract.

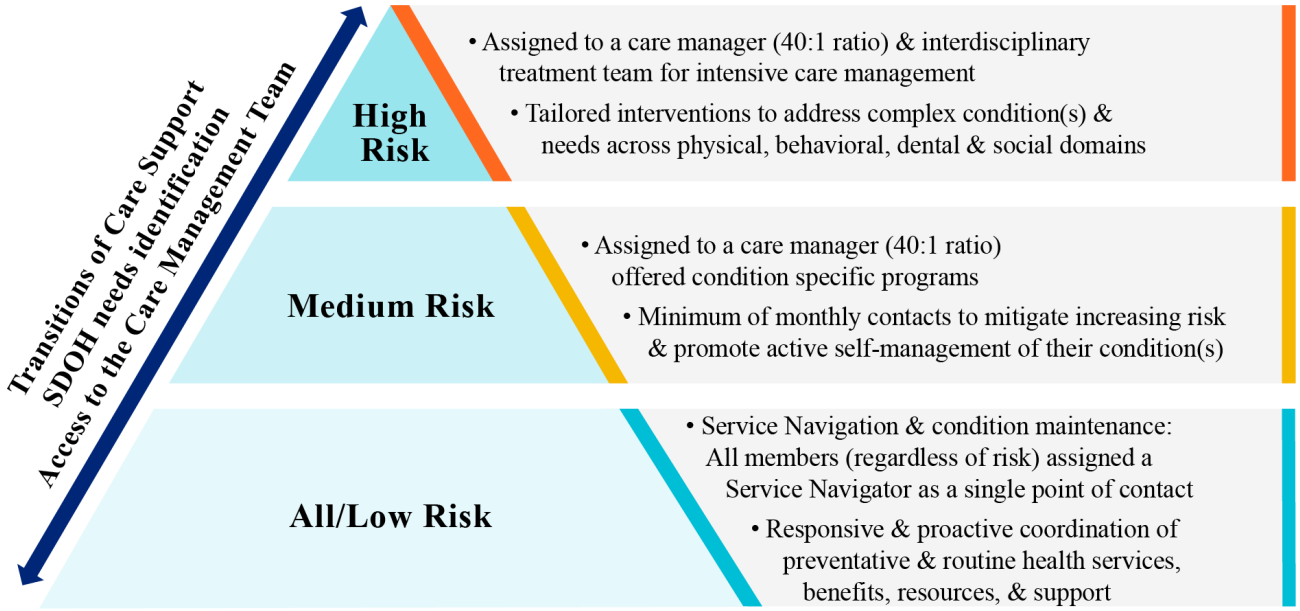


Figure 2. Health Pyramid. Our approach to member outreach and engagement

Tools, Processes and Procedures

Across our states, our strong care management teams have extensive experience in physical, behavioral and social support programs. We have augmented this experience with tools, processes and procedures that support consistent but customizable member-centered experiences. Taken together, these assets make sure that: All members and/or authorized family or guardians are involved in treatment planning, as appropriate; pharmacy utilization data is used to tailor care management services; closed-loop referrals and warm handoffs to specialists and sub-specialists are made consistently, documented in medical records and followed up on; all urgent care, emergency encounters and any medically indicated follow-up care is documented in the member's medical record; changes in PCP or PCMH trigger a review of and revision to treatment plans and referral services; and continuity of care is maintained when a provider is no longer available.

Close Monitoring and Easy Escalation for Members at Medium Risk

Members stratified into the medium-risk level have medical or behavioral health needs that suggest emerging risk for increased utilization of services and poor outcomes. Members may have multiple conditions or life circumstances that make it difficult for them to consistently access and engage in services. Our goal for care management is to provide integrated coordination across providers and ongoing support to make it easier for members to get the care they need, mitigate risk and promote self-management strategies.

After completing a CHA, the member and care manager will discuss referrals and connect the member with necessary appointments and resources. Members in the medium risk level will work with their care manager on the maintenance of a recovery and resiliency plan if appropriate to their condition and goals. The member and care manager will collaborate on relapse prevention plans, particularly for those with substance use disorders, depression or other high-risk behavioral health conditions. Specific programs and monitoring tools will be used by the care manager and the member to monitor conditions, behaviors or unmet needs. At least monthly, the care manager will outreach to the member to make sure needs are being met. Members in the medium risk care management programs will receive the services outlined in Section 7.5.2 of the model contract.

Care managers are supported by the care management team, including service navigators, leaders, CHWs, peer support specialists and local and national subject matter experts.

Targeted Support for Members at High-Risk

When a member is identified for high-risk care management, they will be assigned a care manager with expertise aligned to their condition, location and other needs. Our Mississippi-based care managers will be staffed 40:1 care management ratio, trained and equipped to address the needs of high-risk members. Specialized care management expertise includes, but is not limited to, pregnancy, care of the chronically ill, children and youth in foster care, behavioral health and substance use disorders, and children with special health care needs. Members who are part of Mississippi's Native American community will be assigned to a care manager trained and equipped to address their needs. The care manager will reach out to the member to introduce the program, complete the CHA and learn about their goals and any unmet needs. This assessment will form the foundation of the action and goals-oriented treatment plan that will be maintained in our care management platform and made available to the member through their member portal and their PCP. Care managers will inquire about member's communication and meeting preferences, access to technology for virtual visits, identify others to be involved in their care management experience, and their priorities for improving chronic conditions and reducing risk for health decline. Based off the initial conversations, the care manager will build an interdisciplinary treatment team (ITT) that aligns with the behavioral, physical or social health needs and goals of the member.

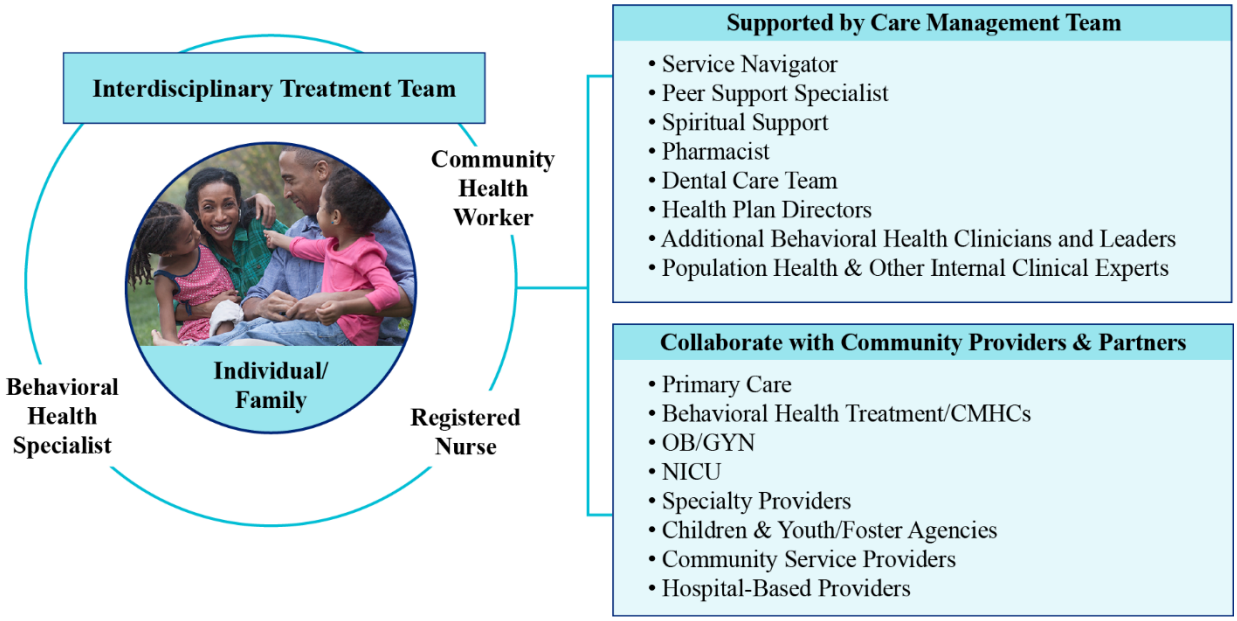


Figure 3. Interdisciplinary treatment team. Wrap around member through integrated approach and enable

Care managers will meet with members at least monthly to facilitate progress on individualized treatment plans and provide the services outlined in Section 7.5.3 of the model contract. As part of the person-centered treatment planning process, care managers will work with members to identify gaps in knowledge or understanding on topics related to their conditions, unmet needs, and when and how to connect with providers or emergency support services. The care manager and member will identify changes in symptoms, signs of distress, or environmental triggers in a way that empowers the member to prepare for these occurrences, anticipate increasing needs and seek care before a crisis occurs. The member and care manager will document a plan for responding to symptom exacerbations, preferred interventions and communication strategies to share with natural/family supports, health care and service providers.

Staffing Ratios

Our member to care manager caseload ratio will not exceed 40:1, allowing us to provide high touch, intensive clinical service delivery across our medium and high-risk levels of care management. For individuals enrolled in our NCQA-aligned, high-risk, integrated care management intervention, care manager to member ratios are lower than the Division requirement, at approximately 25:1.

Staffing Ratios for Members in Care Management	High Risk
Medium- to High-Risk Member: Care Manager	40:1
High-Risk ICM Intervention Member: Care Manager	25:1

Training and Education Provided to Care Managers

Onboarding/New Employee. All new care managers attend a rigorous 10-day standard immersive training. This curriculum includes key regulatory, adherence and clinical model topics to orient care managers around the delivery of care that upholds our member-centered, trauma-informed approach and quality standards. Care managers then complete population- and program-specific modules. New care managers are assigned a "mentor" who helps integrate and apply training content to support consistency in care delivery while supporting staff during this phase of their employment. They train on and receive a Mississippi-specific integrated care coordination guide with protocols, evidence-based interventions, population-specific information and available community resources. Additional topics covered include contractual and model of care requirements for programs and populations.

Annual Requirements. For topics that are federally or contractually required, or the organization deems necessary for annual refresher training, we assign those trainings to care managers through our electronic platform in a self-paced delivery model. We monitor completion and work with managers to help staff maintain their adherence rates.

Population- and State-Specific Training. As an extension to our new hire trainings, our care management team will receive specific MississippiCAN and CHIP population training. Topics may include physical health, behavioral health, functional and SDOH needs of the communities being served, community and population assets, local health equity and health care access considerations, and education on services and supports for individuals with special needs.

Ongoing/Continuing Education. Care managers can access a catalog of training topics, affording them the opportunity to become more proficient in clinical topics, enhance intervention skills (e.g., motivational interviewing or person-centered care planning) and explore topic areas of interest. Care managers who possess specific certifications (such as CCM) or licensure (LPN, RN, LCSW) have complete access to these courses, many of which are free of charge to staff and offer continuing education credits.

Learning Modalities/Platforms. Our program uses a self-paced curriculum through electronic delivery, instructor-led curriculum facilitated by dedicated training teams and blended approaches that integrate didactic learning with self-guided components. Our highly skilled instructional designers are oriented toward adult learner theory and make sure content is constructed and delivered for adult learners. We leverage clinical and subject matter experts to host and facilitate clinical "Lunch and Learns" on emerging clinical approaches or trending public health topics.

Additional Opportunities. In addition to the structured learning, we offer a generous tuition reimbursement program for staff pursuing degree attainment. We offer a cohort-based health care MBA program and an RN-MSN program for our nursing staff.

5. Describe the entity's process to work towards managed care organization (MCO) accreditation status from the NCQA. Include ...

In Mississippi, we hold two NCQA Health Plan accreditations, and **we are currently the only CCO with the NCQA Multicultural Health Care Distinction**. Twenty-two UnitedHealthcare Medicaid health plans are NCQA accredited, validating our commitment to quality that demonstrates achievement of plan requirements, documented processes and an operational infrastructure of continuous improvement. Historically, we have met all required time frames to achieve accreditation, and we have never experienced an unsuccessful accreditation attempt.

Figure 4. We have maintained NCQA accreditation since 2013.

As a state partner for CHIP since 2010 and MississippiCAN since 2011, we have consistently maintained NCQA accreditation for both programs since 2013, and we are committed to doing so in the future. In fact, we successfully completed our most recent NCQA Health Plan Accreditations in January 2022, where we scored 100%, carrying our accreditation through Jan. 25, 2025.

Figure 5. We are the only CCO in Mississippi with this NCQA distinction.

After a review of all program areas, reviewers found no deficiencies, and **we scored 100% on standards compliance**. Areas surveyed included:

- Quality improvement
- Utilization management
- Population health management
- Network
- Member services
- Credentialing

Our next aim is to further distinguish ourselves by applying for the Health Equity Accreditation and Health Equity Plus, which demonstrates high commitment to addressing the impacts of social determinants of health and community on our members.

In addition, we are one of the seven UnitedHealthcare health plans that has received the NCQA Award of Distinction for Multicultural Health Care (which will become Health Equity Accreditation as of the July 2022 surveys). In Mississippi, we received this NCQA award in recognition of our role as a leader in providing culturally and linguistically appropriate services and our efforts toward reducing health care disparities for MississippiCAN and CHIP members.

Optum, our behavioral health benefits administrator, currently maintains the NCQA accreditations for its managed behavioral health care operations. Optum has met all the required time frames to achieve accreditation and has never experienced an unsuccessful accreditation attempt.

In Mississippi, our national accreditation team collaborated with local health plan staff on an established work plan to assure ongoing compliance with NCQA standards and that was tailored to meet the needs of Mississippi's membership and state requirements. This work plan assures that we will remain aligned with and positioned to exceed the standards for this distinction. We will continue to comply with the requirements outlined in Section 8.2 of the model contract.

6. Describe staff who will be responsible for the entity's Fraud, Waste and Abuse program and their qualifications.

Local Fraud, Waste and Abuse Staff

Our Mississippi fraud, waste and abuse (FWA) staff have significant FWA experience and are on point for day-to-day anti-FWA efforts in partnership with the Division's Office of Program Integrity (OPI).

The following table summarizes the responsibilities and qualifications of our three FWA staff members. At the direction of our local compliance officer, they receive significant support from our national FWA program framework, as described below.

Position	Responsibilities	Education and Qualifications
Compliance Officer	■ Oversees monitoring and enforcement of the fraud, waste and abuse (FWA) compliance program pursuant to state and federal rules and regulations, implementing any corrective actions, as needed ■ Develops and manages site compliance committee meetings ■ Coordinates and supports implementation of compliance training and educational programs with the appropriate business areas. Verifies that procedures are in place to review, and reports possible violations in accordance with reporting requirements ■ Validates standards and processes are in place to confirm subcontractors meet regulatory and contract requirements for effective pre-contracting evaluation and service level requirements, ongoing monitoring and contract management activities ■ Coordinates with legal counsel, government programs investigators and others as needed to conduct investigations ■ Serves as key point of contact for regulatory agencies interfacing with UnitedHealthcare	■ Bachelor's degree or equivalent experience ■ 3+ years of experience in direct management of a health plan compliance program ■ Experience leading government program audits and compliance initiatives ■ Experience developing relationships with regulatory agencies ■ Ability to navigate and influence a complex, matrixed environment across health plan and other delegated entities and drive to resolution ■ Demonstrated ability to be adept at understanding and resolving complex concepts and situations presented by the business environment; ability to assess complex problems and recommend the appropriate compliance solutions ■ Ability to effectively deal with ambiguity — can effectively cope with change, can shift gears comfortably, can decide and act without having the total picture, comfortably handles risk and uncertainty in a manner consistent with UnitedHealth Group's core values, culture and common language of leadership
Program Integrity Manager	■ Makes sure internal processes are executed for instances of health care FWA by medical profession or insured member ■ Acts as FWA subject matter expert for federal and local FWA regulations and subsequent regulatory policy and process implementation ■ Ensures that changes in requirements are included in education and carried out for required audiences ■ As necessary, gather and analyze all information and documents related to an FWA investigation ■ Ensures that procedures are in place to review and report possible violations in accordance with the reporting requirements as outlined in the FWA Plan ■ Reviews vendors to make sure that all aspects of FWA are managed and policies are developed where gaps are identified	■ 2+ years of experience in an FWA, investigations, regulatory or compliance role, or related experience ■ 2+ years of experience working in a government, health care, managed care or insurance environment, or related experience ■ Intermediate or advanced proficiency using MS Word, MS Excel and MS PowerPoint ■ Bachelor's degree or equivalent experience ■ 2+ years of experience auditing medical billing and coding ■ Proven record of ability to translate highly complex concepts in ways that can be understood by a variety of audiences ■ Ability to identify root cause issues and enable appropriate corrective action ■ Demonstrated ability to communicate effectively in written and verbal English ■ Ability to manage multiple projects and multiple relationships across the matrix; Ability to stay organized and use time management skills; Ability to work effectively and congenially with employees at all levels
Investigator	■ Conducts audits and performs data analytics activities as assigned to identify FWA and confirm the program integrity function under the contract ■ Prepares reports of findings and submits them to the program integrity manager	■ Associate degree or bachelor's degree in compliance, analytics, government/public administration, auditing, security management or pre-law ■ 2+ years of health care data analytics or relevant FWA investigation experience

Position	Responsibilities	Education and Qualifications
	■ Liaison with the state in all matters regarding program integrity ■ Oversees the development and operations of a fraud control program within the claims payment system ■ Coordinates FWA and investigation efforts with the program integrity manager, and as assigned, other agencies concerning program integrity issues	■ Experience in managed care and government programs ■ Experience leading audits and major program initiatives

National Support for Fraud, Waste and Abuse Activities

Our national FWA program consists of more than 70 UnitedHealthcare FWA staff across the country having a diverse set of backgrounds and more than 730 combined years' experience identifying and resolving FWA activities. In addition to national support, our local Mississippi-based staff collaborate with more than 90 anti-FWA investigators and a broad network of support personnel across our member and provider operations teams at our affiliate subcontractor Optum. This network includes senior investigators, analysts, coding consultants, recovery representatives, RNs and LPNs. All FWA staff are dedicated to monitoring provider and member behavior for any aberrant or wasteful trends.

Fraud, Waste and Abuse Staff Training

New investigators are required to go through an extensive multi-week orientation course. The course covers a wide range of topics, including, but not limited to:

- Fundamentals of insurance and managed care
- Subjects of investigations
- Indications of fraud and abuse (schemes and indicators)
- Regulatory and client obligations
- Business resources
- Investigative tools
- Development of action plan
- Documentation
- Gathering information (data access)
- Data analysis
- Working with law enforcement
- Legal remedies
- Negotiations

FWA Savings
During the past three years, our FWA activities have saved Medicaid $357 million, including $5.98 million for Mississippi.

At least annually, our fraud, waste and abuse staff stays up to date on programmatic changes through a mandatory course on LearnSource, our companywide, online learning management system for all employees. In addition, we require our investigators to take a minimum of nine hours of fraud, waste and abuse training annually. In 2021, they each completed a total of 24 hours of additional specialized training. Our fraud and abuse operations training unit provides much of the follow-up training and coordinates external training opportunities, including:

- The National Health Care Anti-Fraud Association (NHCAA) Institute for Learning (fraud-specific training in schemes, analysis techniques, tools)
- Technical training via nationally recognized vendors
- Clinically based training in high-risk specialty areas (e.g., durable medical equipment, cosmetic surgery, dermatology)

In addition to our FWA program staff, FWA training is required for all UnitedHealth Group employees, managers, directors, applicable company subcontractors and employees of other companies who perform work on our behalf. All FWA-related employee training must be completed within 30 days of hire and annually thereafter. Training begins with the new employee orientation, which is augmented by organizational training

courses relating to the Code of Conduct, Privacy and Security and Conflicts of Interest. We require specialized courses covering identification and reporting of suspected FWA; communication between employees and our compliance department; the False Claims Act and Whistleblower Protection. Mandatory retraining requires an attestation and/or a passing test score.

7. Describe how staff will respond to requests from the Division regarding complaints, ad hoc reports, etc., as required in Section …

Our staff are committed to providing complete, timely and accurate responses to all Division requests. Our compliance officer is accountable for the tracking and timely submission of all complaints and ad hoc reports. We have a strong process and secure system in place, managed by our compliance team, to confirm we meet or exceed all requirements for submission of required contract deliverables and ad hoc requests.

All ad hoc reports, requests and Division-initiated complaints will be tracked in our enterprise tracking system and managed by our compliance team. Our processes for intake, triage, tracking and submission include:

- Acknowledging receipt of the Division's written, electronic or verbal requests for assistance, including the required date of resolution, no later than one business day from receipt of the request from the Division in the same manner the request was received — and in the case of verbal requests, acknowledging the request both verbally and electronically
- Acknowledging the Division's urgent requests for assistance immediately, without unreasonable delay and granting urgent requests priority
- Entering the ad hoc request in the regulatory account management portal of our enterprise tracking system dedicated to tracking ad hoc regulator requests
- Assigning an internal due date, triaging and distributing the request to the accountable business owner
- Upon receipt of the information from the accountable owner, performing a quality check to verify that all aspects of the request are addressed
- Receiving and reviewing the response to fulfill the Division's request, including replying to the Division's original request for information to make sure our response is complete
- Monitoring outstanding requests via regulatory account management reporting and escalating as necessary to enable timely response
- Submitting the response within five business days, if the Division does not specify a specific due date conforming to specifications requested by the Division concerning form, format or content of the summary, if any

We will collaborate with the Division on the Division-initiated complaints and will close them out in our system when we receive notification from the Division that they have closed the complaint. All urgent ad hoc reports or Division-initiated complaints are acknowledged immediately and have compliance officer, executive and appropriate functional area engagement.

8. Describe staff who will be responsible for subrogation and Third Party Liability activities, including staffing levels and …

Our compliance officer oversees a dedicated team of professionals responsible for our subrogation, coordination of benefits (COB) and third-party liability (TPL) activities. Guided by formal policies and procedures — and assisted by information systems dedicated to TPL identification, validation and recovery — these team members handle all aspects of subrogation, COB and TPL. This concerted effort makes certain that the Division is the payer of last resort for covered services when appropriate.

The compliance officer holds a monthly compliance meeting at which any matters about payment integrity, including COB, subrogation and TPL are discussed with health plan leadership.

Staffing Levels and Qualifications

The following table outlines the staff resources and qualifications designated to carry out our subrogation, COB and TPL activities.

Title	Minimum Experience & Qualifications	Skills Required
Compliance Officer	■ 3+ years of experience in direct management of a health plan compliance program ■ Experience leading government program audits and compliance initiatives ■ Experience developing relationships with regulatory agencies ■ Experience leading audits and major program initiatives	■ Adept at understanding and resolving complex concepts and situations presented by the business environment; ability to assess complex problems and recommend the appropriate compliance solution(s) ■ Ability to navigate and influence across UnitedHealthcare, Optum and other delegated entities and drive to resolution ■ Ability to effectively deal with ambiguity – can effectively cope with change, can shift gears comfortably, can decide and act without having the total picture; comfortably handles risk and uncertainty in a manner consistent with UnitedHealthcare's core values, culture and common language of leadership ■ Solid skills in goal(s) setting and working independently to achieve them ■ Advanced writing/presentation skills
COB Staff: ■ Three managers ■ 59 recovery resolution representatives ■ One COB plan strategist	**Manager** ■ High School Diploma or GED ■ 1+ years previous leadership experience required ■ 1+ years of experience developing a team and coaching to meet production needs ■ 1+ years of experience working in a claims or call center environment **Recovery Resolution Representatives** ■ High School Diploma or GED ■ 1+ years of claims or call center experience ■ 1+ year of customer service experience analyzing and solving customer problem **COB Plan Strategist** ■ High School Diploma or GED ■ 2+ years of business analysis experience identifying business needs and determining solutions ■ 2+ years of data analysis experience, including root cause identification ■ 2+ years of working knowledge of Medicare and/or Medicaid claims experience (i.e., processing, reviewing, auditing, billing etc.)	**Manager** Enthusiastic, willing to identify disorganization and convene the right partners to promote clarity of purpose **Recovery Resolution Representatives** Ability to utilize multiple systems and platforms while on a call with a member; ability to listen skillfully, collect relevant information, determine immediate requests and identify the current future needs of the member **COB Plan Strategist** COB investigation, identification of potential other insurance for cost savings, member and provider services, quality assurance, training delivery and instructional design, reporting, project implementation/management, insurance claims processing

Title	Minimum Experience & Qualifications	Skills Required
	2+ years of CSP Facets system experience in a claims, service or data role	
Subrogation Staff: ■ One manager ■ One investigator ■ Two subrogation analysts	**Manager** Undergraduate degree or equivalent work experience	**Manager** Manages and is accountable for the activities of the subrogation analysts and investigators. Responsible for overall knowledge of the business and system application functions for training and coaching. Sets team direction, resolves problems and provides guidance to team members. Adapts departmental plans and priorities to address business and operational challenges. Provides input to forecasting and planning activities.
	Investigator High school diploma and equivalent job experience	**Investigator** Responsible for intake of information, gathering missing accident details, initiating subrogation cases and communication with involved parties. Reviews paid claims data and medical history to create accident-related paid claims itemizations to attorneys and insurance carriers. Ensures adherence to state and federal compliance policies, reimbursement policies and contract compliance.
	Subrogation analysts High school diploma and experience handling subrogation cases or working in the insurance industry or legal profession	**Subrogation analysts** Investigate and pursue recoveries and payables on subrogation claims and file management, including processing of recoveries. Ensures adherence to state and federal compliance policies, reimbursement policies, contract compliance and legal compliance. May conduct investigations to review medical history.

Coordination of benefits staff responsibilities:

- Monitor and implement COB processes to confirm compliance with MississippiCAN and CHIP contract requirements
- Monitor inbound COB files to make sure files are correct
- Monitor, trend and identify COB savings
- Validate COB leads and set COB flags
- Review weekly claims reports to identify claims error trends and verify claims processing correctly applies COB
- Review processed COB claims to validate processing accuracy and SOP compliance
- Review, research and approve COB standard operating procedure updates and changes
- Act as liaison between health plans and other business segments regarding COB
- Act as COB representative and participate in health plan or state audits, as needed

Subrogation, TPL and payment integrity staff responsibilities:

- Review paid claims to confirm all related paid claims are included in a subrogation file
- Notify involved parties (i.e., insurance carriers and attorneys) of the subrogation interest and any applicable laws
- Investigate using available resources to obtain accident information, as necessary

- Confirm compliance with contract policies and procedures for coordinating and communicating with the Division
- Negotiate reimbursement with the involved parties (i.e., attorneys, insurance carriers)

9. Describe staff who will be responsible for the entity's encounter reconciliation policies and process, including staffing levels and …

Achieving Operational Excellence

We understand and value the importance of timely and accurate encounter data submission. At the executive level, our chief financial officer is the key team leader responsible for overseeing our financial operations. The chief financial officer focuses on financial outcomes specific to MississippiCAN and CHIP, and works closely with the encounter operations staff and the Division to maintain accurate and complete encounter data.

Further executive oversight includes our chief information officer, who oversees the information technology (IT) capabilities that support our operations, including the submission of accurate and timely encounter data. The chief information officer leads a capable team that provides system deliverables to safeguard encounter reporting and accuracy effectively.

We have a core encounter operations team of three staff members who support MississippiCAN and CHIP: a director, an associate director and a senior business analyst. This team is responsible for encounter submission, reconciliation policies and associated processes. This team works with IT staff to send all data, validate claims system data, reconcile encounter submission reports and match financial fields of a claim with the financial fields of adjudicated encounters. Staff qualifications include an undergraduate degree and experience in business and financial analysis, data analysis and process improvement.

Name, Title	Responsibilities	Education and Qualifications
Director, Encounter Program Management	■ Maintains accountability for meeting all CHIP encounter commitments ■ Responsible for staffing and qualifications of the encounter team ■ Assists associate director on issues requiring escalation for swift resolution	■ Undergraduate degree ■ 10+ years previous operations, industry or program management experience ■ Demonstrated success in strategic decision making ■ Prior experience leading a team, including developing relevant skills ■ Experience identifying, escalating and resolving risks
Associate Director, Encounter Program Management	■ Encounter team leader responsible for meeting CHIP encounter commitments ■ Participate as key contributor in standing meetings with the Division and its fiscal agent ■ Supports issue identification and resolution ■ Measures compliance with contractual requirements monthly	■ Undergraduate degree ■ Experience leading and developing teams, including 1+ year leading direct reports ■ 5+ years of project/program management experience, managing multiple work streams ■ Demonstrated experience managing team through changing priorities and ambiguity ■ Demonstrated ability to communicate effectively across internal functional leaders and teams and with external stakeholders
Senior Business Analyst	■ Serves as CHIP encounter subject matter expert, understanding Division requirements and translating them into business processes ■ Identifies and corrects encounter data file rejects and works with IT team on resubmission ■ Collaborates with other functional teams to conduct root cause analysis and drive resolution of any identified encounter operation issues	■ High school diploma or GED ■ 4 years of work experience in the health care industry analyzing data or any experience with claims or SQL knowledge ■ Intermediate or higher level of proficiency with MS Word and Excel

Name, Title	Responsibilities	Education and Qualifications
	■ Facilitates biweekly standing meetings with the Division and its fiscal agent to collaborate on process improvement and issue resolution	

Our proposed encounter senior business analyst holds recurring meetings with health plan leaders and internal partners to review reports on encounter submission trends and completeness.

10. Describe staff who will be wholly dedicated to the associated Contract and those staff members that are shared.

UnitedHealthcare will operate and oversee all administrative services covered under the MississippiCAN and CHIP contract. Our chief executive officer (CEO) has overall responsibility for oversight and coordination of administrative services performed within the health plan and has ultimate responsibility for meeting the programs' requirements. We maintain a local health plan that is fully dedicated to MississippiCAN and CHIP members, while benefiting from the economies of scale derived through our parent company, UnitedHealth Group's, national administrative resources. Our strong local presence includes a projected 350 full-time employees, thereby benefits from UnitedHealth Group's nearly half-century experience serving 7,690,000 members in 31 states and the District of Columbia.

Our national administrative services augment the health plan's services for those functions best managed through a centralized administrative office. This collaboration enables us to retain local health plan accountability while gaining administrative and operational efficiencies through shared resources and experience; some functions are performed by wholly dedicated staff, others by shared staff, and the remainder by a combination, or hybrid, of the two. Each of these functional areas has a direct reporting relationship with our CEO. Our chief operating officer and functional area directors and managers work in concert with our administrative services and operations personnel to create business strategies and operational plans that optimize the use of our resources to best serve our members.

We interpret wholly dedicated staff as those positions comprising key personnel or employees whose time is 100% allocated to the implementation or operationalization, regardless of location, of the MississippiCAN and Mississippi CHIP contract. Shared staff refers to those positions whose time is allocated across more than one health plan or line of business, while hybrid functions are those using some combination of the two.

Figure 6. Health Plan Reporting Relationship.

The following table indicates those business functions performed by wholly dedicated, hybrid or shared staff. All functions have accountable staff at the Mississippi health plan.

Functions Performed by Wholly Dedicated Staff	Hybrid Functions (Wholly Dedicated + Shared Staff)	Functions Performed by Shared Staff
■ Executive Leadership ■ Operations ■ Marketing and Member Services ■ Continuous Improvement ■ Quality Management and Continuous Quality Improvement (CQI) ■ Annual Budget Oversight ■ Business and Strategic Plans	■ Clinical ■ Contract Management ■ Compliance and Program Integrity ■ Risk Management ■ Information Management ■ Grievance and Appeals Management	■ Human Resources Director ■ Legal Department ■ Facilities Management

The following paragraphs describe these key Mississippi functions, our approach to oversight and coordination of those services, and which position or department has responsibility for oversight and coordination of the service.

Wholly Dedicated Functions

Executive Leadership: The executive leadership team maintains operational oversight and direction for all plan administrative services, enabling us to retain local direction while benefiting from the use of shared resources and experience. Our CEO is responsible for the overall performance of MississippiCAN and CHIP. This includes driving strategic conversations with the executive leadership team (i.e., chief operating officer, chief financial officer, medical director, behavioral health/SUD executive director, quality management director, health services director, population health director, pharmacy director, chief information officer and compliance officer), developing strategic plans and assuring operational excellence.

Operations: The CEO is responsible for all performance in administering the MississippiCAN and CHIP contract. Our chief operating officer, supported by our local leadership team, oversees all daily operations, including member services and experience, provider services, operation and contract management, vendor management and performance excellence. The chief operating officer supports the CEO by serving as the liaison with county agency stakeholders and the Division in matters regarding program performance. Other supporting staff include our network contracting manager, member services and marketing manager, and data management.

Marketing and Member Services: Our member services manager oversees our marketing teams, providing expertise and customer service support to members, customers and providers. The member services manager develops and executes growth and marketing strategies to drive continued growth and innovation in Mississippi and has accountability for the strategic growth and retention efforts in the state.

Continuous Improvement: To promote continuous improvement, our chief operating officer oversees critical operations, administrative services and fiscal management. We use outcomes and reporting data to monitor and continually improve our performance through updated standard operating procedures and innovative system enhancements. This role continually assesses performance, defines and drives improvement initiatives, and monitors progress to enhance member services and increase operational efficiencies. These functions include member services, provider services, IT systems, performance data reporting and encounter claims submission, claims payment, grievances and appeals.

Quality Management and Continuous Quality Improvement (CQI): Our quality management director makes sure our quality goals meet Division and national benchmarks, MississippiCAN and CHIP requirements, and drive meaningful improvement in member health outcomes. The quality management director identifies improvement opportunities through ongoing monitoring of key quality of care or service indicators. If a key quality indicator misses our performance expectations, we use established quality improvement tools and techniques to drive improvement.

Annual Budget Oversight: Our chief financial officer continually analyzes and assesses the annual budget and the total cost of care to identify opportunities to improve efficiencies and gain greater value for Division expenditures. In addition, the chief financial officer evaluates our forecasting and financial performance, measured against Division program requirements, to determine our ability to achieve the Medicaid contract goals and objectives. This individual tracks expenditures, driving economies of scale and operational efficiencies to help reduce the cost of care.

Business and Strategic Plans: Our policies and procedures support the integration of financial and performance data to allow us to comply with all applicable federal and state requirements. Our leaders review and approve the reports provided by functional areas to evaluate service delivery and seek operational efficiencies. Communication occurs daily and at routine intervals between professionals within and across departments. In the business reviews, we evaluate performance targets and results to formulate operational improvement plans, gauge progress on current plans and discuss additional relevant topics.

Our CEO is responsible for the overall performance of MississippiCAN and CHIP, including all contractual commitments in our business and strategic plan. He aligns and incorporates UnitedHealthcare's operational strategies into our Mississippi strategic and operational business plans, with support from the leadership team, including the chief operating office, chief financial officer, health equity director, medical director, regional human capital partner, IT director, compliance officer and other key leaders (e.g., network director, state growth leader, behavioral health and medical director).

Hybrid Functions

Clinical: The clinical team provides total population health, including clinical oversight of health services, risk stratification, clinical management and care coordination, quality management, utilization management (UM) and case management. The clinical leadership is responsible for assuring the integration of physical, behavioral health and pharmacy services and is led by the following:

- Chief medical officer (CMO)
- Care management director
- Behavioral health/SUD executive director
- Clinical pharmacist
- Population health director

Contract Management: Ultimate accountability for our performance resides with our CEO, who establishes mechanisms to verify that each contract management function meets performance expectations. We leverage national provider contracting and support, subcontractor and vendor management, and grievances and appeals resources to comply with the MississippiCAN and CHIP contracts.

- **Provider Contracting:** Our national shared network team (shared function) oversees, establishes and maintains strong business relationships with hospital, physician, pharmacy or ancillary providers and makes sure the network includes an appropriate distribution of provider specialties. In partnership with our Mississippi-based team, they oversee provider contracting functions to yield a geographically competitive, broad access, stable network that achieves unit cost performance and trend management objectives, and produces an affordable and predictable product for customers and business partners.
- **Provider Network Program Management:** Our national network program management team is responsible for successful program design, compliance with network requirements, network assessment and selection, and program/product implementation. This team oversees the provider operations team, which verifies that network providers are in the claim's platform and directory, as well as the local provider advocates, who assist network providers in resolving administrative issues and provide quality improvement training.

- **Vendor Contract Management:** Dedicated vendor relationship owners (VROs) oversee our Mississippi subcontractors and confirm that their staff, policies and procedures meet the requirements of their agreement. The VROs interact with subcontractors and vendors at least quarterly, and more often as necessary, to share performance indicators, program changes and suggestions for improved alignment of services in support of the state's MississippiCAN and CHIP goals. The VROs conduct subcontractor monitoring activities locally, along with quality and compliance committees and executive leadership, to verify subcontractors are meeting performance metrics.

Compliance and Program Integrity: Our compliance officer leads our compliance team and is responsible for overseeing the program integrity and compliance-related activities. This includes complying with state and federal rules and regulations, preventing and detecting fraud, communicating with the Division's Program Integrity Unit and the Medicaid Fraud Control Unit of the Attorney General's Office, coordinating implementation of the contract, tracking and submission of contract deliverables and coordinating audits.

Risk Management: Our compliance officer oversees risk management. Our enterprise risk management (ERM) team collectively draws on broad and diverse professional backgrounds and experiences, including audit, accounting, compliance, finance, information technology, marketing, and operations, to operationalize our strategic goals and objectives. Our ERM team assists the compliance officer with risk identification and assessments, facilitating risk validation workshops, risk response development, project risk management, process improvement and risk measurement development. Together, they assess MississippiCAN and CHIP contract compliance and any associated risk, including fraud, waste and abuse. The compliance officer is accountable to the CEO and receives administrative support from our corporate compliance team.

Information Management: Our chief information officer oversees administrative and fiscal management, performance data reporting and encounter claims submissions, and IT systems. This individual is part of the leadership team and reports to our national IT team.

Grievance and Appeals Management: Our grievance and appeals manager monitors member and provider grievance and appeals intake, investigation, communication and resolution activities. This individual works closely with our compliance officer and UnitedHealthcare's national compliance team to confirm our grievance and appeals processes and outcomes comply with state and federal requirements.

Shared Functions

Legal Department: Our chief legal officer (CLO) oversees the national legal, compliance & regulatory affairs (LCRA) team. The LCRA team provides high-quality, professional services that help UnitedHealthcare deliver on commitments to customers, providers, regulators and business partners. The CLO oversees our local legal, compliance and regulatory affairs professionals. Compliance maintains its independence as it sits on the leadership team and reports directly to our leadership. These teams monitor changes to requirements, regulations and laws, oversee compliance with contractual and regulatory requirements, manage fraud, waste and abuse activities, conduct legal research, advise business partners, and establish and implement standard policies and procedures. The LCRA team updates health plan process to align with industry best practices across the organization to promote compliance with applicable laws and contractual obligations.

Facilities Management: The UnitedHealthcare associate director of real estate services oversees facilities management under our enterprise real estate services department. Facilities management services makes sure workplace facilities are clean, orderly and in good repair, and provides flexible workplace solutions to support our business operations. They support the transaction, construction and facility services (cleaning, security, food service), and create shared spaces to support connections between our employees and members.

Human Resources: Our regional human capital leader oversees our human resource functions, including talent acquisition, compensation, retention and development initiatives. The regional leader closely partners with our

local leaders to support inclusion and diversity hiring practices that consider race, ethnicity, gender, gender identity, culture, language, veteran status and people of all abilities.

[END OF RESPONSE]

4.3.3.5 Subcontractors (Marked)

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

Please see descriptions of the subcontractors we expect to use for this contract after our narrative response to 4.3.3.5 Subcontractors.

Our organization is designed in such a way that subcontractor operations and staff at all levels are aligned and integrated philosophically, organizationally and operationally to deliver accountability and quality performance. Because this philosophy and management structure is based on command and control, we are built, organized and integrated for success.

The subcontractors we select afford us access to a unique array of technologies, innovations and intellectual capital that help 1) create a more efficient and effective health care delivery system, 2) improve the health of the people we serve and 3) reduce health disparities across all populations.

Philosophy for Hiring Subcontractors

We vet and select our subcontractors, affiliates and other partners in Mississippi based on their demonstrated commitment to the high expectation of quality service and care that we maintain, and that our members, providers and state partners expect. We select only subcontractors who support improving the effectiveness and efficiency of service delivery, and who have a strong reputation for administrative excellence. We look for local options first because we believe that Mississippians helping Mississippians better supports our core value of Compassion. We aim to develop business relationships that are as diverse as our membership, so we actively look for opportunities to engage with businesses that certify as a Minority Business Enterprise (MBE) and/or a Woman Business Enterprise (WBE) through the Mississippi Development Authority.

During the selection process, our vendor management team evaluates each subcontractor in three categories: quality, accessibility and cost. This process includes a due diligence review of the candidate’s past performance and experience, financial strength, innovation, ability to perform the activities to be delegated, and the ability to meet our security standards. We make sure each business has appropriate licensure and certification to operate in Mississippi.

We require all subcontracted entities to sign a contract that aligns with our contract with the Division. We then work with them to establish internal standards and methods for reporting and performance measurement based on our internal — and state contractual — requirements. Our compliance officer verifies that all subcontracts are compliant with Medicaid, state and federal regulations. In addition, she makes sure that we submit all subcontracts to the Division for approval. Notifications of any changes to a subcontract that materially affect the subcontract are approved by our chief executive officer and provided to the Division 60 calendar days before the execution of the change amendment.

In accordance with HIPAA, we enter into business associate agreements with certain subcontractors to verify compliance with privacy and security regulations. This agreement includes delivery of administrative services at a standard to meet all contract requirements.

Approach to Subcontractor Management and Oversight

Accountability and responsibility for full contract and program compliance is a core organizational belief, goal and imperative, and our subcontractors are an extension of this belief. We designate account directors within our subcontractor partner organizations to serve as our key points of contact for each contract, providing targeted responsibility and accountability with direct subcontractor access to key personnel. We designate accountable relationship owners from MississippiCAN and CHIP in the appropriate functional area to work with specific subcontractors. The local relationship owner works with regional and national relationship owners to perform oversight functions.

We monitor and manage our Mississippi subcontractors' performance relative to our internal and MississippiCAN and CHIP contractual requirements through the mechanisms described below:

Internal functional area leaders, quality and compliance committees, and executive leadership, together with the subcontractors' staff performing the services, regularly monitor subcontractors. This consistent governance oversight helps to verify that subcontractors are meeting performance metrics and their staff, policies and resources are appropriate to the requirements of their agreement. Results of these monitoring activities are reported in the Delegated Vendor Joint Oversight Committee (DVJOC), Service Quality Improvement Subcommittee (SQIS) and compliance committee meetings, which include our executive leadership.

Delegation and Vendor Joint Oversight Committee

Our chief operating officer and delegated services manager oversee our DVJOC and are accountable for oversight of all subcontractor functions for MississippiCAN and CHIP.

The DVJOC maintains an effective and efficient delegate oversight program that exceeds our regulatory and contractual obligations. Its specific focus is the qualifications and performance of delegated vendors that provide coordination of behavioral health, physical health, dental, vision, transportation and nurse advice hotline benefits. In addition to reviewing the overall relationship between us and vendors at a local and national level, the responsibilities of the committee include the following:

- Review clinical, quality and operational performance metrics of delegated activities against plan-level targets as outlined by established service level agreements
- Discuss any necessary or ongoing corrective action plans, remedial actions or areas for opportunity
- Discuss any ongoing, open or significant issues related to member challenges or specific states and collaborate on opportunities for new strategic initiatives

The DVJOC meets monthly to monitor performance metrics, quality and contract compliance of subcontractors. The DVJOC reports any identified delegated vendor issues to the delegated vendor manager and through our SQIS. Our vendor management team will work with the subcontractor through the resolution of any identified issues. In addition, our Healthcare Quality and Utilization Management (QUM) Committee will monitor all clinical quality improvement and utilization management activities within our organization, and our SQIS will track metrics for compliance of subcontractors. This includes extensive review of our care management and disease management programs and review of utilization metrics from pharmacy, HEDIS® indicators for behavioral health, and grievances and appeals.

Scorecards: We use itemized scorecards during governance meetings to monitor vendor performance against contract requirements. Vendors are provided with their scorecard results, which are made available to the Division.

Statistics and Reports: Subcontractors are required to report KPIs daily, weekly, monthly or quarterly. These reports allow us to monitor and evaluate subcontractors and indicate action steps for improvements well before a small problem has a chance to evolve into a large problem. Review of these statistics occurs in our monthly DVJOC meetings.

We receive monthly utilization and encounter reports from our care management, disease management, dental, transportation and vision subcontractors. In addition, we will receive monthly reports regarding fraud, waste and abuse, subrogation, and third-party liability activities. All required records and timelines for delivery are outlined in each service level agreement (SLA) with the subcontractor. Our delegated vendor manager will confirm all required data are received from our subcontractors as scheduled.

Surveys: We perform annual member and provider surveys to gain feedback on the service of subcontractors. Our member services center performs ad hoc surveys if a caller elects to participate in a survey after their call is completed.

[END OF RESPONSE]

<table>
<tr><th colspan="5">Subcontractor</th></tr>
<tr><td colspan="5">Name of Subcontractor: Dental Benefit Providers, Inc.</td></tr>
<tr><td colspan="2">TIN/SSN (as applicable): 41-2014834</td><td colspan="3">The entity is a:
[ ] Subcontractor
[ ] Wholly-Owned Subsidiary
[X] Affiliate under the same common ownership</td></tr>
<tr><td colspan="5">Address Line 1: 10175 Little Patuxent Parkway</td></tr>
<tr><td colspan="5">Address Line 2:</td></tr>
<tr><td>City: Columbia</td><td>State: MD</td><td colspan="2">Zip Code: 21044</td><td>County: Howard</td></tr>
<tr><td>Mailing Address (P.O. Box): Same as Above</td><td>City:</td><td>State:</td><td>Zip Code:</td><td>County:</td></tr>
<tr><td colspan="5">Description of Services to be Rendered by Subcontractor for this Contract: Provides dental benefit administration and management services, such as network development and maintenance, provider credentialing and re-credentialing, customer service, oral health education, claims adjudication and payment, utilization review and management, fraud, waste and abuse services, quality management, claims encounter and reporting services, and ongoing account management.</td></tr>
<tr><td colspan="5">How will the Offeror monitor and manage this Subcontractor? Our organization leverages internal and external subcontractors to augment our operations, and service offers when appropriate. We have programs in place to monitor and ensure these partners meet relevant performance, operational, contractual, and regulatory standards. Monitoring of subcontractor functions are accomplished through several ongoing activities that include monthly Delegated Vendor Oversight Committee meetings. These meetings are held to review performance metrics, policies, and resources. Subcontractors also deliver established reports that identify any operational trends or issues, and performance initiatives are undertaken as needed. Appropriate documentation is also used to demonstrate that oversight is effective. Our structure is coordinated, transparent and designed to exceed the Division’s expectations to facilitate oversight, and enhances lines of communication, accountability, and authority to provide visibility for senior leadership.</td></tr>
<tr><td colspan="5">Has the Offeror worked with the subcontractor on a managed care contract in the past three (3) years? [X] Yes [ ] No

If yes, fill out Prior Experience with Subcontractor for each applicable instance.</td></tr>
<tr><td colspan="5"></td></tr>
</table>

Prior Experiences with Subcontractor				
Client's Name: Dental Benefit Providers, Inc.				
Client Location				
Address Line 1: 10175 Little Patuxent Parkway				
Address Line 2:				
City: Columbia	**State:** MD	**Zip Code:** 21044	**County:** Howard	
Mailing Address (P.O. Box): Same as Above	**City:**	**State:**	**Zip Code:**	**County:**
Direct Contact for Client				
Name: Jennifer King				
Title: Senior Account Manager, Client Services				
Phone Number: 651-414-8852	**Email Address:** Jennifer.King5@uhc.com			
Work Details				
Number of covered lives: End December 2021 - 186,983				
Time period of contract: Evergreen. This contract continues to renew unless termination by one of the parties.				
Total number of staff hours expended during time period of contract: 2021 - 30,160 staff hours per year				
Personnel requirements: 2021 - 14.5 FTE's – 3 Network, 0.5 Clinical, 1 Account Management, 10 Call Center				
Geographic and population coverage requirements: Geographic area is state-wide. Population is all covered Medicaid program members.				
Publicly funded contract cost: 2021 - $60.5 million				
Description of work performed under this contract				
Provides dental benefit administration and management services, such as network development and maintenance, provider credentialing and re-credentialing, customer service, oral health education, claims adjudication and payment, utilization review and management, fraud, waste and abuse services, quality management, claims encounter and reporting services, and ongoing account management.				

Subcontractor				
Name of Subcontractor: CareCore National, LLC dba eviCore healthcare ("eviCore")				
TIN/SSN (as applicable): 14-1831391		**The entity is a:** **[X] Subcontractor** **[ ] Wholly-Owned Subsidiary** **[ ] Affiliate under the same common ownership**		
Address Line 1: 400 Buckwalter Place Blvd.				
Address Line 2:				
City: Bluffton	**State:** SC	**Zip Code:** 29910	**County:** Beaufort	
Mailing Address (P.O. Box): Same as Above	**City:**	**State:**	**Zip Code:**	**County:**
Description of Services to be Rendered by Subcontractor for this Contract: Provides utilization management services/prior authorization for radiology and cardiology covered services. This subcontractor is an evidence-based health care solutions firm that conducts management services for outpatient advanced radiology and cardiology benefits by targeting utilization and quality. Through the program, advanced radiology modalities include magnetic resonance imaging (MRI), magnetic resonance angiogram (MRA), computed tomography (CT) — including contrast and three-dimensional identity (3DI), positron emission topography (PET) and nuclear medicine.				
How will the Offeror monitor and manage this Subcontractor? Our organization leverages internal and external subcontractors to augment our operations, and service offers when appropriate. We have programs in place to monitor and ensure these partners meet relevant performance, operational, contractual, and regulatory standards. Monitoring of subcontractor functions are accomplished through several ongoing activities that include monthly Delegated Vendor Oversight Committee meetings. These meetings are held to review performance metrics, policies, and resources. Subcontractors also deliver established reports that identify any operational trends or issues, and performance initiatives are undertaken as needed. Appropriate documentation is also used to demonstrate that oversight is effective. Our structure is coordinated, transparent and designed to exceed the Division's expectations to facilitate oversight, and enhances lines of communication, accountability, and authority to provide visibility for senior leadership.				
Has the Offeror worked with the subcontractor on a managed care contract in the past three (3) years? [X] Yes [ ] No **If yes, fill out Prior Experience with Subcontractor for each applicable instance.**				

Prior Experiences with Subcontractor				
Client's Name: CareCore National, LLC dba eviCore healthcare ("eviCore")				
Client Location				
Address Line 1: 400 Buckwalter Place Blvd.				
Address Line 2:				
City: Bluffton	**State:** SC	**Zip Code:** 29910	**County:** Beaufort	
Mailing Address (P.O. Box): Same as Above	**City:**	**State:**	**Zip Code:**	**County:**
Direct Contact for Client				
Name: Cayce Awe				
Title: VP, Strategic Client Relationship Executive				
Phone Number: 860-808-9124	**Email Address:** CAwe@evicore.com			
Work Details				
Number of covered lives: ~190k				
Time period of contract: 2/01/2014 - present				
Total number of staff hours expended during time period of contract: Varies (20,800-41,600 per year)				
Personnel requirements: Varies (10-20 FTEs)				
Geographic and population coverage requirements: All members/providers state-wide				
Publicly funded contract cost: 2021 Annual revenue for all UHC Community and State was $15,472,607.				
Description of work performed under this contract				
eviCore provides utilization management for radiology services which include a review of requested procedures for clinical appropriateness using evidence-based guidelines to support that review.				

Subcontractor				
Name of Subcontractor: Medical Transportation Management (MTM)				
TIN/SSN (as applicable): 43-1719762		**The entity is a:** **[X] Subcontractor** **[ ] Wholly-Owned Subsidiary** **[ ] Affiliate under the same common ownership**		
Address Line 1: 16 Hawk Ridge Circle				
Address Line 2:				
City: Lake St. Louis	**State:** MO	**Zip Code:** 63367	**County:** St. Charles	
Mailing Address (P.O. Box): Same as Above	**City:**	**State:**	**Zip Code:**	**County:**
Description of Services to be Rendered by Subcontractor for this Contract: MTM is a family owned and operated transportation services company. They are a Woman-Owned Business Enterprise (WBE) certified by the Women's Business Enterprise National Council. MTM is one of the largest and most established NEMT brokers, operating in 31 states, scheduling more the 20 million trips for 12 million members while handling 7.5 million calls every year.				
How will the Offeror monitor and manage this Subcontractor? Our organization leverages internal and external subcontractors to augment our operations, and service offers when appropriate. We have programs in place to monitor and ensure these partners meet relevant performance, operational, contractual, and regulatory standards. Monitoring of subcontractor functions are accomplished through several ongoing activities that include monthly Delegated Vendor Oversight Committee meetings. These meetings are held to review performance metrics, policies, and resources. Subcontractors also deliver established reports that identify any operational trends or issues, and performance initiatives are undertaken as needed. Appropriate documentation is also used to demonstrate that oversight is effective. Our structure is coordinated, transparent and designed to exceed the Division's expectations to facilitate oversight, and enhances lines of communication, accountability, and authority to provide visibility for senior leadership.				
Has the Offeror worked with the subcontractor on a managed care contract in the past three (3) years? [X] Yes [ ] No **If yes, fill out Prior Experience with Subcontractor for each applicable instance.**				

Prior Experiences with Subcontractor				
Client's Name: UnitedHealthcare Mississippi				
Client Location				
Address Line 1: 795 Woodlands Parkway, Ste. 301				
Address Line 2:				
City: Ridgeland	**State:** MS	**Zip Code:** 39157		**County:** Madison
Mailing Address (P.O. Box): Same as Above	**City:**	**State:**	**Zip Code:**	**County:**
Direct Contact for Client				
Name: Alicia Fields				
Title: Delegated Services Manager				
Phone Number: 601-718-6609		**Email Address:** Alicia_Fields@uhc.com		
Work Details				
Number of covered lives: 180K Medicaid				
Time period of contract: 8/1/19 to Present				
Total number of staff hours expended during time period of contract: 36,976 contract hours per year (2021)				
Personnel requirements: 17.78 FTE weighted between CC, Ops, and Executive/Overhead				
Geographic and population coverage requirements: Entire state of Mississippi; TANF (majority of population)				
Publicly funded contract cost: $2,800,000				
Description of work performed under this contract				
NET services				

Subcontractor				
Name of Subcontractor: MARCH® Vision Care Group, Incorporated				
TIN/SSN (as applicable): 95-4874334		**The entity is a:** **[ ] Subcontractor** **[ ] Wholly-Owned Subsidiary** **[X] Affiliate under the same common ownership**		
Address Line 1: 6601 Center Drive West, Suite 200				
Address Line 2:				
City: Los Angeles	**State:** CA	**Zip Code:** 90045	**County:** Los Angeles	
Mailing Address (P.O. Box): Same as Above	**City:**	**State:**	**Zip Code:**	**County:**
Description of Services to be Rendered by Subcontractor for this Contract: Provides routine vision and eye care benefit administration services, including provider network development, credentialing and education, eligibility, and benefit maintenance, claims processing, provider and member customer service and reporting (ad hoc, state-mandated and client specific) and claims processing.				
How will the Offeror monitor and manage this Subcontractor? Our organization leverages internal and external subcontractors to augment our operations, and service offers when appropriate. We have programs in place to monitor and ensure these partners meet relevant performance, operational, contractual, and regulatory standards. Monitoring of subcontractor functions are accomplished through several ongoing activities that include monthly Delegated Vendor Oversight Committee meetings. These meetings are held to review performance metrics, policies, and resources. Subcontractors also deliver established reports that identify any operational trends or issues, and performance initiatives are undertaken as needed. Appropriate documentation is also used to demonstrate that oversight is effective. Our structure is coordinated, transparent and designed to exceed the Division's expectations to facilitate oversight, and enhances lines of communication, accountability, and authority to provide visibility for senior leadership.				
Has the Offeror worked with the subcontractor on a managed care contract in the past three (3) years? [X] Yes [ ] No **If yes, fill out Prior Experience with Subcontractor for each applicable instance.** Offeror has worked with March Vision Care Group, Incorporated to provide vision care and related services to Medicaid and CHIP members since January 1, 2017 and adding Medicaid & Medicare eligible members since December 1, 2019.				

Prior Experiences with Subcontractor				
Client's Name: MARCH® Vision Care Group, Incorporated				
Client Location				
Address Line 1: 6601 Center Drive West, Suite 200				
Address Line 2:				
City: Los Angeles	**State:** CA	**Zip Code:** 90045	**County:** Los Angeles	
Mailing Address (P.O. Box): Same as Above	**City:**	**State:**	**Zip Code:**	**County:**
Direct Contact for Client				
Name: Ann C. Ritchey				
Title: Director, Client Relations & Business Development				
Phone Number: 310-216-2314	**Email Address:** ARitchey@marchvisioncare.com			
Work Details				
Number of covered lives: As of 1/24/2022: 185,069 Medicaid members and 16,209 Medicare members.				
Time period of contract: Evergreen. This contract continues to renew unless termination by one of the parties.				
Total number of staff hours expended during time period of contract: For approximately 143 full-time employees, an estimated 297,440 staff hours per year.				
Personnel requirements: Approximate breakdown of full-time employees are as follows: 42 in Customer Service, 38 in Business Operations/Systems, 22 in Claims, 25 in Information Technology, 7 in Client Relations & Bus Dev, 5 in Provider Network Solutions, and 4 in Senior Management.				
Geographic and population coverage requirements: Geographic area is state-wide. All members/providers statewide.				
Publicly funded contract cost: $925,436.35				
Description of work performed under this contract				
Provides routine vision and medical services within the scope of an optometrist. Eye care benefit administration services, to include provider network development, credentialing and education, provider customer services, eligibility and benefits maintenance, reporting and claims processing.				

<table>
<tr><th colspan="5">Subcontractor</th></tr>
<tr><td colspan="5">Name of Subcontractor: OptumHealth Care Solutions, LLC (Optum)</td></tr>
<tr><td colspan="2">TIN/SSN (as applicable): 41-1591944</td><td colspan="3">The entity is a:
[ ] Subcontractor
[ ] Wholly-Owned Subsidiary
[X] Affiliate under the same common ownership</td></tr>
<tr><td colspan="5">Address Line 1: 11000 Optum Circle</td></tr>
<tr><td colspan="5">Address Line 2:</td></tr>
<tr><td>City: Eden Prairie</td><td>State: MN</td><td colspan="2">Zip Code: 55344</td><td>County: Hennepin</td></tr>
<tr><td>Mailing Address (P.O. Box): Same as Above</td><td>City:</td><td>State:</td><td>Zip Code:</td><td>County:</td></tr>
<tr><td colspan="5">Description of Services to be Rendered by Subcontractor for this Contract: Provides clinical care coordination and network access to the “Centers of Excellence” network for members seeking high cost and treatment-variable transplant procedures; 24-hour, seven-day a week health information through NurseLine, where members can seek advice on symptoms and support navigating their health plan, network and community resources; and, network access for chiropractic care, physical, occupational and speech therapy; and complementary alternative medicine.

Additionally, Optum provides Utilization Review and Utilization Management for three programs: 1) Therapy Prior Authorization program, which improves quality of care and reduces clinical variance by aligning member care with evidence-based practice, 2)The Neonatal Resource Services Program, which facilitates appropriate use of healthcare services for members requiring Neonatal Intensive Care services and 3) The Healthy First Steps™ program for expectant mothers, which facilitates appropriate use of healthcare services for members requiring in patient prenatal admission or outpatient prenatal services requiring authorization.</td></tr>
<tr><td colspan="5">How will the Offeror monitor and manage this Subcontractor? Our organization leverages internal and external subcontractors to augment our operations, and service offers when appropriate. We have programs in place to monitor and ensure these partners meet relevant performance, operational, contractual, and regulatory standards. Monitoring of subcontractor functions are accomplished through several ongoing activities that include monthly Delegated Vendor Oversight Committee meetings. These meetings are held to review performance metrics, policies, and resources. Subcontractors also deliver established reports that identify any operational trends or issues, and performance initiatives are undertaken as needed. Appropriate documentation is also used to demonstrate that oversight is effective. Our structure is coordinated, transparent and designed to exceed the Division’s expectations to facilitate oversight, and enhances lines of communication, accountability, and authority to provide visibility for senior leadership.</td></tr>
<tr><td colspan="5">Has the Offeror worked with the subcontractor on a managed care contract in the past three (3) years? [X] Yes [ ] No

If yes, fill out Prior Experience with Subcontractor for each applicable instance.</td></tr>
<tr><td colspan="5"></td></tr>
</table>

Prior Experiences with Subcontractor				
Client's Name: OptumHealth Care Solutions, LLC (Optum)				
Client Location				
Address Line 1: 11000 Optum Circle				
Address Line 2:				
City: Eden Prairie	**State:** MN	**Zip Code:** 55344	**County:** Hennepin	
Mailing Address (P.O. Box): Same as Above	**City:**	**State:**	**Zip Code:**	**County:**
Direct Contact for Client				
Name: Jenny Garcia				
Title: Assoc. Director Care Advocacy				
Phone Number: 952-687-3998	**Email Address:** jenny.garcia@optum.com			
Work Details				
Number of covered lives: 162K in MSCAN, 28K in CHIP				
Time period of contract: Since 2010				
Total number of staff hours expended during time period of contract: 95,680 per year (pertains to both Optum entities, United Behavioral Health, Inc. and OptumHealth Care Solutions, LLC)				

Personnel requirements:
The total number of FTEs is 46.0 and pertains to both Optum entities, United Behavioral Health, Inc. and OptumHealth Care Solutions, LLC.

Job Title	FTE
Executive Director	1.0
Director of Clinical Operations	0.2
Sr. Clinical Program Manager	1.6
Care Advocate Team Lead	1.0
Care Advocate - Field	9.5
Care Advocate - UM	7.9
Care Advocate - UM (A&T Member)	0.4
UM Coordinator	1.0
Psychiatrist - STEM/Outpt Practice Mgmt	0.03
Care Advocate - STEM	1.6
Provider Enablement Consultant	1.0
IOP Care Advocate (CA)	0.5
Peer Reviewer - PhD	0.4
Retro Review CA	0.4
Autism CA	1.1
Outpatient (OP) Practice Manager	0.7

Care Advocate - After Hours	1.0	
Intake After Hours	0.1	
Clinical Appeals Reviewer (formerly A&G telephonic)	0.1	
Clinical Admin Coordinator (formerly Dept Assistant - Clinical)	0.5	
Psychiatrist (ECS)	1.55	
Recovery & Resiliency Manager (new role being recruited outside of the rebid today)	1.0	
Peer Support Specialist (one additional peer added 12/4/21)	2.0	
QI Specialist	0.5	
Complaint Specialist	0.9	
Appeals & Grievance Representative - Administrative	0.2	
Integrated Care Model (ICM) Liaison	1.0	
Provider Relations Director	0.0	
Provider Relations Advocate	1.6	
Clinical Quality Analyst, Sr.	0.4	
Network Claims Liaison	0.1	
Claims Supervisor	0.2	
Sr. Claims Business Analyst	0.5	
Sr. Claims Examiner Lead (SME)	0.2	
Claims Quality Audit Representative	0.2	
Claims Rework	0.2	
Claims Rep Associate	3.0	
Finance Manager	0.4	
FWA - Investigator	0.2	
FWA - Pre-Pay	0.2	
FWA - Auditor	1.2	
FWA - Data Reporting Analyst	0.2	
FWA - Intake Coordinator	0.2	

Geographic and population coverage requirements: All members/providers state-wide, including adults and children

Publicly funded contract cost: Estimated annual revenue: $122M

Description of work performed under this contract

Provides clinical care coordination and network access to the "Centers of Excellence" network for members seeking high cost and treatment-variable transplant procedures; 24-hour, seven-day a week health information through NurseLine, where members can seek advice on symptoms and support navigating their health plan, network and community resources; and network access for chiropractic care, physical, occupational and speech therapy; and complementary alternative medicine.

Additionally, Optum provides Utilization Review and Utilization Management for three programs: 1) Therapy Prior Authorization program, which improves quality of care and reduces clinical variance by aligning member care with evidence-based practice, 2)The Neonatal Resource Services Program, which facilitates appropriate use of healthcare services for members requiring Neonatal Intensive Care services and 3) The Healthy First Steps™ program for expectant mothers, which facilitates appropriate use of healthcare services for members requiring in patient prenatal admission or outpatient prenatal services requiring authorization.

<table>
<tr><th colspan="5">Subcontractor</th></tr>
<tr><td colspan="5">Name of Subcontractor: OptumInsight, Inc.</td></tr>
<tr><td colspan="2">TIN/SSN (as applicable): 41-1858498</td><td colspan="3">The entity is a:
[ ] Subcontractor
[ ] Wholly-Owned Subsidiary
[X] Affiliate under the same common ownership</td></tr>
<tr><td colspan="5">Address Line 1: 11000 Optum Circle</td></tr>
<tr><td colspan="5">Address Line 2:</td></tr>
<tr><td>City: Eden Prairie</td><td>State: MN</td><td colspan="2">Zip Code: 55344</td><td>County: Hennepin</td></tr>
<tr><td>Mailing Address (P.O. Box): Same as Above</td><td>City:</td><td>State:</td><td>Zip Code:</td><td>County:</td></tr>
<tr><td colspan="5">Description of Services to be Rendered by Subcontractor for this Contract: Provides data analytics, technology and operational services, including payment integrity services for data mining and analytics; investigation and detection of fraud, waste and abuse; recovery; and coordination of benefits and subrogation.</td></tr>
<tr><td colspan="5">How will the Offeror monitor and manage this Subcontractor? Our organization leverages internal and external subcontractors to augment our operations, and service offers when appropriate. We have programs in place to monitor and ensure these partners meet relevant performance, operational, contractual, and regulatory standards. Monitoring of subcontractor functions are accomplished through several ongoing activities that include monthly Delegated Vendor Oversight Committee meetings. These meetings are held to review performance metrics, policies, and resources. Subcontractors also deliver established reports that identify any operational trends or issues, and performance initiatives are undertaken as needed. Appropriate documentation is also used to demonstrate that oversight is effective. Our structure is coordinated, transparent and designed to exceed the Division’s expectations to facilitate oversight, and enhances lines of communication, accountability, and authority to provide visibility for senior leadership.</td></tr>
<tr><td colspan="5">Has the Offeror worked with the subcontractor on a managed care contract in the past three (3) years? [X] Yes [ ] No

If yes, fill out Prior Experience with Subcontractor for each applicable instance.</td></tr>
<tr><td colspan="5"></td></tr>
</table>

Prior Experiences with Subcontractor				
Client's Name: OptumInsight, Inc.				
Client Location				
Address Line 1: 11000 Optum Circle				
Address Line 2:				
City: Eden Prairie	**State:** MN	**Zip Code:** 55344		**County:** Hennepin
Mailing Address (P.O. Box): Same as Above	**City:**	**State:**	**Zip Code:**	**County:**
Direct Contact for Client				
Name: Cheryl Knaut				
Title: President, Optum Payment Integrity				
Phone Number: 952-205-0861		**Email Address:** Cheryl.Knaut@optum.com		
Work Details				
Number of covered lives: Estimated 187K Medicaid				
Time period of contract: Agreements/services renewed annually; contract start date first calendar day of the year and end date last calendar date of the year (January 1st and December 31st).				
Total number of staff hours expended during time period of contract: Coordination of Benefits – 60 FTEs (122,720 hours per year) Subrogation – 4 FTEs (8,320 hours per year) Reimbursement Policy/Policy Implementation – 4.5 FTEs (9,360 hours per year) Prepay Data Mining (CCM, SAM Edit, Automation, PIPPA) – 3 FTEs (6,204 hours per year) Post Pay Data Mining – 2.5 FTEs (5,200 hours per year) Prepay Fraud & Analytics – 27 FTEs (56,468 hours per year)				
Personnel requirements: Coordination of Benefits - 60 Coordination of Benefit Representatives and Manager performing COB investigations identifying potential other insurance for cost savings. Subrogation – 1 Intake Processor, 2 File Handlers, 3 Managers performing subrogation investigations identifying accident insurance sources for recovery opportunities. Reimbursement Policy/Policy Implementation – 0.5 Health Plan Manager, 0.5 Policy Maintenance Manager, 0.5 Policy Creation, 1 Edit Developer, 1 Edit Tester, 1 Business Analyst Prepay Data Mining (CCM, SAM Edit, Automation, PIPPA) – 2 Prepay Auditors, 0.5 Prepay Support Staff, 0.5 Prepay Analytics Post Pay Data Mining – 2 Post Pay Auditors, 0.5 Post Pay Analytics Prepay Fraud & Analytics – 13.22 Registered Coders, 0.56 Licensed Practical/Vocational Nurses, 0.48 Registered Nurses				

Geographic and population coverage requirements: All members/providers state-wide.
Publicly funded contract cost: Approximately $2.24M for all products and services. This was based on actual 2021 revenue for State of MS under the UHC C&S agreement.
Description of work performed under this contract
OptumInsight Payment Integrity will provide Coordination of Benefits, Audit Recovery Operations, Payment Policy, Subrogation, Prepay Fraud and Analytics, and Claims Cost Management Services to UHC C&S.

<table>
<tr><th colspan="5">Subcontractor</th></tr>
<tr><td colspan="5">Name of Subcontractor:
OptumRx, Inc.</td></tr>
<tr><td colspan="2">TIN/SSN (as applicable): 33-0441200</td><td colspan="3">The entity is a:
[ ] Subcontractor
[ ] Wholly-Owned Subsidiary
[X] Affiliate under the same common ownership</td></tr>
<tr><td colspan="5">Address Line 1: 1600 McConnor Parkway</td></tr>
<tr><td colspan="5">Address Line 2:</td></tr>
<tr><td>City: Schaumburg</td><td>State: IL</td><td colspan="2">Zip Code: 60173-6801</td><td>County: Cook</td></tr>
<tr><td>Mailing Address (P.O. Box): Same as Above</td><td>City:</td><td>State:</td><td>Zip Code:</td><td>County:</td></tr>
<tr><td colspan="5">Description of Services to be Rendered by Subcontractor for this Contract: UnitedHealthcare expects to engage OptumRx to provide high quality, Pharmacy Care Management Service to include but not limited to retrospective Drug Utilization Review (rDUR) and Adherence programs.</td></tr>
<tr><td colspan="5">How will the Offeror monitor and manage this Subcontractor? Our organization leverages internal and external subcontractors to augment our operations, and service offers when appropriate. We have programs in place to monitor and ensure these partners meet relevant performance, operational, contractual, and regulatory standards. Monitoring of subcontractor functions are accomplished through several ongoing activities that include monthly Delegated Vendor Oversight Committee meetings. These meetings are held to review performance metrics, policies, and resources. Subcontractors also deliver established reports that identify any operational trends or issues, and performance initiatives are undertaken as needed. Appropriate documentation is also used to demonstrate that oversight is effective. Our structure is coordinated, transparent and designed to exceed the Division’s expectations to facilitate oversight, and enhances lines of communication, accountability, and authority to provide visibility for senior leadership.</td></tr>
<tr><td colspan="5">Has the Offeror worked with the subcontractor on a managed care contract in the past three (3) years? [X] Yes [ ] No

If yes, fill out Prior Experience with Subcontractor for each applicable instance.</td></tr>
<tr><td colspan="5"></td></tr>
</table>

Prior Experiences with Subcontractor				
Client's Name: OptumRx, Inc.				
Client Location				
Address Line 1: 1600 McConnor Parkway				
Address Line 2:				
City: Schaumburg	**State:** IL	**Zip Code:** 60173-6801	**County:** Cook	
Mailing Address (P.O. Box): Same as Above	**City:**	**State:**	**Zip Code:**	**County:**
Direct Contact for Client				
Name: Michael Anderson				
Title: Market President, UHC Government Programs				
Phone Number: 952-205-1934	**Email Address:** MJanderson@optum.com			
Work Details				
Number of covered lives: 215,000				
Time period of contract: 2015 to current				
Total number of staff hours expended during time period of contract: 18,200				
Personnel requirements: 1.25 average FTEs per month Clinical – 0.25 Non-Clinical – 1				
Geographic and population coverage requirements: Services apply to all Mississippi UHC plan member populations.				
Publicly funded contract cost: $5.7M				
Description of work performed under this contract				
Description of Services to be Rendered by Subcontractor for this Contract: Provides high quality, integrated pharmacy care management services, including retail pharmacy network claims processing, network contracting and management, mail order pharmaceuticals, specialty pharmaceutical management and clinical programs.				

Subcontractor				
Name of Subcontractor: United Behavioral Health, Inc. (operating under the brand name of "Optum")				
TIN/SSN (as applicable): 94-2649097		**The entity is a:** **[ ] Subcontractor** **[ ] Wholly-Owned Subsidiary** **[X] Affiliate under the same common ownership**		
Address Line 1: 425 Market Street 14th Floor				
Address Line 2:				
City: San Francisco	**State:** CA	**Zip Code:** 94105	**County:** San Francisco	
Mailing Address (P.O. Box): Same as Above	**City:**	**State:**	**Zip Code:**	**County:**
Description of Services to be Rendered by Subcontractor for this Contract: Provides a continuum of mental health and substance abuse services including utilization management and case management; 24 hours a day, seven days a week call center for members and providers to address routine, urgent and emergent call needs; behavioral health network contracting and management, behavioral health provider relations; behavioral health claims, administration, quality oversight, and fraud, waste, and abuse.				
How will the Offeror monitor and manage this Subcontractor? Our organization leverages internal and external subcontractors to augment our operations, and service offers when appropriate. We have programs in place to monitor and ensure these partners meet relevant performance, operational, contractual, and regulatory standards. Monitoring of subcontractor functions are accomplished through several ongoing activities that include monthly Delegated Vendor Oversight Committee meetings. These meetings are held to review performance metrics, policies, and resources. Subcontractors also deliver established reports that identify any operational trends or issues, and performance initiatives are undertaken as needed. Appropriate documentation is also used to demonstrate that oversight is effective. Our structure is coordinated, transparent and designed to exceed the Division's expectations to facilitate oversight, and enhances lines of communication, accountability, and authority to provide visibility for senior leadership.				
Has the Offeror worked with the subcontractor on a managed care contract in the past three (3) years? [X] Yes [ ] No **If yes, fill out Prior Experience with Subcontractor for each applicable instance.**				

Prior Experiences with Subcontractor				
Client's Name: United Behavioral Health, Inc. (operating under the brand name of "Optum")				
Client Location				
Address Line 1: 425 Market Street 14th Floor				
Address Line 2:				
City: San Francisco	**State:** CA	**Zip Code:** 94105	**County:** San Francisco	
Mailing Address (P.O. Box): Same as Above	**City:**	**State:**	**Zip Code:**	**County:**
Direct Contact for Client				
Name: Kristi Plotner				
Title: Associate Director, General Manager				
Phone Number: 763-361-6694	**Email Address:** Kristi.Plotner@uhc.com			
Work Details				
Number of covered lives: 162K in MSCAN, 28K in CHIP				
Time period of contract: Since 2010				
Total number of staff hours expended during time period of contract: 95,680 per year (pertains to both Optum entities, United Behavioral Health, Inc. and OptumHealth Care Solutions, LLC)				

Personnel requirements:
The total number of FTEs is 46.0 and pertains to both Optum entities, United Behavioral Health, Inc. and OptumHealth Care Solutions, LLC.

Job Title	**FTE**
Executive Director	1.0
Director of Clinical Operations	0.2
Sr. Clinical Program Manager	1.6
Care Advocate Team Lead	1.0
Care Advocate - Field	9.5
Care Advocate - UM	7.9
Care Advocate - UM (A&T Member)	0.4
UM Coordinator	1.0
Psychiatrist - STEM/Outpt Practice Mgmt	0.03
Care Advocate - STEM	1.6
Provider Enablement Consultant	1.0
IOP Care Advocate (CA)	0.5
Peer Reviewer - PhD	0.4
Retro Review CA	0.4
Autism CA	1.1
Outpatient (OP) Practice Manager	0.7

Care Advocate - After Hours	1.0	
Intake After Hours	0.1	
Clinical Appeals Reviewer (formerly A&G telephonic)	0.1	
Clinical Admin Coordinator (formerly Dept Assistant - Clinical)	0.5	
Psychiatrist (ECS)	1.55	
Recovery & Resiliency Manager (new role being recruited outside of the rebid today)	1.0	
Peer Support Specialist (one additional peer added 12/4/21)	2.0	
QI Specialist	0.5	
Complaint Specialist	0.9	
Appeals & Grievance Representative - Administrative	0.2	
Integrated Care Model (ICM) Liaison	1.0	
Provider Relations Director	0.0	
Provider Relations Advocate	1.6	
Clinical Quality Analyst, Sr.	0.4	
Network Claims Liaison	0.1	
Claims Supervisor	0.2	
Sr. Claims Business Analyst	0.5	
Sr. Claims Examiner Lead (SME)	0.2	
Claims Quality Audit Representative	0.2	
Claims Rework	0.2	
Claims Rep Associate	3.0	
Finance Manager	0.4	
FWA - Investigator	0.2	
FWA - Pre-Pay	0.2	
FWA - Auditor	1.2	
FWA - Data Reporting Analyst	0.2	
FWA - Intake Coordinator	0.2	
Geographic and population coverage requirements: All members/providers state-wide, including adults and children with behavioral health needs		
Publicly funded contract cost: Estimated annual revenue: $122M		
Description of work performed under this contract		
Providing behavioral health services.		

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 ...

Additionally, include a narrative explanation no longer than two (2) pages of other investments, if any, that the Offeror plans to ...

The expected wages of our Mississippi-based executive, administrative and other positions who will serve our MississippiCAN and CHIP members are provided after our narrative response to 4.3.3.6 Economic Impact.

In addition to our Mississippi-based staff, our ongoing investment in select private, state and community-based organizations affords our members and providers the benefit of those organizations' established community presence, efficiencies and expertise, and access to the national expertise and resources of our other health plans serving 7,690,000 Medicaid and CHIP members in more than 25 states.

Our local and national leadership meets regularly to vet and select proposed MississippiCAN and CHIP investments relative to the Division's evolving priorities and will continue to do so in the contract years ahead. As illustrated in the following table, our investments in Mississippi private, state and community-based organizations totaled $1,850,652 in 2021, and we have already committed $5,905,000 to similar initiatives in the contract years ahead.

Year	Initiative	Description	Investment
Planned Investments	**Social Determinants of Health**	Three million dollars in funding to support Gulf Coast Housing Partnership, Inc.'s redevelopment of the historic former Jackson Southwest Hotel, a 66,000 square foot, 76-unit, low-income housing initiative that will have an on-site medical clinic staffed by Jackson-Hinds Comprehensive Health Center.	$ 3,000,000
	Maternal Health Grants	$1,000,000 Home Visiting $550,000 Remote Patient Monitoring $130,000 Doula Pilots $100,000 Group Prenatal Care	$ 1,780,000
	Empowering Health Grants	We have invited Mississippi community-based organizations to submit grant proposals focused on health education, food access and nutrition, and behavioral health. Awards are expected to be announced this summer.	$ 500,000
	UnitedHealthcare Catalyst™	Continued work with community-based partners to address health disparities with a concentration on prevention via improved access to care and addressing SDOH needs.	$ 250,000
	School-Based Access to Care	We will partner with the Mississippi Department of Education and spend up to $200,000 deploying iPads to needy districts to assist school staff in connecting students with physical and behavioral health services and social services.	$ 200,000
	PCMH Recognition Fund	Funding to support providers becoming NCQA Patient-Centered Medical Home (PCMH) recognized.	$ 250,000
	United for Giving Program	Match employee contributions, dollar for dollar, to nearly all nonprofit organizations. Dependent on individual employee giving. *Includes both employee and employer contribution.	$ 40,000*

Year	Initiative	Description	Investment
	Flexible Support Funding	We will make flexible support funds available for use at care managers' discretion to reduce lengths of stay and increase community stability. Up to $250 per person can fund nonstandard needs in the community for members in residential or inpatient settings and ready for discharge, and children receiving wraparound services (e.g., utility deposits, room furnishings and youth activity expenses).	$ 20,000
	Diverse Scholars Initiative	Partnered with nonprofit and civic organizations to provide funding for scholarships for students of color pursuing careers as primary care health professionals.	$ 15,000
2021	**Empowering Health Grants**	Awarded grants to six community-based organizations in Mississippi to expand access to care and address the social determinants of health for uninsured individuals and underserved communities.	$1,000,000
	Maternal Health Grants	Awarded maternal health grants to eight community organizations aimed at improving maternal health outcomes, reducing disparities and expanding access to care.	$ 285,700
	UnitedHealthcare Catalyst™	Worked with community-based partners to address health disparity issues, with a concentration on prevention via improved access to care and addressing SDOH needs.	$ 250,000
	ECHO	Partnered with University of Mississippi Medical Center to promote technology-enabled collaborative learning that links expert interdisciplinary specialist teams with primary care clinicians through teleECHO clinics, enabling clinicians to develop the skills and knowledge to treat patients with common, complex conditions in their own communities.	$ 169,500
	Telemedicine	Partnered with MS Medical Association to provide rural physicians with telemedicine tools.	$ 90,452
	United for Giving Program	Matched employee contributions, dollar for dollar, to nearly all nonprofit organizations. *Includes both employee and employer contribution.	$ 40,000*
	Diverse Scholars Initiative	Partnered with nonprofit and civic organizations to provide funding for scholarships for students of color pursuing careers as primary care health professionals.	$ 15,000

[END OF RESPONSE]

Economic Impact: Wage Chart	
Title of Position: Chief Executive Officer (CEO) (Key Personnel)	
If Position is not a Key Position, provide description: N/A	
Number of Staff Expected to Fill this Position/Staffing Need: 1	**Expected Wage of Position (Hourly rate or salary):** [redacted]
Employee(s) filling this position would be: **[ ] Hourly [X] Salaried**	**Employee(s) filling this position would be:** **[X] Full-Time [ ] Part-Time**
Title of Position: Chief Operating Officer (COO) (Key Personnel)	
If Position is not a Key Position, provide description: N/A	
Number of Staff Expected to Fill this Position/Staffing Need: 1	**Expected Wage of Position (Hourly rate or salary):** [redacted]
Employee(s) filling this position would be: **[ ] Hourly [X] Salaried**	**Employee(s) filling this position would be:** **[X] Full-Time [ ] Part-Time**
Title of Position: Medical Director (Key Personnel)	
If Position is not a Key Position, provide description: N/A	
Number of Staff Expected to Fill this Position/Staffing Need: 1	**Expected Wage of Position (Hourly rate or salary):** [redacted]
Employee(s) filling this position would be: **[ ] Hourly [X] Salaried**	**Employee(s) filling this position would be:** **[X] Full-Time [ ] Part-Time**
Title of Position: Chief Financial Officer (CFO) (Key Personnel)	
If Position is not a Key Position, provide description: N/A	
Number of Staff Expected to Fill this Position/Staffing Need: 1	**Expected Wage of Position (Hourly rate or salary):** [redacted]
Employee(s) filling this position would be: **[ ] Hourly [X] Salaried**	**Employee(s) filling this position would be:** **[X] Full-Time [ ] Part-Time**
Title of Position: Compliance Officer (Key Personnel)	
If Position is not a Key Position, provide description: N/A	
Number of Staff Expected to Fill this Position/Staffing Need: 1	**Expected Wage of Position (Hourly rate or salary):** [redacted]
Employee(s) filling this position would be: **[ ] Hourly [X] Salaried**	**Employee(s) filling this position would be:** **[X] Full-Time [ ] Part-Time**
Title of Position: Project Manager (Key Personnel)	
If Position is not a Key Position, provide description: N/A	
Number of Staff Expected to Fill this Position/Staffing Need: 1	**Expected Wage of Position (Hourly rate or salary):** [redacted]
Employee(s) filling this position would be: **[ ] Hourly [X] Salaried**	**Employee(s) filling this position would be:** **[X] Full-Time [ ] Part-Time**

Title of Position: Perinatal Medical Director (Key Personnel)	
If Position is not a Key Position, provide description: N/A	
Number of Staff Expected to Fill this Position/Staffing Need: 1	**Expected Wage of Position (Hourly rate or salary):** [redacted]
Employee(s) filling this position would be: **[ ] Hourly [X] Salaried**	**Employee(s) filling this position would be:** **[ ] Full-Time [X] Part-Time**
Title of Position: Behavioral Health /Substance Use Disorder (SUD) Executive Director (Key Personnel)	
If Position is not a Key Position, provide description: N/A	
Number of Staff Expected to Fill this Position/Staffing Need: 1	**Expected Wage of Position (Hourly rate or salary):** [redacted]
Employee(s) filling this position would be: **[ ] Hourly [X] Salaried**	**Employee(s) filling this position would be:** **[X] Full-Time [ ] Part-Time**
Title of Position: Provider Services Manager (Key Personnel)	
If Position is not a Key Position, provide description: N/A	
Number of Staff Expected to Fill this Position/Staffing Need: 1	**Expected Wage of Position (Hourly rate or salary):** [redacted]
Employee(s) filling this position would be: **[ ] Hourly [X] Salaried**	**Employee(s) filling this position would be:** **[X] Full-Time [ ] Part-Time**
Title of Position: Network Contracting Manager (Key Personnel)	
If Position is not a Key Position, provide description: N/A	
Number of Staff Expected to Fill this Position/Staffing Need: 1	**Expected Wage of Position (Hourly rate or salary):** [redacted]
Employee(s) filling this position would be: **[ ] Hourly [X] Salaried**	**Employee(s) filling this position would be:** **[X] Full-Time [ ] Part-Time**
Title of Position: Member Services Director (Key Personnel)	
If Position is not a Key Position, provide description: N/A	
Number of Staff Expected to Fill this Position/Staffing Need: 1	**Expected Wage of Position (Hourly rate or salary):** [redacted]
Employee(s) filling this position would be: **[ ] Hourly [X] Salaried**	**Employee(s) filling this position would be:** **[X] Full-Time [ ] Part-Time**
Title of Position: Quality Management Director (Key Personnel)	
If Position is not a Key Position, provide description: N/A	
Number of Staff Expected to Fill this Position/Staffing Need: 1	**Expected Wage of Position (Hourly rate or salary):** [redacted]
Employee(s) filling this position would be: **[ ] Hourly [X] Salaried**	**Employee(s) filling this position would be:** **[X] Full-Time [ ] Part-Time**

Title of Position: Care Management Director (Key Personnel)	
If Position is not a Key Position, provide description: N/A	
Number of Staff Expected to Fill this Position/Staffing Need: 1	**Expected Wage of Position (Hourly rate or salary):** [redacted]
Employee(s) filling this position would be: **[ ] Hourly [X] Salaried**	**Employee(s) filling this position would be:** **[X] Full-Time [ ] Part-Time**
Title of Position: Utilization Management Coordinator (Key Personnel)	
If Position is not a Key Position, provide description: N/A	
Number of Staff Expected to Fill this Position/Staffing Need: 1	**Expected Wage of Position (Hourly rate or salary):** [redacted]
Employee(s) filling this position would be: **[ ] Hourly [X] Salaried**	**Employee(s) filling this position would be:** **[X] Full-Time [ ] Part-Time**
Title of Position: Population Health Director (Key Personnel)	
If Position is not a Key Position, provide description: N/A	
Number of Staff Expected to Fill this Position/Staffing Need: 1	**Expected Wage of Position (Hourly rate or salary):** [redacted]
Employee(s) filling this position would be: **[ ] Hourly [X] Salaried**	**Employee(s) filling this position would be:** **[X] Full-Time [ ] Part-Time**
Title of Position: Grievance & Appeals Coordinator (Key Personnel)	
If Position is not a Key Position, provide description: N/A	
Number of Staff Expected to Fill this Position/Staffing Need: 1	**Expected Wage of Position (Hourly rate or salary):** [redacted]
Employee(s) filling this position would be: **[ ] Hourly [X] Salaried**	**Employee(s) filling this position would be:** **[X] Full-Time [ ] Part-Time**
Title of Position: Claims Administrator (Key Personnel)	
If Position is not a Key Position, provide description: N/A	
Number of Staff Expected to Fill this Position/Staffing Need: 1	**Expected Wage of Position (Hourly rate or salary):** [redacted]
Employee(s) filling this position would be: **[X] Hourly [ ] Salaried**	**Employee(s) filling this position would be:** **[X] Full-Time [ ] Part-Time**
Title of Position: Data & Analytics Manager (Key Personnel)	
If Position is not a Key Position, provide description: N/A	
Number of Staff Expected to Fill this Position/Staffing Need: 1	**Expected Wage of Position (Hourly rate or salary):** [redacted]
Employee(s) filling this position would be: **[ ] Hourly [X] Salaried**	**Employee(s) filling this position would be:** **[X] Full-Time [ ] Part-Time**

Title of Position: Clinical Pharmacist (Key Personnel)	
If Position is not a Key Position, provide description: N/A	
Number of Staff Expected to Fill this Position/Staffing Need: 1	**Expected Wage of Position (Hourly rate or salary):** [redacted]
Employee(s) filling this position would be: **[ ] Hourly [X] Salaried**	**Employee(s) filling this position would be:** **[X] Full-Time [ ] Part-Time**
Title of Position: Claims and Business Process Associate Director	
If Position is not a Key Position, provide description: Additional staff as required in model contract. Job description included in Appendix H - 4.3.3.2 Job Descriptions and Responsibilities of Key Positions (Marked).	
Number of Staff Expected to Fill this Position/Staffing Need: 1	**Expected Wage of Position (Hourly rate or salary):** [redacted]
Employee(s) filling this position would be: **[ ] Hourly [X] Salaried**	**Employee(s) filling this position would be:** **[X] Full-Time [ ] Part-Time**
Title of Position: Senior Provider Relations Advocate (Network Provider)	
If Position is not a Key Position, provide description: Additional staff as required in model contract. Job description included in Appendix H - 4.3.3.2 Job Descriptions and Responsibilities of Key Positions (Marked).	
Number of Staff Expected to Fill this Position/Staffing Need: 8	**Expected Wage of Position (Hourly rate or salary):** [redacted]
Employee(s) filling this position would be: **[ ] Hourly [X] Salaried**	**Employee(s) filling this position would be:** **[X] Full-Time [ ] Part-Time**
Title of Position: Provider Relations Services Advocacy Manager	
If Position is not a Key Position, provide description: The provider relations services advocacy manager is accountable for the full range of provider relations and service interactions within UnitedHealthcare, including working on end-to-end provider claim and call quality, ease of use of physician portal and future service enhancements, and training and development of external provider education programs. The role designs and implements programs to build and nurture positive relationships with providers and practice managers.	
Number of Staff Expected to Fill this Position/Staffing Need: 1	**Expected Wage of Position (Hourly rate or salary):** [redacted]
Employee(s) filling this position would be: **[ ] Hourly [X] Salaried**	**Employee(s) filling this position would be:** **[X] Full-Time [ ] Part-Time**
Title of Position Outreach Coordinator	
If Position is not a Key Position, provide description: Additional staff as required in model contract. Job description included in Appendix H - 4.3.3.2 Job Descriptions and Responsibilities of Key Positions (Marked).	
Number of Staff Expected to Fill this Position/Staffing Need: 3	**Expected Wage of Position (Hourly rate or salary):** [redacted]
Employee(s) filling this position would be: **[X] Hourly [ ] Salaried**	**Employee(s) filling this position would be:** **[X] Full-Time [ ] Part-Time**

Title of Position: Senior Outreach Coordinator	
If Position is not a Key Position, provide description: Additional staff as required in model contract. Job description included in Appendix H - 4.3.3.2 Job Descriptions and Responsibilities of Key Positions (Marked).	
Number of Staff Expected to Fill this Position/Staffing Need: 1	**Expected Wage of Position (Hourly rate or salary):** [redacted]
Employee(s) filling this position would be: **[X] Hourly [ ] Salaried**	**Employee(s) filling this position would be:** **[X] Full-Time [ ] Part-Time**
Title of Position: Clinical Coordinator - RN	
If Position is not a Key Position, provide description: Additional staff as required in model contract. Job description included in Appendix H - 4.3.3.2 Job Descriptions and Responsibilities of Key Positions (Marked).	
Number of Staff Expected to Fill this Position/Staffing Need: 27	**Expected Wage of Position (Hourly rate or salary):** [redacted]
Employee(s) filling this position would be: **[X] Hourly [ ] Salaried**	**Employee(s) filling this position would be:** **[X] Full-Time [ ] Part-Time**
Title of Position: Care Management Manager	
If Position is not a Key Position, provide description: Additional staff as required in model contract. Job description included in Appendix H - 4.3.3.2 Job Descriptions and Responsibilities of Key Positions (Marked).	
Number of Staff Expected to Fill this Position/Staffing Need: 5	**Expected Wage of Position (Hourly rate or salary):** [redacted]
Employee(s) filling this position would be: **[ ] Hourly [X] Salaried**	**Employee(s) filling this position would be:** **[X] Full-Time [ ] Part-Time**
Title of Position: Community Health Worker (CHW)	
If Position is not a Key Position, provide description: Additional staff as required in model contract. Job description included in Appendix H - 4.3.3.2 Job Descriptions and Responsibilities of Key Positions (Marked).	
Number of Staff Expected to Fill this Position/Staffing Need: 26	**Expected Wage of Position (Hourly rate or salary):** [redacted]
Employee(s) filling this position would be: **[X] Hourly [ ] Salaried**	**Employee(s) filling this position would be:** **[X] Full-Time [ ] Part-Time**
Title of Position: Spiritual Care Support	
If Position is not a Key Position, provide description: Additional staff as required in model contract. Job description included in Appendix H - 4.3.3.2 Job Descriptions and Responsibilities of Key Positions (Marked).	
Number of Staff Expected to Fill this Position/Staffing Need: 1	**Expected Wage of Position (Hourly rate or salary):** [redacted]
Employee(s) filling this position would be: **[X] Hourly [ ] Salaried**	**Employee(s) filling this position would be:** **[X] Full-Time [ ] Part-Time**

Title of Position: Clinical Administrative Coordinator (CAC)	
If Position is not a Key Position, provide description: Additional staff as required in model contract. Job description included in Appendix H - 4.3.3.2 Job Descriptions and Responsibilities of Key Positions (Marked).	
Number of Staff Expected to Fill this Position/Staffing Need: 6	**Expected Wage of Position (Hourly rate or salary):** [redacted]
Employee(s) filling this position would be: **[X] Hourly [ ] Salaried**	**Employee(s) filling this position would be:** **[X] Full-Time [ ] Part-Time**
Title of Position: Senior Clinical Administrative Coordinator (CAC)	
If Position is not a Key Position, provide description: Additional staff as required in model contract. Job description included in Appendix H - 4.3.3.2 Job Descriptions and Responsibilities of Key Positions (Marked).	
Number of Staff Expected to Fill this Position/Staffing Need: 2	**Expected Wage of Position (Hourly rate or salary):** [redacted]
Employee(s) filling this position would be: **[X] Hourly [ ] Salaried**	**Employee(s) filling this position would be:** **[X] Full-Time [ ] Part-Time**
Title of Position: Peer Support Specialist	
If Position is not a Key Position, provide description: Additional staff as required in model contract. Job description included in Appendix H - 4.3.3.2 Job Descriptions and Responsibilities of Key Positions (Marked).	
Number of Staff Expected to Fill this Position/Staffing Need: 2	**Expected Wage of Position (Hourly rate or salary):** [redacted]
Employee(s) filling this position would be: **[X] Hourly [ ] Salaried**	**Employee(s) filling this position would be:** **[X] Full-Time [ ] Part-Time**
Title of Position: Recovery and Resiliency Manager	
If Position is not a Key Position, provide description: Additional staff as required in model contract. Job description included in Appendix H - 4.3.3.2 Job Descriptions and Responsibilities of Key Positions (Marked).	
Number of Staff Expected to Fill this Position/Staffing Need: 1	**Expected Wage of Position (Hourly rate or salary):** [redacted]
Employee(s) filling this position would be: **[ ] Hourly [X] Salaried**	**Employee(s) filling this position would be:** **[X] Full-Time [ ] Part-Time**
Title of Position: Care Advocate	
If Position is not a Key Position, provide description: Additional staff as required in model contract. Job description included in Appendix H - 4.3.3.2 Job Descriptions and Responsibilities of Key Positions (Marked).	
Number of Staff Expected to Fill this Position/Staffing Need: 9	**Expected Wage of Position (Hourly rate or salary):** [redacted]
Employee(s) filling this position would be: **[ ] Hourly [X] Salaried**	**Employee(s) filling this position would be:** **[X] Full-Time [ ] Part-Time**

Title of Position: Service Navigator	
If Position is not a Key Position, provide description: Additional staff as required in model contract. Job description included in Appendix H - 4.3.3.2 Job Descriptions and Responsibilities of Key Positions (Marked).	
Number of Staff Expected to Fill this Position/Staffing Need: 50	**Expected Wage of Position (Hourly rate or salary):** [redacted]
Employee(s) filling this position would be: **[X] Hourly [ ] Salaried**	**Employee(s) filling this position would be:** **[X] Full-Time [ ] Part-Time**
Title of Position: Health Equity Director	
If Position is not a Key Position, provide description: Additional staff as required in model contract. Job description included in Appendix H - 4.3.3.2 Job Descriptions and Responsibilities of Key Positions (Marked).	
Number of Staff Expected to Fill this Position/Staffing Need: 1	**Expected Wage of Position (Hourly rate or salary):** [redacted]
Employee(s) filling this position would be: **[ ] Hourly [X] Salaried**	**Employee(s) filling this position would be:** **[X] Full-Time [ ] Part-Time**
Title of Position: Health Equity Improvement Lead	
If Position is not a Key Position, provide description: The incumbent is responsible for community engagement, rural health strategies, social responsibility and the health plan's overall social determinants of health strategy. Monitors social determinants of health and strategically plans with community partners and providers how to remove barriers such as food insecurity, housing insecurity, transportation and utility assistance.	
Number of Staff Expected to Fill this Position/Staffing Need: 1	**Expected Wage of Position (Hourly rate or salary):** [redacted]
Employee(s) filling this position would be: **[ ] Hourly [X] Salaried**	**Employee(s) filling this position would be:** **[X] Full-Time [ ] Part-Time**
Title of Position: Empowerment Manager (SDOH Navigator)	
If Position is not a Key Position, provide description: This Empowerment Manager (SDOH Navigator) will be supporting the GEDWorks value-added benefit. Supports of this position include: - Helping connect members to job interviews and transportation - Providing interest and skill-based assessments that assess career path recommendations - Connecting to local agencies that offer real-life experience through internships that can be used to build a resume - Resume writing support services coordination	
Number of Staff Expected to Fill this Position/Staffing Need: 1	**Expected Wage of Position (Hourly rate or salary):** [redacted]
Employee(s) filling this position would be: **[ ] Hourly [X] Salaried**	**Employee(s) filling this position would be:** **[X] Full-Time [ ] Part-Time**

Title of Position: Senior Administrative Assistant	
If Position is not a Key Position, provide description: This position will provide administrative assistant support for the executive team, including answering the phone, typing documents, creating spreadsheets, building presentations, scheduling meetings, making travel arrangements, copying, faxing, greeting visitors, setting up files, tracking expenses, managing executive calendars and helping with logistics for internal meetings and market-facing events.	
Number of Staff Expected to Fill this Position/Staffing Need: 1	**Expected Wage of Position (Hourly rate or salary):** [redacted]
Employee(s) filling this position would be: **[X] Hourly [ ] Salaried**	**Employee(s) filling this position would be:** **[X] Full-Time [ ] Part-Time**
Title of Position: Delegated Services Manager	
If Position is not a Key Position, provide description: The delegated services manager oversees appeals and grievance coordinator and subcontractor oversight. Leads regulatory compliance issues involving subcontractors and ensures responsiveness of inquiries and subcontractors' inquiries.	
Number of Staff Expected to Fill this Position/Staffing Need: 1	**Expected Wage of Position (Hourly rate or salary):** [redacted]
Employee(s) filling this position would be: **[ ] Hourly [X] Salaried**	**Employee(s) filling this position would be:** **[X] Full-Time [ ] Part-Time**
Title of Position: Vendor Management Oversight Liaison	
If Position is not a Key Position, provide description: Incumbent has full accountability for the oversight of external vendors, and management of internal business partners and monitors adherence to service level agreements and statements of work, monitors and remediates key performance indicators, supports vendor programs and initiatives and enables compliance with health plan's contractual requirements. Provides other operational leadership and support for the health plan, as needed.	
Number of Staff Expected to Fill this Position/Staffing Need: 1	**Expected Wage of Position (Hourly rate or salary):** [redacted]
Employee(s) filling this position would be: **[ ] Hourly [X] Salaried**	**Employee(s) filling this position would be:** **[X] Full-Time [ ] Part-Time**
Title of Position: Manager of Quality Improvement (QI)	
If Position is not a Key Position, provide description: The manager of QI is responsible for program measure development and monitoring, analyzing and reporting all clinical quality measures required by the state and accrediting bodies. The manager of QI also develops performance improvement projects (PIPs) that meet all requirements of the state contract and external review guidelines.	
Number of Staff Expected to Fill this Position/Staffing Need: 3	**Expected Wage of Position (Hourly rate or salary):** [redacted]
Employee(s) filling this position would be: **[ ] Hourly [X] Salaried**	**Employee(s) filling this position would be:** **[X] Full-Time [ ] Part-Time**

Title of Position: Clinical Practice Consultant	
If Position is not a Key Position, provide description: The incumbent is responsible for strategically developing clinically oriented provider and community-based partnerships to increase HEDIS quality scores and state-specific quality measures. This role will be responsible for ongoing management of provider practice quality measures and HEDIS medical record collection to support NCQA accreditation compliance.	
Number of Staff Expected to Fill this Position/Staffing Need: 3	**Expected Wage of Position (Hourly rate or salary):** [redacted]
Employee(s) filling this position would be: **[ ] Hourly [X] Salaried**	**Employee(s) filling this position would be:** **[X] Full-Time [ ] Part-Time**
Title of Position: Investigator (Special Investigator Unit - SIU)	
If Position is not a Key Position, provide description: The SIU investigator will provide administrative and data analytics support pertaining to fraud, waste and abuse (FWA) and the program integrity efforts required under the MississippiCAN and CHIP contract. The SIU investigator has open and immediate access to all claims, claims processing data and any other electronic or paper information, and analyzes the data as part of investigations and as required to verify that program integrity activity is sufficient to meet all state and federal requirements.	
Number of Staff Expected to Fill this Position/Staffing Need: 1	**Expected Wage of Position (Hourly rate or salary):** [redacted]
Employee(s) filling this position would be: **[ ] Hourly [X] Salaried**	**Employee(s) filling this position would be:** **[X] Full-Time [ ] Part-Time**
Title of Position: Customer Service Supervisor	
If Position is not a Key Position, provide description: The incumbent is responsible for managing, coordinating and supervising daily, weekly and monthly activities of customer services team members. The customer service supervisor identifies and resolves operational problems using defined processes, expertise and judgment.	
Number of Staff Expected to Fill this Position/Staffing Need: 3	**Expected Wage of Position (Hourly rate or salary):** [redacted]
Employee(s) filling this position would be: **[ ] Hourly [X] Salaried**	**Employee(s) filling this position would be:** **[X] Full-Time [ ] Part-Time**
Title of Position: Claims Representative Associate	
If Position is not a Key Position, provide description: Responsible for analyzing complex health care claims that require research to determine action steps and mathematical calculations necessary to produce an accurate payment. The claims position requires a high level of quality, which is to be maintained while achieving a productivity goal. Responsible for reviewing, researching and processing medical claims.	
Number of Staff Expected to Fill this Position/Staffing Need: 19	**Expected Wage of Position (Hourly rate or salary):** [redacted]
Employee(s) filling this position would be: **[X] Hourly [ ] Salaried**	**Employee(s) filling this position would be:** **[X] Full-Time [ ] Part-Time**

Title of Position: Customer Service Representative	
If Position is not a Key Position, provide description: Incumbent is accountable for resolving issues on the first call, navigating through complex computer systems to identify the status of the issue and provide appropriate response to caller and deliver information and answer questions in a positive manner to facilitate strong relationships with providers and their staff.	
Number of Staff Expected to Fill this Position/Staffing Need: 10	**Expected Wage of Position (Hourly rate or salary):** [redacted]
Employee(s) filling this position would be: **[X] Hourly [ ] Salaried**	**Employee(s) filling this position would be:** **[X] Full-Time [ ] Part-Time**
Title of Position: Data Analyst	
If Position is not a Key Position, provide description: The data analyst is responsible for working with vast data from multiple sources to provide analyses (i.e., descriptive, predictive, exploratory) for the MississippiCAN and CHIP programs that yield measurable value to the business (e.g., increased quality sales growth; channel optimization; improved competitive positioning). Initially, the position will focus on enabling data-driven decisions in support of the operations and underwriting. The data analyst will implement innovative analytic approaches to keep up with emerging industry trends and is responsible for providing insights in addition to well-structured analyses.	
Number of Staff Expected to Fill this Position/Staffing Need: 3	**Expected Wage of Position (Hourly rate or salary):** [redacted]
Employee(s) filling this position would be: **[ ] Hourly [X] Salaried**	**Employee(s) filling this position would be:** **[X] Full-Time [ ] Part-Time**
Title of Position: Trainer	
If Position is not a Key Position, provide description: The trainer is responsible for facilitating engaging and innovative programs to support our internal operations business segments in a professional atmosphere. The trainer facilitates instructor-led, virtual and blended learning to a variety of audiences, including new and tenured employees and leadership. In addition, the trainer partners with learning architects, process documentation and learning coordinators on content/process documentation maintenance and improvement, and business leaders on national metric remediation efforts.	
Number of Staff Expected to Fill this Position/Staffing Need: 1	**Expected Wage of Position (Hourly rate or salary):** [redacted]
Employee(s) filling this position would be: **[X] Hourly [ ] Salaried**	**Employee(s) filling this position would be:** **[X] Full-Time [ ] Part-Time**
Title of Position: Dental Case Manager	
If Position is not a Key Position, provide description: The dental case manager, a licensed dental hygienist, is responsible for facilitating a collaborative process of telephonic dental care management services for our members that promotes cost-effective, quality oral health care. They will conduct outreach, engagement and deliver oral health education to members by completing a member-specific dental and coordinating dental appointments with their dental home provider who will develop a treatment plan for members' oral health needs.	
Number of Staff Expected to Fill this Position/Staffing Need: 1	**Expected Wage of Position (Hourly rate or salary):** [redacted]
Employee(s) filling this position would be: **[ ] Hourly [X] Salaried**	**Employee(s) filling this position would be:** **[X] Full-Time [ ] Part-Time**

Title of Position: Integrated Care Model (ICM) Medical Director	
If Position is not a Key Position, provide description: The ICM medical director participates in telephonic outreach for collaboration with treating providers. This will include discussion of evidence-based guidelines, opportunities to close clinical quality/service gaps, and care plan changes that can impact health care expenses. The incumbent is responsible to collaborate with operational and business partners on clinical and quality initiatives at the site and customer level to address customer expectations.	
Number of Staff Expected to Fill this Position/Staffing Need: 1	**Expected Wage of Position (Hourly rate or salary):** [redacted]
Employee(s) filling this position would be: **[ ] Hourly [X] Salaried**	**Employee(s) filling this position would be:** **[X] Full-Time [ ] Part-Time**
Title of Position: Pre-service Review RN	
If Position is not a Key Position, provide description: The pre-service review RN is responsible for reviewing and processing all home and community-based services (HCBS) service authorization requests, intake of provider, care coordinator, and continuity of care HCBS assisted technology and environmental modifications authorization requests.	
Number of Staff Expected to Fill this Position/Staffing Need: 1	**Expected Wage of Position (Hourly rate or salary):** [redacted]
Employee(s) filling this position would be: **[X] Hourly [ ] Salaried**	**Employee(s) filling this position would be:** **[X] Full-Time [ ] Part-Time**
Title of Position: Prior Authorization Coordinator	
If Position is not a Key Position, provide description: The prior authorization coordinator manages administrative intake of members and works with hospitals, clinics, facilities and the clinical team to manage requests for services from members and/or providers in regard to prior authorizations. Processes incoming and outgoing referrals, and prior authorizations, including intake, notification and census roles, and assists the clinical staff with setting up documents/triage cases for clinical coverage review.	
Number of Staff Expected to Fill this Position/Staffing Need: 1	**Expected Wage of Position (Hourly rate or salary):** [redacted]
Employee(s) filling this position would be: **[X] Hourly [ ] Salaried**	**Employee(s) filling this position would be:** **[X] Full-Time [ ] Part-Time**
Title of Position: Utilization Management Nurse	
If Position is not a Key Position, provide description: The utilization management (UM) nurse is responsible for utilization management, which includes concurrent review (on-site or telephonic inpatient care management). Reviews current inpatient services. Determines medical appropriateness of inpatient and outpatient services following evaluation of medical guidelines and benefit determination and assesses and interprets customer needs and requirements.	
Number of Staff Expected to Fill this Position/Staffing Need: 4	**Expected Wage of Position (Hourly rate or salary):** [redacted]
Employee(s) filling this position would be: **[ ] Hourly [X] Salaried**	**Employee(s) filling this position would be:** **[X] Full-Time [ ] Part-Time**

Title of Position: Clinical Claims Review RN	
If Position is not a Key Position, provide description: The clinical claims review RN is responsible for assessing and interpreting customer needs and requirements and identifying solutions to nonstandard requests and problems.	
Number of Staff Expected to Fill this Position/Staffing Need: 1	**Expected Wage of Position (Hourly rate or salary):** [redacted]
Employee(s) filling this position would be: **[X] Hourly [ ] Salaried**	**Employee(s) filling this position would be:** **[X] Full-Time [ ] Part-Time**
Title of Position: Clinical Quality Analyst	
If Position is not a Key Position, provide description: The clinical quality analyst is responsible for providing a complete continuum of quality care through close communication with members via phone interaction or in-person interaction. May assist members with the transition from a care facility back to their home.	
Number of Staff Expected to Fill this Position/Staffing Need: 1	**Expected Wage of Position (Hourly rate or salary):** [redacted]
Employee(s) filling this position would be: **[X] Hourly [ ] Salaried**	**Employee(s) filling this position would be:** **[X] Full-Time [ ] Part-Time**
Title of Position: General Management Associate Director	
If Position is not a Key Position, provide description: The incumbent is responsible for supporting short- and long-term operational and strategic business activities by developing, enhancing and maintaining operational information and models and developing and implementing effective strategic business solutions through research and analysis of data and business processes.	
Number of Staff Expected to Fill this Position/Staffing Need: 1	**Expected Wage of Position (Hourly rate or salary):** [redacted]
Employee(s) filling this position would be: **[ ] Hourly [X] Salaried**	**Employee(s) filling this position would be:** **[X] Full-Time [ ] Part-Time**
Title of Position: Business Operations Specialist	
If Position is not a Key Position, provide description: This person will be responsible for sourcing, developing, organizing and producing analysis and actionable reports that support performance discussions and improvement opportunities with the range of functions and partners that support the health plan.	
Number of Staff Expected to Fill this Position/Staffing Need: 1	**Expected Wage of Position (Hourly rate or salary):** [redacted]
Employee(s) filling this position would be: **[X] Hourly [ ] Salaried**	**Employee(s) filling this position would be:** **[X] Full-Time [ ] Part-Time**

Title of Position: Senior Behavioral/Substance Use Disorder (SUD) Medical Director	
If Position is not a Key Position, provide description: The medical director will provide clinical oversight to the clinical care managers, oversee inpatient hospitalizations and keep current regarding prevalent treatment protocols and philosophies, including those that address consumer cultural preferences. Responsible for maintaining the clinical integrity of the program, including concurrent reviews of inpatient and rehabilitation services, providing oversight to utilization management and quality staff and providing consultation to providers and other community-based clinicians, including general practitioners.	
Number of Staff Expected to Fill this Position/Staffing Need: 1	**Expected Wage of Position (Hourly rate or salary):** [redacted]
Employee(s) filling this position would be: **[ ] Hourly [X] Salaried**	**Employee(s) filling this position would be:** **[X] Full-Time [ ] Part-Time**

[END OF RESPONSE]

4.3.4 Management and Control

4.3.4.1 Day-to-Day Management (Marked)

Serving CHIP members since 2010 and MississippiCAN members since 2011, we have implemented and refined our administrative policies, procedures and business infrastructure to promote the Division's goals and priorities. As we adapt our infrastructure to support the evolution of the Division of Medicaid's MississippiCAN program and CHIP, our Mississippi-based leadership team will continue to collaborate with local and national experts to deliver operational excellence and improve the health of the people we serve.

Implementation Success
Since January 2020, UnitedHealthcare has successfully led 11 growth implementations in its Medicaid business, transitioning more than 1 million members into our programs.

As we transition to the new contract, we will use our experienced approach to implementation and readiness, with our implementation and business alignment (IBA) team as the cornerstone. Our chief operating officer will serve as the project manager for the new MississippiCAN and CHIP contract. The IBA team is accountable to our chief operating officer and will apply their in-depth Project Management Body of Knowledge (PMBOK)-driven project management principles and techniques to the project implementation, readiness review and steady-state operations.

Achieving Operational Excellence

Day-to-Day Management and Control

To expedite problem identification and correction, dedicated functional owners for key operational areas are responsible for monitoring performance daily against our contractual and internally determined performance metrics. If performance in any functional area on any given day does not meet required levels, the accountable owner closely monitors the situation to discern the underlying cause (i.e., one-time episode or systemic in nature) and develops a remediation plan appropriate for the situation. If the nature of the issue is systemic, the dedicated functional owner submits the remediation plan to leadership for review and approval. The functional area managers and leadership review and make recommendations through our oversight committees, which meet quarterly and more often, as necessary, to address performance issues.

Systemic Management and Control

If our performance is found deficient or we are at risk, we proactively implement an internal remediation action plan, including the necessary change, more rigorous monitoring and oversight through our compliance officer and Compliance Oversight Committee. If there is a system fail, we will notify the Division and impacted stakeholders within required time frames and according to prescribed notification methods (i.e., in writing, to a specific person or department). The committee oversees the implementation of a formal process to evaluate the root cause of the issue, develop a remediation action plan, and oversee timely and correct completion of activities. This process makes sure issues are addressed quickly and systemically to prevent recurrence.

We produce weekly reports of remediation action plans for our local, regional and national leadership teams, in addition to our local Compliance Oversight Committee and UnitedHealthcare's national Compliance Oversight Committee. In addition to ongoing self-monitoring processes, we participate in external regulatory and accrediting reviews and audits. Our compliance officer reports findings to senior and executive leadership and the Division.

Risk Mitigation

Risk assessments are ongoing and involve input from our key staff. Our key operations systems use established algorithms to detect performance anomalies. In addition to technological assistance, we have staff dedicated to resolving problems and quickly repairing systemic issues, including performance issues we may need to address with our subcontractors. We assign accountable owners within our Mississippi-based team to work with subject matter experts (based locally and with our national teams) to remediate risks. These accountable owners report

their progress to the Compliance Oversight Committee. We have quarterly compliance meetings where employees present and discuss any potential areas of risk.

Annually, our compliance team conducts a formal risk assessment to identify areas needing attention or risk mitigation and controls. Our compliance officer makes sure outcomes of our compliance risk assessments are reviewed and updated annually and as needed. Our Compliance Oversight Committee, chaired by our compliance officer, makes sure any necessary remediation actions are implemented and oversees corrective actions. The objective of our Compliance Oversight Committee is to drive operational performance excellence and meet national, state and local quality and compliance requirements. Through our oversight committee framework, further supported by quality committees and subcommittees, we monitor the quality of service delivered to members, providers and the Division. The committees create awareness through the reporting and discussion of operational performance issues and metrics, including performance meeting defined goals and performance not meeting thresholds. Documentation includes improvement plans and remediation actions.

In the following narrative, we provide details and descriptions of our program management and control activities, and the reports we use to evaluate progress and the effectiveness of our approach.

1. Program management approach;

Day-to-day management of MississippiCAN and CHIP is the responsibility our chief executive officer. Our chief executive officer has an experienced executive leadership team, who work from our primary office in Ridgeland, Mississippi, composed of local experts overseeing various functional areas. Our chief operating officer and our chief medical officer oversee health plan operations and care delivery, respectively. Our chief financial officer oversees health plan financial operations. Our compliance officer assures compliance with regulatory aspects of health plan management.

We maintain health information technology (IT) systems and dashboards to collect, analyze, integrate and report data across all our operational and administrative functions. Our IT systems support data collection and analysis, internal monitoring and performance assessment activities. For MississippiCAN and CHIP, our IT systems enable managers and business leads to generate required and ad hoc reports and compliance scorecards.

Our ongoing approach to program management focuses on achieving high-quality outcomes addressing health equity, affordability and person-centered service delivery. We work alongside local community partners with whom we have well-established relationships. The longevity of our relationships has allowed us to build strong oversight programs, understand contractual requirements, and apply compliance protocols effectively for the clinical and nonclinical services our members need.

Following the implementation phase, we will continue to apply PMBOK principles in our day-to-day management of MississippiCAN and CHIP. Our approach focuses on key program management elements, including:

- **Scope Management:** Using the contract as the source of truth, we define and document all deliverables using methods similar to our implementation work plan. When contract modifications occur, our compliance officer collaborates with the dedicated functional owner to create a contractual roadmap to identify and record each new or modified contractual and program requirement.
- **Cost Management:** Our chief financial officer is accountable for the day-to-day development and management of financial models and performance as it relates to business goals and objectives. Our chief financial officer works closely with key leaders to make sure the business is operating effectively, with sound financial analysis and with appropriate financial and operating controls in place. To do this, our chief financial officer works with health plan executive leaders to generate and review:
  - Financial reports regarding key business initiatives monthly

  - Financial analysis of development and ongoing operational results against the budget
  - Forecasts and trend analyses for administrative costs, provider performance, product line profitability, membership, medical costs, premium yields and other areas of the business
  - Strategic projects affecting departments or operations inside and outside of finance
- **Operational Quality Management:** Our chief operating officer oversees our operational quality with daily oversight and regular engagement with key functional areas, such as claim processing, call center operations, fee schedule maintenance, reimbursement policy, enrollment and eligibility, provider credentialing, network contracting, provider relations and business intelligence. Our chief operating officer applies knowledge of contract and regulatory requirements in various performance improvement initiatives involving other business units. We communicate and monitor unique needs, such as Mississippi-specific requirements, state updates and other directives issued by the Division, to make sure necessary updates are completed.
- **Clinical Operations Management:** Our chief medical officer oversees our overall care management strategies. Our chief medical officer is accountable for establishing clinical policies, procedures and clinical guidelines, confirming their implementation and adapting them as needed. Our chief medical officer provides medical oversight, expertise, leadership and direction for the administration of MississippiCAN and CHIP health services and medical management program to verify the delivery of quality health care services meet or exceed the Division's contract and national and local standards. Our chief medical officer oversees and directs an integrated approach to all clinical services, including quality, pharmacy, behavioral health, population health, utilization and care management. Our chief medical officer serves as a liaison with the Division's medical leadership and other stakeholders.
- **Personnel Management:** Our local employee workforce partner works with health plan leadership and our recruitment services team to oversee workforce planning activities, including forecasting staffing volumes given membership and needs in the community for on-the-ground care management staff.
- **Communications Management:** Our compliance officer is accountable for timely communications between our health plan and the Division. Working with health plan leadership, our compliance officer uses our Enterprise Governance Risk and Compliance (eGRC) Filings Management system to maintain all Division requests, confirm their completion and document the Division's acceptance of deliverables. The eGRC enables proactive workflow management and monitoring of submission timeliness at the specific deliverable level. To facilitate communications between the Division and our staff, we can provide the Division with a communication tracker listing contact information for accountable health plan staff by functional area of responsibility.
- **Compliance Risk Management:** Our compliance officer is accountable for compliance risk management and monitoring of changes to laws and regulations to verify compliance with state and federal laws, regulations and mandates as well as contract compliance. Our compliance officer ensures that policies, procedures, processes and best practices are established and implemented to promote compliance with applicable laws and contractual obligations. Our compliance officer collaborates with the health plan attorney to conduct state-specific legal research and monitor changes to requirements to mitigate risks and achieve compliance.

Program Governance

Our program governance framework supports swift intervention and provides clarity on critical decisions, escalation and assignment of accountability to decision-makers. After implementation, ongoing activities our leadership team oversees and manages to confirm we are achieving operational excellence include:

- Identifying, tracking and resolving issues
- Contingency and mitigation planning

- Risk management
- Transition management
- Tracking and managing communication, status and implementation progress

We use this governance framework and project management approach to confirm our active monitoring and tracking of implementation and steady-state progress and the quality of our deliverables to meet contract requirements.

In 2017, when many program updates were occurring (e.g., membership expansion, inpatient management added, hospital and access payments delegated), we formed a functional leadership work group to focus on operational excellence and accountability. With guidance and direction from our chief operating officer, this work group continues today by convening all functional areas to increase awareness and engagement in addressing items and making sure all functional areas participate in implementation and resolution as needed. The work group meets twice a month to discuss operational and program issues or concerns, such as program changes, identified problems and issues, operational improvement projects, state-initiated directives and other topics related to contract management, performance and service delivery.

Compliance Oversight Committee

Our Compliance Oversight Committee, co-chaired by our compliance officer and our chief executive officer, is another key element of our ongoing program management. The committee meets at least quarterly and assists us in fulfilling our responsibilities for developing, implementing and monitoring our compliance program. The committee reports on, at a minimum, the following core elements of an effective compliance program based on the Federal Sentencing Guidelines: High Level Oversight – Governance; Written Standards, Policies and Procedures; Training and Education; Effective Lines of Communication; Monitoring and Auditing; Enforcement and Discipline; and Responding to Identified Issues. Committee membership includes health plan leadership and major functional area leads. Minutes are recorded and are available for review and audit.

Quality Management Committees

Our Quality Management (QM) program drives program outcomes and cost efficiencies to achieve Division requirements and goals as outlined in Appendix A, Draft Contract. We use a rigorous and ongoing process to identify opportunities for improvement in care practices and program management. Our QM program infrastructure encompasses two primary operating committees and subcommittees that oversee and drive quality excellence at all levels of MississippiCAN and CHIP. Our primary quality management committees include:

- **Board of Directors (Board):** The Board has ultimate oversight of all quality management functions and provides feedback and recommendations to the Quality Management Committee (QMC).
- **Quality Management Committee:** The QMC, chaired by our chief executive officer, is the decision-making body ultimately responsible for the implementation, coordination and integration of all our QM activities. The QMC reviews and accepts decisions that were delegated by the Board. QMC membership includes a representative from each subcontractor.

Our QMC structure includes subcommittees that oversee and drive quality and report information at QMC meetings. Each subcommittee chair is a member of the QMC to provide alignment between the subcommittees and the QMC's Quality Plan. The subcommittees reporting to our QMC include:

- **Provider Advisory Committee (PAC):** Chaired by our medical director, the PAC is a peer-review committee with local community and hospital-based clinicians who support our efforts to improve health equity and quality of care across the care continuum. The PAC is responsible for performing peer review activities and providing confirmation of final decisions by the National Credentialing Committee (NCC).

The PAC is responsible for evaluating and monitoring the quality, continuity, accessibility, availability, utilization and cost of the health care rendered to our members.

- **Healthcare Quality and Utilization Management (HQUM) Committee:** Our medical director chairs the HQUM Committee, which meets at least quarterly and monitors clinical QM and utilization management (UM) activities, including a review of quality management activities, progress on clinical performance measures and effectiveness of performance improvement projects (PIPs). The committee monitors for overutilization and underutilization issues and recommends corrective action if needed.
- **Service Quality Improvement Subcommittee (SQIS):** The SQIS is chaired by our chief operating officer and meets quarterly to monitor the quality of member and provider services and our overall service performance levels. The SQIS oversees delegated service functions to monitor and support improved services to members and providers.
- **Behavioral Health Joint Operating Committee:** This subcommittee is chaired by our behavioral health executive director, who is responsible for the review of systemic issues related to the coordination of medical and behavioral health requirements and the collaboration and oversight of accreditation processes as related to behavioral health.
- **Delegated Vendor Joint Operating Committees:** Our delegated services manager leads these committees and is responsible for performing continuous review of delegate vendor and subcontractor performance activities (such as dental and vision). Our delegated services manager meets monthly with delegated vendors and subcontractors to review performance metrics and make recommendations to department leaders based on issues identified, corrective actions needed and opportunities for improvement.
- **Member Advisory Committee:** Known as the Community Partnership Advisory Committee (CPAC) participants represent a broad cross section of MississippiCAN and CHIP membership and key grassroots community stakeholders. Our member services manager chairs the CPAC and co-facilitates meetings with our community relations specialist.
- **Diversity, Equity and Inclusion Council:** This council is under the executive sponsorship of our chief executive officer and co-chaired by a revolving group of health plan employees. This council is charged with assuring that our operational and care delivery processes are most representative and supportive of our membership. The council is a place for all voices to be heard.

2. Program control approach;

Based on contractual, regulatory and clinical requirements, our approach to program control involves creation of relevant metrics along with applicable performance goals and thresholds specific to each key functional area. Each functional area manager is responsible for collecting and analyzing data and reporting outcomes at defined intervals to executive leaders and our established quality committee structure. Functional area managers are responsible for making necessary changes, assuring steady state and creating, reviewing and adapting policies and procedures relevant to their operational areas.

To evaluate the effectiveness and success of their unit's program control approach, our functional area managers receive ongoing data analytics support from our Business Analytics Sciences Insights and Strategies (BASIS) team. The BASIS team provides our managers and team leads with standard, scheduled, customized and ad hoc reports. Our BASIS team lead lives in Natchez, Mississippi. We have over 100 BASIS staff who access various systems within our organization and integrate external systems, all into a uniform reporting and analytics platform. Using the data and reports the BASIS team provides, our managers and team leads make informed decisions to augment and adjust processes to maintain operational performance excellence and contractual compliance.

Our data analytics platform integrates various information, including, but not limited to, medical, behavioral health, pharmacy, financial, socioeconomic, geographic, social determinants of health (SDOH) and demographic data to produce meaningful information and analytics. In addition to providing current information, the data and reports from the BASIS team enhance our predictive modeling and risk stratification processes. Collating and cross-referencing data from these areas enables us to effectively administer our program, assess our performance, improve operational efficiencies, meet the Division's expectations and manage outcomes. As applicable, we share information with our network providers, such as gap-in-care reports, to help them improve care delivery, clinical performance and overall efficiencies. We make the data and educational materials available to providers at all times via our secure provider portal.

Descriptions of Our Program Control Approach in Critical Areas

While our program control approach covers every aspect of our program and operations, in this section, we provide detail regarding our focused approach to maintaining program control in these critical areas: matters central to the Division, population health management, care management, member services and provider services. We want to draw attention to these areas because with the new contract, we anticipate these will be areas where coordinated care organizations (CCOs) must deliver program control excellence to enable the Division to reach its goals for MississippiCAN and CHIP.

Matters Central to the Division

With the new contract, we will continue to focus in areas of addressing health equity and SDOH and improving health outcomes for our existing members and individuals transitioning into or out of UnitedHealthcare. Our ultimate priorities are continuity of quality care for members and partnering with the Division to achieve its goals for MississippiCAN and CHIP.

To honor our chief obligation to members and their uninterrupted access to care and services, we dedicate key staff for each aspect of our program control approach. Our executive team will lead all quality, innovation, access and commitment activities. They receive companywide support in making commitments to improve the lives of the people we serve in Mississippi, such as:

- **Commitment:** Our national and regional staff will work to support and assist the chief executive officer and senior management team in communicating and coordinating with the Division and associated agencies or CCOs on commitments and shared initiatives.
- **Collaborative Innovation:** Our IT and operations leadership will collaborate with the Division to introduce and implement technologies aimed at reducing administrative burden for providers and end-users of shared data while improving the quality and speed of shared data delivery.
- **Access:** To augment our stable and statewide provider network, we are advancing value-based payment arrangements with providers. We are securing stronger referral links between medical providers and community-based providers for behavioral health and recovery and resiliency services. We added member-facing staff dedicated to population health initiatives, peer support, telehealth and SDOH gap-closures to remove underlying access barriers for members. To help providers expand capacity and to promote health equity, our provider education and ongoing service support emphasizes best practices for delivering care in an environment focused on health equity, individualized access to services, and using technology to streamline access to services.
- **Quality:** At UnitedHealthcare, delivering quality is everyone's responsibility and touches every aspect of our business operations, organizational culture and service delivery. We will support joint performance improvement projects (PIPs) involving the Division and other CCOs, as appropriate. We have in-depth experience operating various integrated and coordinated physical and behavioral health managed care programs with demonstrated outcomes and results. With national and local experience gained from

operating these programs, we access best practices, national clinical experts and resources to successfully develop and implement innovative PIPs for MississippiCAN and CHIP members.

Population Health Management Focus

With our integrated service delivery approach and advanced analytics, we look for ways to capture SDOH data about individual members as early as possible and to use the data to promptly address their identified SDOH needs. We use several data collection and analytical techniques to conduct population health analyses and to assess our population health management program's influence on the population served. Our analyses confirm we are allocating resources efficiently and effectively to programs that would most benefit the population.

With the new contract, as we expand our population health management and related outreach activities, we have dedicated staff who will track, trend and evaluate outcomes and effectiveness of our programs and who will do so for the duration of the contract.

Care Management Focus

For our Care Management program, we use readily available data, predictive modeling and population health tools for detecting trends and changes. Using outcomes data, we evaluate program effectiveness, enabling our care management team to focus our efforts to meet new or changing conditions. We extract information from our clinical and administrative data sources to coordinate and evaluate activities such as:

- Reviewing clinical episodes for continuity of care and evaluating current and prior use of prescription drugs for optimum medication treatment
- Mitigating health risks by creating risk markers both predictive and clinically insightful to reduce or eliminate hospitalizations and complications
- Decision making using evidence-based guidelines to support care and disease management and identification of gaps in care
- Enhancing wellness opportunities and promoting preventive care

With the new contract, our care management activities will continue to focus on integrated service delivery in the most appropriate setting. Our care management teams have undergone training regarding our initiatives to address health disparities in Mississippi and will continue to augment our care management approach with sharper focus on addressing underlying SDOH needs and health disparities within the care continuum.

Clinical leadership, under the direction of our chief medical officer, will be responsible for identification of credentialed staff needed for completion of assessments and medical management activities. Our care management team is responsible for proactively identifying, triaging and coordinating access to services with other health plan(s) for members identified as currently receiving or in immediate need of services, such as inpatient care, pharmacy, specialty providers and durable medical equipment. Our early identification and intervention protocols enable our care management team to identify members who are not high-risk but who may benefit from additional assistance to maintain continuity of care. This includes proactively tracking prior authorization information in our system and establishing a more aggressive approach to continuity of care for these members.

Member Services Focus

Because the member experience and access to care are priorities, our member services and provider services teams work together and focus on improving member health and service experience. Our member services and network management team leaders are key liaisons with the Division and community stakeholders. Together, team leads train, guide and motivate our member services and provider services staff in our ongoing efforts to close care gaps and eliminate barriers to care. In cooperation with the Division, our call center, member

outreach team, care coordination teams and provider education and outreach teams proactively assist members in accessing care, addressing members' SDOH and carrying out health literacy campaigns.

Provider Services Focus

Our network management and provider services teams use an early intervention approach to identify service areas, providers or member demographics (e.g., individuals who are pregnant) and share information regarding authorizations as appropriate to mitigate risks to gaps in care or service disruption. Our network team is responsible for advancing value-based payment arrangements with providers and frequent interaction with internal provider relations and network contracting staff to identify potential network issues. Our provider services teams — consisting of field-based, call center, credentialing and contracting staff — provide ongoing assistance to providers.

Much of our program control centers on how we partner with the provider community to assure members' needs are identified and met. We use predictive analytics and other provider-facing tools to enable real-time interventions with providers. An example of how our program control approach delivers meaningful outcomes is the Care Provider Early Warning System (CP-EWS) we launched in Mississippi in 2016. This capability provides enhanced insight to monitor claims trends and tailor provider outreach and education to avert or mitigate provider claims concerns. Our increased understanding and transparency in the claims process offers a platform for continuous improvement. For example, over the past three years (2019 through 2021), we had 4,900 CP-EWS alerts regarding provider coding practices resulting in claims rework savings of $258,300.

To keep our approach to serving providers fresh and relevant, we have established collaborative partnerships with Mississippi's premier provider organizations. State collaborations include partnerships with provider-hosted events and participation in joint meetings with provider groups such as the following:

- Mississippi Rural Healthcare Association
- Community Health Center Association of Mississippi
- Mississippi Association of Medical Equipment Suppliers
- Mississippi Chapter of the American Academy of Pediatrics

With the new contract, provider and network management services will continue to focus on increasing value-based payment arrangements and ongoing education regarding integrated service delivery. Our provider services teams consist of clinical practice consultants and nonclinical provider advocates who work directly with Mississippi providers to improve referral processes and care coordination activities between physical and behavioral health providers and that includes nontraditional services (i.e., community-based organizations, SDOH) in the overall system of health care delivery.

3. Manpower and time estimating methods;

Depending on scenarios — such as operational area use of human and IT resources, workload and cyclical activities — team leads use tools and methods geared toward their needs for manpower, resources and the time needed to implement or manage projects and workloads. Our current infrastructure is scalable and able to support significant membership changes and growth. We achieve system consistency, stability and performance through a combination of system-driven load balancing thresholds, advanced hardware and virtualization capabilities for our systems.

For operational areas serving members and providers, we use a standardized Workforce Management Projection Model (WMPM) that accommodates membership changes and can project the number of full-time equivalent (FTE) personnel required for each functional area. For example, in addition to having standard staffing metrics, we have planning models that incorporate trajectories and run rates for our call centers, claims adjudicators and

appeals and disputes areas, which calculate workforce projections. This helps managers to make staffing projections and proactively plan for hiring and training ahead of when and where we need staff.

If significant changes in enrollment are anticipated, our local leadership team will enlist our national implementation team to assist us locally, as needed. These national resources free our local leaders and staff from high-volume administrative burdens and enable them to focus on the members, expansion of our operational infrastructure and seamless transition of members and potential provider impact.

4. Sign-off procedures for completion of all deliverables and major activities (Note: The level of final sign-off on deliverables at …

We will obtain the Division's prior written approval of all deliverables 60 calendar days before the contract's operational date and for the duration of the contract as an incumbent, we do not anticipate significant implementation rework because we have had an office in Ridgeland for years, our day-to-day operations are at full scale, and we are currently fully staffed.

While signoff procedures and accountabilities may vary depending upon the deliverable, our project manager and chief operating officer will maintain ultimate signoff authority. Throughout the implementation and transition to the new contract, we will capture and track all program deliverables, major activities and Division requests to completion, including Division acceptance and signoff throughout implementation.

Following implementation and for the duration of the contract, our signoff procedures will align with the Division's requirements and our quality assurance and program integrity practices. Currently, we use multilevel signoff procedures that start with the functional owner's initial review and approval of the deliverable or major activity to be initiated. Next, the project moves to the functional area directors for review and refinement of implementation details and accountabilities, then to the executive team for review and signoff approval. Our project manager and chief operating officer will oversee each project's progress toward completion. They will be responsible for project signoff and reporting any signoff requirements to the Division specific to implementation and readiness activities.

Signoff Procedures for Specific Deliverables and Commitments Post-Implementation

In keeping with our commitments, each functional leader engages with entities to secure an agreement that includes defined expectations and actions. Functional areas are responsible for fulfilling the commitment and monitoring compliance. Our chief executive officer is authorized to sign off on commitments. For example, when we deploy targeted population health management programs, our medical directors will lead implementation of the initiatives, which includes tracking, trending and reporting progress and outcomes through our quality committee structure (e.g., PAC, HQUM, QMC). Upon completion, our chief executive officer and the functional area leader make the signoff determination and communicate with the Division as required and depending upon the specific deliverable or commitment.

In concert with this RFQ submission, the IBA team has activated our implementation plan and builds out the critical elements required for a successful implementation in preparation for the readiness review and aligned to the Division's timeline. During implementation, the IBA team will capture action items identified in meetings and will assign identified action items to a functional owner (e.g., enrollment, claims, member services, provider contracting, subcontractors) per the project manager's direction and as delineated in the accountability matrix. Functional owners will be responsible for completing the action, leading cross-functional completion of the item and escalating any further development decisions, in compliance with state requirements. The IBA team will report implementation progress to our project manager and status through our Mississippi QMC structure. They will report regularly on the status of each work plan action item and communicate directly with the functional owner until the action item is completed or resolved.

While carrying out our current obligations to the Division, we will keep the implementation plan on schedule to facilitate a smooth and seamless transition experience for members, the Division and providers. To transition seamlessly to the new contract and any new requirements, we use stage gate reviews to assess requirements, confirm operational process functionality, evaluate progress, confirm status details and identify potential risks and issues. The stage gate process helps our project manager and IBA team to ascertain we can deliver on all contract requirements. This process enables us to create an overview of the end-to-end experience of our members, providers and other stakeholders. Using stage gate reviews, we gain understanding and anticipate possible disruption points regarding new requirements, contract changes and changes in membership or provider network composition to mitigate any disruption.

Based on each stage gate assessment where a risk or problem has been identified, we create specific solutions such as contingency, back up, redundant and communication plans to proactively address these potential issues. Beyond the implementation phase, we employ continuous quality assurance and quality improvement strategies through structured monitoring and ongoing assessment of program performance. We will continue to execute our demonstrated quality and oversight methods to swiftly identify and correct problems.

Following readiness and confirmation from the IBA team that steady-state has been achieved and maintained for at least 60 days, our project manager will transition our work plan (tailored to the MississippiCAN and CHIP contract) to our Mississippi-based team. Individual team members, who manage the key operations for which they are responsible, will oversee ongoing program management activities and the signoff of all deliverables specific to their designated area. Following implementation, we will continue to manage the full lifecycle of our operational performance, policies and procedures, and safeguard our processes through ongoing assessment, reviews, revisions, approvals and signoff process.

5. Management of performance standards, milestones and/or deliverables;

Achieving Operational Excellence

The processes for managing performance standards, milestones and deliverables extends beyond implementation to readiness and steady-state phases. For each phase and for the duration of the contract, we use formal processes and industry standards to measure internal performance, progress and degree of success along the contract management continuum.

To verify our operations effectively execute the transactions necessary to meet the Division's expectations and performance standards, produce all deliverables on time and meet the Division's requirements, we will:

- Assign a team dedicated to managing the readiness review
- Identify and engage subject matter experts
- Compile required documentation by due dates
- Develop materials and presentations that reflect the Division's requirements
- Respond quickly to Division and stakeholder needs and meet all deadlines

Based on Division requirements, the IBA team develops a summary version of the overall work plan providing a detailed and complete overview of all implementations and go-live activities.

We regularly conduct internal readiness review status meetings to compare our readiness to date alongside the implementation plan effective date. This measures our adherence to the readiness review schedule and our level of preparedness to review all processes and upcoming milestone dates and activities with the Division.

Managing Operational Performance

Our chief operating officer manages daily operational performance across all key operational areas for MississippiCAN and CHIP. Our chief operating officer monitors and makes sure each functional area lead continuously monitors and manages operational performance.

To confirm we are meeting or exceeding performance standards, key operations managers meet at least weekly to review performance outcomes and trends and to course-correct and escalate issues as needed. Key operations managers share the data at least monthly with our leadership team. This information guides discussion and plans for trending performance and potential obstacles, along with any additional remediation activities.

Monitoring Subcontractor Operational Performance

For subcontracted services, our executive team maintains complete accountability and performance oversight of our subcontractors. Our approach to subcontractor performance monitoring is coordinated and transparent — to meet the Division's expectations and to facilitate effective oversight. With each subcontractor, we have a written agreement and have established agreed-upon protocol regarding enhanced lines of communication, data sharing requirements and expectations, accountability and authority hierarchy. This approach provides visibility to leadership about the subcontractor's performance and regulatory issues, to demonstrate effective oversight.

At least once per year, we will conduct a formal review of each subcontractor's performance, and we will incorporate the subcontractor's performance review results into our annual Quality Management program evaluation report. Ongoing, we use several mechanisms to manage and monitor subcontractors. These include, but are not limited to, scheduled reporting deliverables, monthly operations meetings, routine audits and monthly Delegated Vendor Joint Oversight Committee (DVJOC) meetings. Our chief operating officer and delegated services manager oversee our DVJOC. They share accountability for and maintain continuous oversight of all subcontractor functions. We fully integrate affiliate and nonaffiliate subcontractor activities into our operations. We monitor subcontractor performance and validate systemic operational alignment, including execution of corrective actions when necessary. We require subcontractors to sign a contract aligned with our contract with the Division.

Subcontractors are integrated into our performance obligations via accountability for their performance through ongoing collaboration with vendor relationship owners (VROs) and our delegated services manager. Our VROs undergo specific training to hold this role. Our Enterprise Vendor Risk Management program provides the structure and framework to consistently identify, document and mitigate third-party vendor risks. The VROs hold regular meetings with their assigned subcontractor. In collaboration with our functional area leaders, Quality and Compliance Oversight Committees and executive leadership, our subcontractors conduct monitoring activities locally. This regular collaboration and oversight help to verify our subcontractors are meeting performance metrics and confirms subcontractors' staff, policies and resources are appropriate to meet the requirements of their agreement. Results of these monitoring activities are reported in functional area committee and Compliance Oversight Committee meetings, which include executive leadership reviews. If there are performance issues, these committees recommend actions for the subcontractor to remedy operational issues and maintain compliance with the contract. This may include a corrective action plan or if necessary, revocation of the delegation agreement.

Maintaining Subcontractor Accountability

The longevity and success of our subcontractor relationships is evidence of our strong, responsive oversight programs. Information sharing, data reporting and regular communication have driven this success. Just as we monitor our internal groups to verify compliance with laws, regulations and contract requirements, we use similar processes to monitor both affiliate and nonaffiliate subcontractors. These internal control processes enable us to measure our effectiveness and our subcontractors' performance, including their responsiveness to requests from the Division.

For the duration of the contract, our delegated services manager and applicable VRO provide oversight to verify the subcontractor remains responsive to requests from the Division and to confirm ongoing collaboration. We have developed aligned relationships with our affiliate subcontractors that allow us to meet and discuss opportunities as soon as they are discovered, often through emails, phone calls and instant messages.

We hold our subcontractors — both affiliate and nonaffiliate — to required performance levels using contracts, internally set standards, incentives, penalties and established policies and procedures, to include enforcement for nonperformance. All subcontractors must comply with our performance standards or agree to implement our required corrective action plan, as we deem necessary. Our protocols note that if nonperformance issues become apparent, the delegated services manager, through their committee work, recommends next steps to the subcontractor to remedy operational issues and maintain compliance with the contract. If the delegated services manager identifies deficiencies with the subcontractor, corrective action will be implemented. We will conduct audits as needed. The VRO must seek approval from health plan leadership (via our delegated services manager) for any exceptions. The VROs report findings to our Service Quality Improvement Subcommittee consistent with our QMC program and quality program requirements.

Our subcontractor performance monitoring process confirms we respond appropriately to review processes, evaluate outcomes and guide the VROs in determining the subcontractor's level of service delivery excellence. Using this review process, we identify deficiencies through oversight activities, which include:

- Field-based management using VROs
- Ongoing monitoring of performance metrics
- Using compliance audits when needed

Audits performed by compliance, business functional areas, plan personnel and other organizational areas identify, prevent and correct regulatory risk and mitigate any potential delay in services from occurring. We use monitoring activities and active VRO engagement to verify the compliance program is effective and to drive routine feedback on organizational performance and subcontractor compliance with applicable laws, regulations and company policies.

Our audit management team supports the chief compliance officer to centrally manage, support, report and track audits and corrective actions for regulatory compliance audits or studies conducted by federal agencies, including, but not limited to, CMS, Office of Inspector General and General Services Office. Audit management tracks, reports and provides support to regulatory compliance audits conducted by state regulatory agencies and state-contracted entities, such as an External Quality Review Organization, as part of the support provided to the chief compliance officer. This process facilitates high-level oversight and accountability for the accuracy, timeliness and integrity of all reporting and data submissions to the Division.

Upon request or as required, we will provide to the Division the findings of subcontractor performance monitoring and reviews. If we or the subcontractor terminate our agreement, we will notify the Division within one business day of the termination and we will inform the Division of our plans for continuity of service delivery for members and providers. We will notify the Division if a subcontractor is placed on a formal corrective action plan. In addition, we acknowledge the Division will establish and provide any reporting requirements for incorporating subcontractor performance into the reports to be submitted to the Division.

Policies and Procedures for Monitoring and Evaluating Subcontractors

We use several mechanisms and processes to encourage and steer exemplary subcontractor performance. We have established a formalized process, policies and procedures for auditing and monitoring subcontractors, which address their performance. We have adapted these policies and procedures to meet the Division's individualized requirements and needs.

Our policies outline how we measure compliance and performance of all delegated relationships and how we take appropriate action for noncompliance or underperformance. They state that "we know and can demonstrate that our vendors and delegated entities are delivering products and services to the same standards and with the same level of compliance, as if we were delivering the products and services ourselves." Our policies cover regulatory, financial and legal requirements, service level agreement reviews, time frames, timely reporting, audits, subcontractor trends, risk assessment and process improvement. Auditing and monitoring subcontractors' performance is addressed in our policies and included in our stringent compliance program.

Applicable to all subcontractors, the following compliance program elements are included:

- **Adopting Written Policies and Procedures:** Articulates our commitment to comply with all applicable federal and state standards
- **Designating a Compliance Officer and a Compliance Oversight Committee:** Designates a compliance officer and Compliance Oversight Committee accountable to senior management
- **Conducting Effective Training and Education:** Conducts effective training and education for employees
- **Developing Effective Lines of Communication:** Establishes effective lines of communication between the compliance officer and the organization's employees and the entities, as appropriate
- **Enforcing Standards:** Enforces standards through well-publicized disciplinary guidelines
- **Auditing and Monitoring:** Establishes an effective system for routine monitoring and identification of compliance risks, including internal monitoring and auditing
- **Responding to Detected Offenses and Developing Corrective Action Plans:** Adopts effective procedures for promptly responding to detected offenses and to developing corrective action initiatives concerning the organization's delegated contract
- **Risk Assessment and Quality Management Oversight Duties:** Are written into the policies

Subcontractor Oversight Meetings

We meet with our subcontractors monthly through our DVJOC meetings to promote understanding of interdependencies and provide direction to make sure subcontractors meet quality and effectiveness requirements. Local functional area business owners report on subcontractor performance and measurements. The purpose of DVJOC meetings includes developing compliance strategies and initiatives to support the subcontractor's performance, such as:

- Review overall business performance, including key performance indicator monitoring
- Assess key compliance and regulatory issues and risks
- Review of policies and procedures
- Training and education
- Effective lines of communication
- Responding to issues and escalating, when necessary
- Conduct audit planning and reporting
- Review fraud, waste and abuse prevention efforts
- Subcontractor oversight as a key component of quality review

Information from DVJOC meetings flows through our QMC, which is responsible for ongoing analysis of data to monitor and improve the delivery of care, member safety and service. The program uses continuous quality improvement process and Six Sigma problem-solving techniques to monitor improvement. Our QMC uses

meeting information to prioritize performance goals and allocate resources to execute performance improvement activities.

Examples of Subcontractor Quality Goals and Performance Oversight Activities

Our subcontractors must submit detailed reports to us, which we use to perform oversight activities and make sure the subcontractor is meeting established goals consistent with contractual requirements. We use a combination of operating agreements and performance level standards to set forth operational detail regarding performance requirements, expectations and responsibilities. We continuously assess subcontractors' service performance and reporting metrics to identify trends and opportunities for process and quality improvement. We actively seek and provide feedback concerning issues or problems that arise in the delivery of services to members. The most critical aspect of these oversight activities is the monitoring and measuring of subcontractors' service level performance. All key services provided to members are carefully measured and monitored by each subcontractor and the results are analyzed and reported to our chief operating officer and delegated services manager.

Examples of goals subcontractors may be required to report for these performance oversight-monitoring activities include:

- Network access and adequacy per state access requirements for mileage and drive time
- Credentialing and recredentialing meeting all applicable state and federal requirements and regulations, including required application processing turnaround times
- Claims processing results, including measurement of claims processing timeliness and accuracy in compliance with state and Medicaid prompt payment requirements
- Provider services call center metrics, including measurement of call statistics to meet applicable state service level and abandonment rate requirements
- Quality outcomes specific to the type of service or product the subcontractor delivers

6. Internal quality control monitoring;

Using our program governance structure described above, we monitor and manage internal quality control for each key operational area. Each functional area manager has performance monitoring and reporting responsibilities, including deliverable due dates and developing metrics for contractual, administrative, operational, regulatory and clinical requirements. Our compliance officer and our compliance and quality oversight committees hold each functional area accountable for monitoring performance through the collection and analysis of these metrics. Our compliance officer will monitor and verify our compliance with the Division's requirements to submit reports in compliance with the terms described in the contract.

Internal Quality Control Monitoring Processes and Systems

Using our Strategic Management Analytic Reporting Tool (SMART), we collect, analyze, validate, report and store data in a quick and efficient manner. The SMART holds all Medicaid-relevant ad hoc report data, including claims information (e.g., medical, pharmacy, dental, vision, lab), member data, provider data, authorizations, external subcontractor data and predictive modeling information. Our key operations managers and their teams continuously monitor a rolling 12 months of internal data to measure and manage key operational performance in the areas of claims processing, call handling, appeals and grievance processing, credentialing status, Quest Cloud (i.e., GeoAccess) standards compliance, utilization management, prior authorization review turnaround time and other program functional areas. When trends indicate a need to drill down further, we view data at the member level, which supports our root cause determination and ability to plan interventions.

Our systemic data integrity process for claims, encounters and other data extends to data and reports we receive from subcontractors. For example, we use a dashboard report to validate trip data from our non-emergency

transportation subcontractor by comparing the data against member eligibility on the day of the trip and provider claims for the same day of service. We gather data from our SMART data warehouse where clinical and claims data, quality measures, prior authorizations and other applicable data from providers or subcontractors is stored. If a subcontractor has a current month volume that is three or more standard deviations from the mean, the metric fails. For any failed metric, the data integrity team researches the issue to determine the root cause and works with the appropriate teams or subcontractor to achieve resolution.

Ongoing Identification and Correction of Problems
Upon reaching operational steady state, our management and control activities continue for the duration of the contract and beyond. Our continuous quality improvement work plan serves as the north star as we implement, test, analyze and modify processes or programs to resolve identified problems.

7. Program status reporting, including examples of types of reports; and,

We will comply with all Division requirements and instructions regarding report submissions, including, but not limited to, completeness, accuracy, formatting, timeliness and data uploading instructions.

CMS Reporting
We understand and agree to support the Division when they request specific information to prepare their own reports to comply with CMS contractual requirements.

Report Examples
We provide a variety of standard reports to the Division as required and ad hoc reports upon request. The types of reports we provide regularly (monthly, quarterly, annually and ad hoc) include the following:

- Care Management reports, including reports specific to medical care management, behavioral health care management, maternal care management and foster children care management
- Member Enrollment reports, including statistics and trends, in addition to new member card reports
- Utilization Statistics and Trends reports for both medical and behavioral health utilization
- Claims Processing Statistics and Trends reports for medical and behavioral health services
- Call Center Statistics and Trends reports for medical and behavioral health calls and provider call center reports
- Provider Network Statistics reports, including reports on contracted providers, network access and appointment availability
- Prior Authorization reports for medical and behavioral health prior authorization requests
- Grievances and Appeals reports, including those from member medical, member behavioral health, provider grievances and appeals and state issues and Medicaid investigative grievances
- Quality and Utilization Management reports for clinical services
- Fraud, Waste and Abuse and Third-Party Liability/Subrogation reports

We understand the Division reserves the right to audit our self-reported data and change reporting requirements at any time with reasonable notice.

Verifying Reporting Accuracy and Compliance
Our Mississippi-based compliance officer has overall accountability for managing operational milestones and deliverables. Throughout the life of the contract, our compliance officer will:

- Verify compliance and submission of deliverables or regulatory requests for information to the Division
- Provide guidance and clarity about contractual requirements

- Maintain a standing contract deliverable inventory, including each contract citation, requirement, internal due date, state due date, accountable owner, subject matter experts and any Division-issued template
- Confirm each report to be tracked is entered into our filings management system

Implementation and Readiness Status Reports
During readiness, the IBA team will work with the Mississippi team to make sure milestone and deliverables are successfully completed. After go-live and for the duration of the contract, our director of operational oversight is responsible for making sure all deliverables are submitted to the Division on time and in compliance with contract requirements and applicable regulatory agencies. Our director of operational oversight receives ongoing support from our contract management team, which collaborates to:

- Verify we comply with certain requirements of the contract, including deliverables
- Coordinate with internal team leads to gather data
- Confirm the deliverables are complete, accurate and submitted on time
- Notify our compliance officer immediately if there is a role change or new accountable owner
- Complete the data release governance process on all requests for information, legislative inquiries or other special request deliverables meeting criteria and provide registration number to compliance, if requested

Members of our contract management team include the individual(s) with specific business knowledge about a particular process.

Should the Division request ad hoc reports, our compliance officer will work with the Division to confirm ad hoc reporting expectations, including the required data, file specifications, delivery method and due date. In conjunction with the BASIS team, we create ad hoc reports using our reporting systems and analytical tools. If needed, our compliance officer will coordinate meetings with Division representatives to confirm requirements.

8. Approach to the Division's interaction with contract management staff.

As an incumbent administering CHIP since 2010 and MississippiCAN since 2011, our leadership team interacts and communicates with the Division regularly. We value the frequent interactions we have with the Division. Not only has this built trust, but frequent interactions with the Division keeps us aware of the Division's changing needs and priorities, so we can make sure we are fully aligned with the Division's goals and objectives. These interactions afford both parties an opportunity to learn and grow to better support MississippiCAN and CHIP.

The Division facilitates several standing meetings with CCOs, which we participate in regularly. These meetings, listed below, present opportunities to directly interface and exchange ideas with the Division's senior leaders. Other meetings are scheduled as needed.

- Monthly Management Review Meeting
- Quality Task Force and Quality Leadership Meetings
- Pharmacy & Therapeutics Committee Meetings
- Program Integrity Meetings
- Encounters Work Group Meetings
- Executive Leadership Meetings

We work jointly with the Division to plan and conduct a variety of member and provider-focused trainings and workshops and collaborate periodically on informational campaigns to help educate members and providers about programmatic changes or updates.

Nurturing Local Partnerships

Each functional area within our health plan has a leader assigned to work directly with a key leader or member of the Division's staff. We call this "relationship mapping" and encourage open, productive, two-way communication between our employees and those with the Division and Division representatives. In addition to one-to-one communication, we maintain a mailbox the Division can use to reach several functional areas. This facilitates broader insight into programmatic changes impacting several functional areas. If formal communication is warranted, we maintain a compliance inbox accessible only to a core set of leaders and compliance experts who can quickly engage necessary personnel or triage time-sensitive requests from the Division. We will acknowledge 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. 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 for completing the request.

[END OF RESPONSE]

4.3.4.2 Problem Management (Marked)

1. Assessment of program risks and approach to managing them;

Assessing program risks and managing them touches all aspects of our business operations. To deliver a responsive problem management system that spans all operations, each key functional area has defined accountabilities for assessing risks along with reporting, mitigating and resolving identified problems. As part of daily program management, when program risks — including potential risks — are identified, key operational areas use defined escalation and remediation pathways to address the situation and avoid or mitigate ensuing problems.

To prevent problems and manage risks, we follow established standard operating processes, policies and procedures aligned to the health care industry and Medicaid programs. We have governance committees that make recommendations and provide guidance to key operations teams for implementing corrective actions that promote our commitment to systemic program management, quality and compliance. Our executive leaders communicate with the Division and stakeholders and will notify the Division of escalated problems and status of action plans when needed.

Our problem management approach focuses on three fundamental phases: problem identification, resolution and evaluation. Each phase of our approach consists of various tasks that guide our action and response. To facilitate prevention, early detection, resolution and adherence to company policies, we structure our problem management approach based on:

- **Identification:** Each key functional area continuously monitors and assesses performance to recognize aberrancies, define the problem, determine root cause and bring forth solutions.
- **Resolution:** Each functional area communicates a detailed solution action plan and implements corrective actions to prevent future problems. Resolution involves cross-functional collaboration, governance oversight, and training and communication with the affected internal and external parties.
- **Evaluation:** Post-resolution, each functional area performs ongoing review and monitoring with governance oversight to confirm the solution is working properly.

Using these phases, we honor our commitment to the highest standard of problem management and adherence to contract requirements for the Division and MississippiCAN and CHIP members and providers we serve.

Our Compliance & Ethics program underpins our problem management approach and facilitates proactive problem prevention and detection while promoting an organizational culture of ethical conduct and compliance. As part of our Compliance & Ethics program, we include and adhere to the UnitedHealthcare Code of Conduct — “Our Principles of Ethics and Integrity (the Code).” The Code is a guide to acceptable and appropriate business conduct by the company’s employees and contractors. All employees are trained on and must comply with the compliance obligations as described in the Code and the Compliance & Ethics program. All employees are accountable for understanding the laws, regulations and contractual obligations applicable to their specific area.

Our compliance officer will work with health plan leadership and other business partners to make sure we have and maintain internal controls, job aids, policies and procedures to meet the business requirements and standards of MississippiCAN and CHIP as described in Appendix A, Draft Contract and all applicable federal and state requirements. These policies and procedures are updated as needed and reviewed at least annually to confirm they are current.

Our compliance officer oversees our prompt response to reported concerns and instances of identified noncompliance or suspected misconduct. If necessary, we open an inquiry whereupon our compliance, legal or special investigations personnel conduct preliminary investigations. We support ongoing compliance with

applicable regulatory requirements. As appropriate, we work with local business leaders to develop corrective action plans to address the underlying issues contributing to program noncompliance or violations to help prevent future program noncompliance.

Approach to Assessing and Managing Risks

Assessing and managing risks occurs in our daily operational processes at local, regional and national levels. Functional area managers routinely monitor their operational performance against contractual or internal performance metrics. They report performance measures and outcomes data to identify problems at least quarterly during oversight committees. The objective of our oversight committees is to drive operational performance excellence, meet national, state and local quality and compliance requirements (e.g., CMS, NCQA, state provider agreements and regulators) and facilitate problem management strategies.

Elements of our program risk mitigation strategy and approach to managing problems across operational areas include:

- Monitoring day-to-day activities to prevent problems and address issues proactively
- Report preparation and review at defined intervals to identify risks or trends and address problems
- Quality committee oversight to course-correct any systemic issues or problem trends. Our functional operations area leaders chair the oversight committees. The committees monitor the quality of service delivered to members, providers and the Division. The committees create awareness through reporting and discussion of operational performance issues and metrics, including underperformance and performance meeting standards and goals. Documentation includes improvement plans and remediation actions
- Internal data analysis and audit activities to identify issues and trends, investigate root cause, retrain staff, inform appropriate communication with members and providers, resolve problems and determine appropriate corrective actions
- Implementing a corrective action plan (CAP) if performance is found to be at risk of a state imposed or regulatory CAP or sanction. We proactively implement an internal CAP, which includes more rigorous monitoring and oversight in coordination with our compliance officer

Our health plan leaders are actively engaged and lead oversight committees where recommendations are made or corrective actions are finalized. A remediation plan must be submitted to executive leadership and approved if performance in any functional area falls below acceptable standards or defined metrics.

Assessing Risks and Addressing Problems by Key Operational Areas

Aligning with the unique data set a functional area uses or exchanges for the intended internal or external operational or business purpose, we support numerous types and levels of information processing, data exchange and risk assessment activities. In the following list, we describe the top 10 operational areas most used to serve members, providers and the Division and how we manage problems or risks in those areas.

1. **Information Technology:** Risk assessment activities include continual system monitoring. We use transaction baselines and alert thresholds to proactively identify and address system bottlenecks. This tool has enabled us to avoid unnecessary escalation in addressing application issues, while improving application availability and claims processing speed. This system monitoring started with CSP Facets and is expanding across key assets in our portfolio. **Problem management:** Described in detail in this response under the heading “Root Cause Analysis for IT Systems Problem Management.”
2. **Call Center Operations:** Call center managers monitor for performance risks throughout the day to manage speed to answer, call abandonment, on-hold rates and other metrics. They use workforce

management tools and dashboards to monitor call volume and adjust staffing. Call quality analysts make sure our staff provide callers with accurate information and adhere to established policies and procedures. | **Problem management:** We randomly select and record calls received and monitor no less than three percent (3%) of calls for compliance with customer care guidelines. We conduct monthly calibration calls to confirm member service advocates are providing the appropriate response to callers. Issues or problems identified result in additional training for the advocate or team. As part of our quality management program, call center managers provide initial and ongoing training to call center staff; listen in on calls; and provide feedback to call center staff regarding call quality.

Problem Management in Action
In Mississippi, to improve our External Quality Review (EQR) scores, we focused on improving our audit preparation in 2019. We assembled a dedicated compliance readiness group to develop and implement a structured audit readiness process. This group monitors our operations daily to identify and resolve compliance issues. In advance of audits, the group works with our managers to confirm corrective actions were implemented and remain effective. Our structured audit readiness process, coupled with our compliance readiness group's early intervention, has led to improvement in our EQR scores — from 91% in 2019 to 97.7% in 2021.

3. **Claims and Encounter Data:** Risk assessment occurs continually through claims system edits configured to identify claims issues and unusual billing patterns. Upon initial receipt, the claims system auto-checks for compliance and validates claims before they move to the adjudication process. After adjudication, claims flow through our encounter data reporting system, NEMIS (National Encounter Management Information System), where encounter data reports for submission to the Division are generated each month. | **Problem management for claims** is performed by dedicated staff. They use our Care Provider Early Warning System (CP-EWS) to monitor clean claims rates, dollar accuracy rates, claim payment accuracy, denial rates, claim receipts and cash flow. The system alerts us to claims possibly denied in error and to fluctuations in claims receipts and cash flow paid to providers. Our claims management team uses this information to follow up with providers and address claims adjudication issues and mitigate payment concerns. | **Problem management for encounter data** is handled daily by our dedicated encounter data management team; this team uses outcomes data from NEMIS and the Division to correct any encounter data accuracy or submission issues.
4. **Utilization Management (UM):** Our National Medical Care Management Committee (NMCMC) assesses and manages risks regarding our UM program and shares information with our senior executives, who are responsible for UM program quality and performance excellence. | **Problem management:** Our chief medical officer monitors reports of prior authorization volume and services to identify trends and adjust staffing to maintain service quality and turnaround time compliance. Our chief medical officer reviews the data the NMCMC shares and takes action to address performance issues, problematic trends or emerging risks.
5. **Care Coordination:** Our care coordination approach uses a team-based, trauma-informed care approach to serve members in a dynamic, multidisciplinary manner through collaborative engagement with a focus on the member experience and quality of care. Ongoing care coordination is member-focused to make sure the interdisciplinary treatment team (ITT) is aware of the member's current and changing health needs and preferences with an emphasis on effective communication between the ITT team members. The ITT team consists of the member, care manager(s), the members PCP, the member's care giver, pharmacy and specialist providers. To tailor care coordination to each member's level of need, we use a predictive risk stratification model that pulls data from multiple sources, including but not limited to, medical, behavioral, pharmacy, SDOH, claims, assessment data and directly from the member. Our

care coordination platform, CommunityCare, is the mechanism the ITT uses to collaborate and develop a treatment plan tailored to the member's needs, to monitor the member's progress and identify acute events (e.g., hospitalization) so the ITT can coordinate relevant and timely intervention and follow-up. | **Problem management:** Upon identification of care coordination problems, the methods we use to resolve the issue depend upon whether the issue is systemic or case-specific. Our chief medical officer, quality management director and health services director collaborate to address systemic issues, such as the overall quality and effectiveness of our care coordination activities. If the care coordination problem is unique to a member or case, the care coordinator and ITT collaborate to resolve the issue. For example, if a member is missing appointments or nonadherence to the treatment plan is identified, the care coordinator will work with the member to find out why they have not obtained services and will remove barriers to accessing care for the member.

6. **Quality Management (QM):** We focus on HEDIS® rates, care gaps and CAHPS surveys to assess and manage QM risks. We review HEDIS rates gathered from retrospective and prospective reporting to monitor rates and track year-to-date performance. We monitor member level information to identify gaps in care using our Strategic Management Analytic Reporting Tool (SMART) data warehouse. Our SMART captures geographic information, diagnosis and level of care, disease management categorizations, provider contracts, revenue capitation by rate cell, claims/encounters for each service category, service authorizations by day, actuarial reserving completion factors and risk stratification scores by member. We feed SMART data into our HEDIS® rules engine and the HEDIS rule results are fed back into SMART to enable comprehensive assessments of performance and variation. We review annual CAHPS survey results to understand the member's experiences and to identify opportunities to improve the member experience. | **Problem management:** Ongoing, our QM team uses outcomes data from all reports described above to address and course-correct unwanted trends or outcomes.
7. **Network management:** We actively monitor the provider network monthly to identify provider additions and terminations, anomalies and trends with individual providers who are identified through our provider relations outreach or because of formal and informal feedback received from our members. | **Problem management:** Our network development, clinical services and compliance teams perform ongoing reviews of our provider network to verify continued compliance with the Division's access standards.
8. **Grievances and Appeals:** Our Escalation Tracking System (ETS) facilitates administration and expeditious management and processing of grievances and appeals (G&A). | **Problem management:** Using ETS, our customer service teams manage, provide status, follow up and track resolution on submitted grievances and appeals against policy-mandated time frames for member contact and appeal or grievance resolution. Our G&A team generates reports related to the outcomes of grievances, complaints and appeals.
9. **Enrollment/Eligibility:** The enrollment files we receive from the Division go through our secure connection platform, Electronic Customer Gateway (ECG). After file validation, the files are pushed to CSP where the file data is used to populate and refresh databases that key functional areas use to manage business operations (e.g., claims, eligibility verification, PCP auto-assignments). Data in the files is shared with other systems, such as the 270/271 transactions with claims clearinghouses, our call center interactive voice response (IVR) system, member and provider portals and our SMART data warehouse for reporting and analytics purposes. Member enrollment and eligibility updates are shared with subcontractors and downstream operations such as ID card fulfillment, coordination of benefits and care coordination activities. | **Problem management:** If the enrollment file we receive from the Division does not "pass" ECG validation, it is returned to the original submitter with a rejection code. Once ECG validates the file's HIPAA compliance and adherence to business rules, it is pushed to CSP and our activity monitoring platform to quality-check data and route errors for correction to the member services

team. We use the data from the file to generate operational and state-specific reports and adjust workflow management activities.

10. **Claims Disputes:** Our CSP facilitates administration and expeditious management and processing of claim disputes. | **Problem management:** If there is an issue with a claim post-adjudication, our field-aligned support team responds quickly to resolve escalated issues for providers, including aiding with reconsiderations and disputes. The team is a single-point tracking and monitoring team for our Mississippi-based provider services staff. The team streamlines and integrates information from claims, enrollment, clinical episodes of care and utilization history and provides an all-inclusive picture of provider concerns, root cause analysis and resolution. Our claims management team generates reports related to the outcomes of the disputes.

Risk assessment frequency depends upon key operational areas and each area's volume of work and capacity in relationship to current and future workforce and resources needed to operate at peak performance and to comply with the Division's performance requirements.

Overall Approach to Information Technology Service Management

To remain a health care management leader and to enable employees to deliver the ultimate service experience to our state and federal government partners, UnitedHealthcare invests heavily in its IT systems. For example, our "Big Data" investments have introduced Tableau, MarkLogic, BusinessObjects, Splunk, MapR and other software tools into our reporting and analytic subsystems. We are on a continuous trek to simplify, modernize and transform our IT systems and subsystems. For example, we are moving toward systemic automation of certain transactions to eliminate paper processes, digitizing workflows and enabling near-real-time interfaces. We are modernizing our claims subsystems to move away from scheduled processes to real-time interfaces. We continue to advance and invest in new technologies as they become available.

To accommodate large, frequent and complex data transmission, acceptance and submission protocol and processes, we rely on our ECG for interface and data file exchanges. Our ECG provides a secured and security-compliant electronic transport mechanism for internal and external business customers to exchange files on demand or via scheduled integration with job automation and control services, including transmission validation audit reporting. Real-time services route through either a Layer 7 or StarGate gateway. Our systems are designed to support electronic data interchange (EDI) using batch and real-time services for fast, easy integration with state and federal IT systems and data sources.

Information Technology Service Management Incident and Problem Management

We have a dedicated business support team for our IT operations in Mississippi to assist with triaging issues specific to Medicaid programs and managing escalations to maintain optimal business continuity. Our incident and problem management processes are part of our IT Service Management (ITSM) framework, which is based on IT Infrastructure Library (ITIL). Systems and applications we will implement to support MississippiCAN and CHIP receive continuous monitoring and support to proactively identify and address issues, such as interfaces and batch processes or internal hardware and software system issues. Our operations teams provide 24 hours a day, seven days a week, 365 days a year, on-site level 1 support and monitoring of system consoles and batch cycles to confirm critical system availability and make sure expected service levels are met.

The operations teams are aligned to each functional capability or domain (i.e., enrollment, claims or clinical processes) and each system to monitor the health of the system and processes. UnitedHealth Group employs approximately 20,000 IT personnel enterprise wide who support the applications, quickly resolve issues and make sure the systems are running as expected. Across this vast IT team, we have many individuals with specialized expertise to address certain types of IT challenges — expertise we can readily draw upon when needed to support emerging situations in Mississippi.

Root Cause Analysis for IT Systems Problem Management

To determine the most efficient and effective approach to correcting an IT system problem or failure and avoid future issues, we first identify root cause. Our business support services team uses methods such as Why Analysis and Cause and Effect Diagramming. This team quickly determines the root cause of a problem and corrects it with the support from our vast array of IT resources such as application, incident, operations and other IT teams.

If we identify a failure, we capture and log critical information in an incident record in our ServiceNow application. The analyst assigned the incident ticket will review the information, perform the appropriate analysis and identify individuals with backgrounds who can assist with determining the root cause. Upon discovering the root cause, we determine and apply corrective action. When possible, we track root causes in our incident management system so we can use the information to better understand the source of problems and ultimately prevent incidents from occurring in the future.

Ongoing Approach to Problem Management Regarding Information Systems Functionality

Continuously improving IT to better serve our customers is an ongoing quest. Our ITSM approach aims to simplify customer interactions with IT using processes, tools, metrics and reporting. UnitedHealth Group's ITSM model is based on the ITIL, which incorporates processes and operations, such as:

- **Change Management:** Applies standardized methods and procedures for efficient and prompt handling of all changes to our system, including code release, software and system configuration. The process minimizes the impact of change-related incidents upon service quality and improves the day-to-day operations of the organization.
- **Incident Management:** Process to restore normal service operation as quickly as possible and minimize adverse impact to our customers. We strive to maintain the best possible service quality and availability levels at all times.
- **Problem Management:** Manages the life cycle of problems from identification, through investigation, documentation and resolution. The purpose of problem management is to reduce the adverse impact of incidents that are caused by errors within the production environment and to prevent recurrence of incidents related to those errors.
- **Enterprise Configuration Management:** Process and discipline for planning, tracking and mapping infrastructure relationships by identifying, controlling, verifying, recording and reporting the status of all components and their functions within UnitedHealth Group's IT infrastructure as they relate to services and applications. This information is stored in the Configuration Management Database (CMDB).
- **Data and Reporting Services:** Manages, maintains, analyzes and transforms operational measurements into information distributed in the form of static reporting, web applications and reporting databases.
- **Support Readiness:** Brings together the multiple ITSM functions to ensure maximum supportability of services in the production environment.
- **Request Fulfillment:** To support IT requests, including incident reporting, our Request Center supports all UnitedHealth Group employees, contractors, providers, subcontractors and representatives by providing web-enabled forms for submitting business requests and incidents to the technology team. The Request Center is a module within our ServiceNow ITSM tool. A Request Item (RITM) and Request Task(s) are created based on the request made via the corresponding Request Center request item. All requests are properly logged, triaged, prioritized, assigned and managed to resolution using our other ITSM processes, such as incident and problem management.

In addition to our rigorous process implementation using the ITIL v3 framework, our IT staff associated with ITSM and ITIL processes (i.e., change and release management, incident and problem management, event

management, access management, continual service improvement and others) receive in-depth training, which includes both formal training and mentoring. Our IT staff has access to online courses and materials on our ITIL-related processes/operations and the ServiceNow tool, in addition to training for IT staff wishing to pursue ITIL v3 Foundation Certification.

2. Anticipated problem areas and the approach to management of these areas, including loss of key personnel and loss of other …

All operational areas for our MississippiCAN and CHIP programs have been fully functioning since 2010. While we do not anticipate significant problems as we transition to the next contract, as a standard part of our business continuity and event management programs, we anticipate problem areas and worst-case scenarios across all operations and we have developed policies and procedures, emergency and backup plans and protocols for the MississippiCAN and CHIP programs and anticipated, impending or occurring problems.

During readiness review(s), we will demonstrate to the Division that all areas of our operations — including, but not limited to, our IT systems, administrative services, network management and medical management — are functioning properly and can handle additional volume. We understand the Division's readiness review procedures may consist of desk reviews and on-site inspections of our administrative offices and those of our subcontractors. We will comply and will require all subcontractors to comply with the Division's readiness review requirements, procedures and criteria.

Managing Loss of Key Personnel

Because UnitedHealthcare provides managed care services in 31 states plus the District of Columbia, we have a structured approach and deep bench from which to draw key personnel. If additional staff is required to perform the functions of the Draft Contract, our national colleagues will provide qualified staff. While hiring efforts are underway, UnitedHealthcare's national and regional organizational structures support our local executives and staff and allow them to focus on members, expansion of our operational infrastructure and seamless transition of members.

Our regional and national structures create redundancy for us to withstand loss of key personnel with no impact to business operations. This structure enables us to have qualified and experienced backup staff in place until replacements are named. In some cases, we had the talent in-house and used our succession planning process to enable qualified internal staff to step into key roles. This strategy was successfully used most recently in Mississippi when our vice president of integrated solutions was promoted to chief executive officer. Our regional chief executive officer coordinated the placement of an interim chief executive officer who worked alongside and guided the successor as he transitioned to the chief executive officer role. In our business continuity plan, we name the functional partners who would be part of the succession plan. For example, if our compliance officer is unavailable, then our regional compliance officer will step in. In Mississippi, this succession plan was seamlessly and successfully enacted when our chief executive officer retired. During the replacement search, an interim was named from within UnitedHealthcare until the search was completed.

Driving Innovation and Value

If key personnel supporting our members were to leave UnitedHealthcare, our regional leader responsible for the function will provide oversight, leadership and backup support until the Mississippi position is rehired. We post the position immediately and begin recruiting efforts for Mississippi-based positions (or others outside the state). We post positions on our career website and through sites such as LinkedIn. Current leaders maintain a succession pool of potential employees who possess the ability to meet needs.

Managing Loss of Other Personnel

Administrative Staff Stability
All of the 11 administrative positions found in Appendix A, Draft Contract section 1.13.1.2 are currently staffed.

Similar to our approach to managing loss of key personnel, if there are vacancies among staff supporting MississippiCAN and CHIP, the functional area lead will provide oversight, leadership and coordinate backup support until the position is filled. To mitigate the impact of the loss of other personnel, we cross train our staff so we can quickly pivot to using existing staff's skills, knowledge and capabilities. Functional leads work with hiring managers to post openings on our internal hiring site and externally as appropriate for the situation at hand. To mitigate any disruption to the quality service experience our members and providers have come to expect, we cross-train staff, particularly member and provider facing staff, which enables remaining staff to deliver quality service in a seamless manner.

Additional Potential Risks and Mitigation Strategies

The organized, thorough and collaborative approach to program implementation we use has proved effective in mitigating and avoiding risks. Our implementation and IT leads will work with the Division to verify risks are appropriately identified, managed and have an agreed upon risk mitigation strategy.

Our IT systems change management risk mitigation strategy supporting the Division's MississippiCAN and CHIP are described in the table herein using examples of common potential risks we experience during implementations.

Potential Risk	Risk Mitigation and Problem Management Strategy
Timing of the First 834-Enrollment File	It is critical to load the initial 834 enrollment file correctly and confirm enrollment information flows to the appropriate systems correctly so members receive their ID cards and welcome packets on time. To overcome the risk of glitches with this initial 834-enrollment file, we build in additional time to upload this first file compared to subsequent files. Receiving the first 834 file at least 30 days before the go-live date is preferable and enables us to perform downstream outreach activities in a timely manner. Receiving ID cards in advance of their effective date will be especially important for members, particularly for individuals in the midst of receiving services, needing prescriptions filled and those who have scheduled appointments. Sending and loading the file earlier will enable us to produce and distribute ID cards in batches and to manage the related influx of calls that ensue during changeover times. Our implementation and IT leads will work with the Division to develop the file timing for this program.
New IT Systems Implemented	When state agencies change, update or introduce new programs that require system connectivity and data sharing, we must confirm the systems interface flawlessly and correctly before the changes are implemented. We mitigate this risk through proactive and frequent communications with the state agency's IT systems support staff or vendor, produce and distribute system documentation, emphasize system integration testing and the coordination of the data exchange processes. Our implementation and IT leads will work with the Division to ensure a seamless transition to any new system the Division implements.
Mismatch of Provider Data due to Multiple Sources of Record	State agencies often maintain their own provider data, which they collect and enumerate by certain categories or with multiple data elements using home-grown or industry-recognized codes or taxonomy (e.g., NPI, specialty, type, rural, urban). If state's provider data must align with ours, the potential risk is that our systems will not recognize or match the providers appropriately, thus compromising provider data integrity. To maintain our provider data integrity, we obtain provider data through our internal processes such as credentialing and updates from providers. We maintain the Division provider file separately and use it with other business applications, such as claims processing.
Data File Transmission	At times, we receive data from external entities that we cannot open, read or use as intended. To mitigate this risk, we clearly understand and document the expected data exchange and frequency, we perform system integration testing with the external entity submitting data before the go-live date and employ balance, control and alerting in our systems when the data exchange occurs. In this way,

Potential Risk	Risk Mitigation and Problem Management Strategy
	we can identify, alert and correct the issue or apply a workaround solution to use the data as intended.
Implementation Schedule Changes (i.e., go-live or contract execution date)	Implementation delays can be costly for both health plans and state agencies. We mitigate this risk by acknowledging and understanding the need for the change, communicating and jointly modifying plans and putting new plans into action. Due to our national presence and size, we are able to scale and reassign resources if needed to meet and exceed tight implementation schedule changes.

Risk mitigation starts with making sure everyone on our implementation and IT team serving the state understands the Division's expectations, goals and contract requirements. For Mississippi, our teams have studied these items and did not find substantial concerns at this stage. As the teams carry out the implementation and readiness activities, they deploy a series of project management exercises, including systems testing during the readiness review cycle, to address and resolve any identified issues relating to systems installment and functionality.

3. Approach to problem identification and resolution.

Through our comprehensive operational approach, during implementation we assess and manage risks based on our experience and understanding of MississippiCAN and CHIP and the Division's requirements. Guided by our implementation project manager and chief operating officer, the implementation and business alignment (IBA) team quickly assesses problem situations and coordinates the development, execution and monitoring of action plans to mitigate risks.

As we transition to the new contract and as part of preparing for the Division's readiness reviews, our IBA team will conduct internal reviews to identify potential risks and issues. Our project manager will report to health plan leadership regularly on the status of action items and communicate directly with the functional owner until the action item is resolved.

Following the cutover date, our project manager and chief operating officer will continue to collaborate with the IBA team as needed and will monitor and support health plan staff to proactively identify risks and mitigate potential problems. For example, they will review dashboards and trend reports for top member call topics, grievances and appeals topics, provider complaints and early warnings generated by our claims processing system. If they identify risks or problems specific to an operational area, they will require the functional leader to assess the issue and report the concern to health plan leadership and the appropriate oversight committee. Through collaboration during internal meetings with health plan leaders and oversight committee meetings, the accountable functional leader develops an action plan to mitigate the risk or resolve the problem and presents it to health plan leadership for review and approval.

[END OF RESPONSE]

4.3.4.3 Backup Personnel Plan (Marked)

If additional staff is required to perform the functions of the Contract, the Offeror should outline specifically its plans and resources ...

Achieving Operational Excellence

To accommodate changes during the life of the contract, we will deploy well-established backup personnel plans to adapt and adjust staffing. Because UnitedHealthcare is one of the nation's largest companies with over 60,000 employees, we have a highly skilled talent pool — in Mississippi and contiguous states — to call on. Our colleagues can provide additional staff to perform the functions described in Appendix A, Draft Contract if and when needed. Therefore, our Mississippi leadership team will be fully prepared to deliver a fully integrated service experience to MississippiCAN and CHIP members and providers from day one.

Due to our long-standing presence in Mississippi, we have built and maintained collaborative relationships with the Division and other stakeholders that help keep us informed of upcoming changes pointing to additional staffing or resources we will need to seamlessly adapt to the change. If enrollment or utilization spikes or if the provider network composition changes significantly over the course of the contract, we will use centralized managed care functions, assuring efficiency, performance excellence and seamless adaptation to the situation.

In recent years, the pandemic and inclement weather have tested the strength of our ability to quickly adapt staff and resources in response to major shifts in how people receive health care services and how providers deliver care to their patients. As described below, we demonstrate how our backup plans were successful in Mississippi and in all states where UnitedHealthcare operates, and how they will continue to be successful when needed in the next cycle.

Plans and Resources for Adapting to Additional Staffing Needs

Backup and contingency staffing plans guide our key operations managers through day-to-day, impending and ongoing staffing needs. Adapting and adjusting staffing levels and workload responsibilities occurs daily across all key functional areas. Using health care industry staffing tools such as Workforce Management Projection Model (WMPM) software, managers project the number of personnel required by functional area to support membership and workload fluctuations.

In this response, we will focus on and describe how we manage these processes in the areas most important to members and providers: care coordination, member services call center, claims and provider services.

Approach to Additional Staff for Care Coordination Services

As part of our approach to population health management, we have staffing ratio guidelines for functional areas serving members (i.e., member outreach, care coordination) developed over time and across many populations. Daily, our care coordination managers use several tools and resources (described throughout our response) to identify members' current and changing care coordination needs. Using this information, managers adjust staff caseloads and care coordination assignments accordingly. If we need additional staff to deliver care coordination services, we receive backup support from our nearest regional and national care coordination partners. For example, our colleagues serving Medicaid members in Texas, Florida or Tennessee can step in to assist us and our team will do the same for their team, should they need assistance.

Our health services director and behavioral health director work together to oversee our integrated clinical teams and make sure care coordination services align with our population health and health equity goals. Our care coordination staffing approach includes clinical and nonclinical staff such as care coordinators, service navigators, interdisciplinary treatment teams, utilization management, a population health director and population health management staff. Each care coordination role will meet the minimum licensure requirements, as defined by the Division and bring the attitude and aptitude necessary to serve the members in their care.

Our care teams receive ongoing training in a broad range of topics to assure the most effective care coordination experience. Examples of training topics include motivational interviewing, trauma-informed care, cultural competency, person-centered care and condition-specific training (e.g., diabetes, asthma, mental illness, addiction and recovery). Our goal is to develop a team with multiple competencies to enhance their subject matter expertise or specialized education.

Interdisciplinary Treatment Team

Our dynamic Interdisciplinary Treatment Team (ITT) mitigates system fragmentation, activates the right level of support for the right goal and makes sure all components of the member's social-environmental ecosystem are operating in tandem to support the member. We have established the foundation and core functions of our ITT to provide a full offering of care coordination services for all benefits, including behavioral health, medical and dental services. Our ITT includes community providers, our care coordination team and subject matter experts, including pharmacy, SDOH and housing navigator, peers, health equity director, clinical practice consultants, and recovery and resiliency manager.

Our ITT offers a multipronged clinical approach for a range of care management and disease management solutions to meet the MississippiCAN and CHIP population's whole health needs. This approach facilitates adherence to and compliance with regulations, delivers on contractual commitments and optimizes staff resources. Our care coordination team will be regionally located in Mississippi to enable a thorough understanding of the local health care dynamics, community organizations and in-community face-to-face interventions.

Our population health management program is designed to assist individuals with chronic or complex conditions to manage their needs effectively and to address their social, physical, behavioral health, cognitive and functional needs. Our health service director will collaborate with our population health management teams to create bidirectional communication between the ITT and clinical leaders to make sure all levels of our staff are empowered to support members and providers alike.

Approach to Additional Resources and Staff for Claims Services

To meet performance standards, our claims management teams use rigorous processes and controls to actively monitor claims inventory and adjust processes and staff accordingly. Based on a designed hierarchy, team leads assign experienced staff to work directly with providers and internal staff to address complex claims requiring manual intervention. We hold daily cross-functional meetings to mitigate processing barriers and focus on claims at risk of missing the defined timely payment requirements. We have days-on-hand goals for staffing ratio requirements to identify and adjust as claim volumes shift.

Advancing Population Health Outcomes

With claims services, our strong systems for managing and processing claims (described in the ensuing paragraphs) has reduced the need for personnel to manually rework claims.

We maintain top claims management performance through UnitedHealthcare's advanced claims management platform, Community Strategic Platform (CSP). Our leading-edge IT systems, highly trained claims processing staff and well-managed claims management operations enable us to meet or exceed the Division's stringent standards for payment promptness and accuracy. These systems and staff exemplify the expertise we have gained from 35 years of Medicaid experience in successfully processing claims and paying providers.

In addition to CSP, we use other methods to adjust staffing and resources to maintain claims management performance excellence. Ongoing, we conduct internal audits at every stage of the claims management cycle (pre, concurrent, post) using System-Generated and Smart Audit Master System (SAM) edit reviews. During the claims processing review, claims are subjected to several systematic edits to identify unanticipated billing patterns or potential questionable billing practices. Once claims processing is complete, we use the SAM system

to randomly sample the processed claims. Claim auditors access the selected claims within SAM and review the claims to determine processing accuracy.

Approach to Additional Staff for Call Center Operations

For operations such as our call centers, we use workforce management tools such as WMPM to adjust daily staffing levels. This process enables our call centers to consistently meet or exceed the Division's call center performance metrics. Our National Operations Center (NOC) monitors weather, natural disasters and incidents across the United States. If the NOC identifies a threat to local member, provider or employee safety or operational capacity, they will communicate and coordinate with our Mississippi call center managers to proactively manage call routing and backup staffing to maintain services, performance excellence and business continuity. Using call forecasting technology, we shift overflow calls quickly and seamlessly to alternate locations when needed, facilitating top performance and uninterrupted call center service.

Approach to Additional Resources and Staff for Provider Services

We use provider call center data to simplify and improve the service experience for providers. For example, we implemented a triage process to address turnaround time and repeat callers, flagging and forwarding them directly to the appeals and grievances department. To improve provider satisfaction, address provider claims disputes, handle encounter data reporting issues and to meet or exceed the Division's performance requirements, in addition to CSP and subsystems, we use our Escalation Tracking System (ETS) for grievance system tracking, trending and provider follow-up. Our operations managers use these and other resources daily to adjust staffing and workloads to meet demands and maintain performance excellence.

Call Center Performance Excellence
Year after year, our member services call center performance exceeds the Division's requirements. Our 2021 outcomes include:

- Abandonment rate must be 4% or less — our average was 0.04%
- Average speed to answer must be 40 seconds or less — our average was under 10 seconds
- Hold time must be under two minutes — our average was about 1.5 minutes

Plan to Ensure Longevity of Staff for Effective Division Support

Retaining personnel with minimal turnover is critical to the successful management of any organization. To promote longevity among our staff, we hire experienced and qualified personnel. In Mississippi, we maintain a stable workforce and promote retention by attracting, employing and developing talented individuals who understand and respond to the people we serve and who honor the Division's priorities.

Components of our personnel management practices resulting in staffing stability and promoting longevity include, but are not limited to:

- **Succession Planning:** As part of our talent management process, we update succession plans for all key positions annually, reviewing progress on the development of the identified successor quarterly and validating the effectiveness and relevance of the succession plans.
- **Recruiting Locally:** We focus on local and diverse staff recruitment efforts for member services call center, clinical professionals and care management staff. We commit to continuing to recruit locally based talent with direct experience supporting our members in an effort to build trust in the local health care system that addresses individual member needs and empowers our members to advocate for the culturally responsive care they need. Our local and regional talent acquisition teams post the position and begin recruiting, focusing on candidates living in the state. Our recruitment teams are specialized by functional area to make sure we use the right hiring resources according to the talent needed to find the most qualified candidates.

- **Deploying National and Regional Resources:** Due to our Medicaid and CHIP operations across the country, our regional and national teams can provide qualified and experienced interim staff while hiring and training efforts are underway or if temporary backup support is needed. Our national and regional organizational structures collaborate around unique state business requirements, enabling our local team to focus on expanding our operational infrastructure and seamless transition of members.
- **Supplying Additional Staff and Resources:** Deploying additional staff and resources depends upon the operational area, level of need and deployment time frames. For example, if the need is due to anticipated increase in new members or service area expansion, to make sure we have adequate call center and member outreach staff, we:
  - Conduct rigorous workforce planning and forecasting activities volumes based on needs
  - Staff for and fill any Division-specific requirements outside of typical staffing ratios
  - Work with our recruitment services team to fill positions in a timely manner
- **Adjusting Staffing and Resources to Support Targeted Initiatives:** The successful outcome of our targeted initiatives is influenced by the staffing and resources we dedicate to the mission. The methods we use to adjust staffing to support targeted initiatives align to the nature of the initiative, goals and resources needed to implement, manage, monitor and evaluate the initiative's beneficial impact.
- **Adjusting Staffing and Resources to Maintain Top Performance:** We staff for and fill any Division-specific requirements outside of typical staffing ratios. We work with our recruitment services team to fill positions in a timely manner. We hold employees accountable for their performance to make sure we deliver the best possible services to members and providers.

Maintaining top performance is always the goal, with our primary focus on access and service quality for our members, providers and the Division. All employees and key operations are equipped with the technical tools, IT resources and equipment they need to do the job.

The shared objective of the health plan leadership team is to motivate and support staff and to create a positive employee experience by focusing on employee communication, engagement and empowerment. This is facilitated through channels such as social events and employee newsletters.

In addition to our efforts to create a positive employee experience, we maintain a stable workforce through fair hiring practices, a welcoming onboarding experience, intentional focus on soliciting and acting on staff feedback, career development opportunities and pay practices tied to quality performance. We promote a safe and inclusive environment, committed to affirmative action in our employment practices, and we will comply with the Division's nondiscrimination prohibitions, which align with our organization's practices.

Leadership Development

Our leaders demonstrate they can build and focus teams, deliver maximum value to MississippiCAN and CHIP members, drive disciplined and fact-based decisions, execute with discipline and urgency, drive change and innovation and model and demand integrity and compliance. New leaders within our organization receive orientation and training specific to meeting member needs. Key personnel receive additional support for a successful start and a solid foundation from which to lead. A dedicated team of respected leaders in our organization are accountable for onboarding new leaders with special emphasis on orientation within the first few months of joining our organization. The new leaders' hiring manager and employee workforce manager are responsible for helping the leader gain an understanding of the organization and provide insight into how leaders contribute to business goals. Our leaders work to promote organizational effectiveness by providing managers and employees with the right tools, structure, rewards, processes and systems.

Staff Development and Training Resources

UnitedHealthcare provides initial, ongoing, ad hoc and annual training tailored to the program to all employees, with an emphasis on cultural competency. We:

- Have well-established employee training policies and well-developed infrastructure supporting training delivery and management tracking
- Adapt our processes to the unique components of MississippiCAN and CHIP
- Train new and existing staff using multiple methods such as classroom instruction, web-based tutorials, role-playing, shadowing and on-the-job training to meet different learning styles and time constraints
- Continue enhancing our numerous on-the-job tools to assist employees while they are in the field, such as standardized checklists and screening and assessment tools

LearnSource is the companywide, web-based learning management system for our employees. LearnSource focuses on professional development, cultural competency, company policies, state and federal regulations and compliance. This web-based tool allows employees to register for training, take training on their own time and track required and completed training. Supervisors can track registration and course completion using automated tools and reports.

For our clinical teams, we have OptumHealth Education, which is a learning and training resource we use for providing opportunities for continuing education and training for our licensed clinical staff. OptumHealth Education offers free continuing medical education credits and continuing education units for courses on evidence-based practices covering a variety of topics, such as trauma-informed care and treatment approaches for pediatric populations.

Dedicated to a Healthier Mississippi

Career Development Opportunities

Development opportunities are encouraged for all personnel in order to support professional and personal growth and a positive work environment. All team members have a development plan in place, including specific learning action items they are encouraged to develop throughout the year.

[END OF RESPONSE]

4.3.4.4 Emergency Preparedness Plan (Marked)

The Offeror should discuss its services and staffing continuity plans should an emergency, including but not limited to a natural ...

As a health and well-being company with business operations across the United States, we have a well-established business continuity process to address key business interruption risks stemming from the deployment and use of our people, processes, technology and financial assets in carrying out day-to-day business operations. The strategy focuses on our critical business functions and planning for worst-case scenarios, which can include all forms of disasters (e.g., hurricane, flood, fire, terrorism and public health emergencies such as pandemics). We follow state declarations of emergency and extend or relax processes as warranted to support and protect members, providers and the communities we serve before, during and after emergency events.

UnitedHealth Group's Enterprise Resiliency & Response (ER&R) program, which we describe throughout this section, prevents and mitigates events that could disrupt our business and the care delivered to our MississippiCAN and CHIP members by quickly mobilizing national and local leadership teams necessary to manage the response and confirm appropriate resources are available to support business and staffing continuity. Business continuity planning is the basis from which business processes and operations resume, including service to customers and our event management team (EMT) structure brings the components of our ER&R program together for a consistent response.

The pandemic had a profound impact on global workforces and economies. Due to UnitedHealth Group's extensive telecommute capabilities already supporting a substantial proportion of full-time telecommuters before the pandemic, we were able to quickly shift nonclinical office workers to work-from-home connectivity. For example, in January 2020 — when it was becoming clear COVID-19 was developing into a pandemic — 90% of our nonclinical workforce was transitioned to a work-from-home status within days. This quick response has enabled UnitedHealthcare to maintain all service levels and business continuity throughout the pandemic. With all employees having remote capability, we are well-positioned to effectively handle future emergencies.

Emergency Response in Mississippi

In Mississippi, weather-related disasters, including hurricanes, are threats. Our emergency preparedness approach has been tested repeatedly and has successfully maintained business continuity, most recently with Hurricane Ida in 2021. Our EMT team activated our event management plan and coordinated safety strategies to protect members, providers, employees and business continuity. Our EMT team monitored weather conditions, state emergency declarations and maintained communication with all parties managing the event, including the Division — most of which took place over the weekend. As Hurricane Ida threatened to make landfall and under the governor's emergency declaration, we activated event management protocol for members. For example, we:

- Allowed early refills of medications for members living in the impacted counties
- Contacted vulnerable members in the impacted counties to assess their needs and make sure they had medications, durable medical equipment and evacuation plans

While the hurricane did not affect our business continuity, proactively activating our emergency response protocol mitigated after-storm delays in accessing or receiving services for our members and providers.

Emergency Preparedness Plan – Overview

The Division's use of the term "Emergency Preparedness Plan" is synonymous with our business continuity and disaster recovery (BC/DR) plans. Our parent, UnitedHealth Group, is the lead controlling entity of all aspects of our BC/DR plans because UnitedHealth Group relies on an array of interconnected systems to meet the needs of

customers and members dispersed across the nation. UnitedHealth Group protects its business operations against cybersecurity and other threats to business continuity and data security within the U.S. and globally. UnitedHealth Group's BC/DR and emergency management standards are reviewed regularly to align with industry best practices, including NFPA 1600, ASIS Security standard and ISO 22301 and BS 65000.

Early in the pandemic, UnitedHealth Group played a national leadership role in many ways, such as distributing CARES Act funding to care providers on behalf of the U.S. Government and helping to support development and distribution of a vaccine in collaboration with the World Health Organization. In Mississippi and across the United States, to confirm continuity of operations, we maintain policies and procedures based on the following:

- Disaster Recovery Strategies and Objectives
- Scenario-Based Planning for Disaster Recovery
- Employee Training on Preparedness, Natural Disaster and Recovery
- Critical Business Functions and Key Employees
- Continuity Plans that Cover Critical Essential Business Functions
- Communication with Staff and Suppliers when Normal Systems are Unavailable
- Member and Provider Call Center Operations

Preparedness is key to disaster recovery planning and protecting organizational resources possibly rendered unusable if a disaster or enemy attack occurs.

Critical Business Functions and Key Employees

The EMT team provides a consistent and reliable approach for communication and engagement between all parties involved in managing major events. Local subject matter experts manage business recovery actions within their functional teams. They work with the EMT team to quickly engage, communicate and make decisions between teams. The EMT team:

- Consists of national and health plan leaders responsible for event communication and response
- Engages required executive leadership necessary to respond to the event
- Executes decisions made by executive leadership
- Provides central coordination of communications, resources, personnel, issues and other information through the notification and response phases of event management
- Determines the strategy for effectively managing an event to a resolution
- Facilitates critical decisions for remediation and coordinates with internal and external stakeholders

For MississippiCAN and CHIP, the local business continuity team leads includes:

- **Executive Sponsor:** Our chief executive officer is accountable for verifying the recovery strategy and associated tasks align with the operational recovery time objective. Responsible for making and authorizing critical decisions for determining how to effectively manage a disaster.
- **Business Continuity Lead:** Our chief operating officer is accountable for development, maintenance, testing and execution of the recovery strategies defined in this plan. Responsible for content management, including maintenance and support of the business continuity plan (BCP).
- **Customer Communications Lead:** Our compliance officer is responsible for developing communications for critical customers regarding the impact and remediation efforts for the affected business functions. Coordinates and assists in the execution of the customer communications plan.

- **Subcontractor Communications Lead:** Our delegated services manager is responsible for developing communications for critical vendors regarding the impact and remediation efforts for the affected business functions. Coordinates and assists in the dissemination of vendor communications.

As a national company, we have geographically dispersed staff supporting and supplementing the work at compromised localities. We may deploy a variety of business continuity strategies depending upon the critical business function ranking and established recovery time objectives. UnitedHealthcare's transactional capabilities, including call centers and claim payment centers, can be rerouted so essential services are maintained in locations least affected by the disaster.

Responding to the Pandemic for Mississippians

To date in Mississippi, we have spent nearly $50,000 to purchase health and hygiene supplies and masks, which we continue to supply to federally qualified health centers (FQHCs) and local organizations. Other ways we have helped Mississippians during the pandemic include:

- **Thermometers for early detection:** In early April 2020, UnitedHealthcare provided forehead thermometers to the initiative to be distributed to community members.
- **Blankets for homeless shelters:** Five hundred blankets were split among three homeless organizations: Stewpot, Jackson Reach and MUTEH. We are in conversations with these organizations regarding our Healthcare+Homeless housing initiative.
- **Face masks:** To address the need for protective face coverings for the community, 15,000 reusable masks were donated to the Community Health Center Association of Mississippi for delivery to their participating FQHCs.
- **Home Wellness Kits (Jackson COVID-19 Outreach Initiative):** Kits include information on the CDC and FDA, along with QR codes for educational videos made by medical students on precautionary measures. Kits include personal hygiene and self-care items. We provided self-care items for 250 families.
- **Supplies for Salvation Army and Our Daily Bread:** Secured cases of paper towels, toilet tissue and bleach for the Salvation Army and Our Daily Bread kitchen to help them help others.
- **Diaper and Wipe Pantry:** We donated over 820 cases of diapers and baby bibs to help stock the pantry.
- **Sanitizer:** We sourced sanitizer from a local business, Cathead Distillery, to provide to small business owners across the state as they prepared to reopen. We had 500 hand sanitizers delivered to Family Health Center, Inc. and Coastal Family Healthcare FQHCs.
- **Springboard to Opportunities (STO):** This organization had to close their offices during the pandemic. In response to the needs of people STO had been serving, we supplied maternity care items, cleaning supplies, disinfectants, paper towels, tissues and antibacterial wipes.

Throughout the pandemic, our approach has been to build trust, empower health care personnel and engage communities and individuals. To help members overcome fears about getting the vaccine, answer their questions about the vaccine and where they can get vaccinated, we coordinated messaging campaigns with federal, state and local agencies and partners. We shared clear, complete and accurate messages through newsletters and our public websites. We empowered the health care community by making sure medical practices were equipped to create a culture of confidence in COVID-19 vaccination. We engaged in communities and with individuals by working with health departments and our national partners to engage communities around vaccine confidence and service delivery strategies, including adaptation of vaccination provider sites to meet community needs. We collaborate with trusted messengers — such as faith-based organizations and community leaders in Mississippi — to tailor and share culturally relevant messages and materials with diverse communities across Mississippi.

Approach to Preventing and Protecting Technology and Operational System Failures

Our Enterprise Disaster Recovery (EDR) program is built upon two essentials: prevention and protection. Balancing prevention and protection reduces the probability and impact of a disaster. Our approach is to first eliminate or reduce disaster risk in critical areas, then plan for the most probable disaster scenarios.

Investing in an effective combination of people, processes and technology has created a stable, scalable environment for our applications to perform at operational excellence. This investment supports the preventive aspect of our EDR program to proactively remedy known technology exposures and safeguard against accidents. While avoiding a technology disaster is impossible, our EDR program is structured to anticipate and plan for common types of disasters and activate solutions to address them. Disaster protection addresses recovery from most probable to worst-case scenarios. By identifying critical business processes and transitioning these critical applications, data and supporting infrastructure to an alternate recovery location in a timely manner, we reduce the impact of a technology event to our critical operations.

In the table, we highlight the most common disaster recovery protection components activated to facilitate BC/DR regardless of the disaster type.

Recovery Solution	Description of Prevention and Protection Method
"Lights Out" Mode	Data centers can operate in a lights-out mode for up to three days. If the data center continues to get fuel to run the generators, they run in this mode indefinitely.
Operational Backups	Designed to use high performance disk-to-disk primary copy with physical off-site second copy to virtual tape libraries.
Active-Active/Active-Standby Solutions	Our disaster recovery solutions employ Active-Active and/or Active-Standby components located in two geographically separate data centers where either site can fully support the production application if a disaster occurs with minimal manual intervention.
Native Database Replication	Native database replication technologies can be used depending on the related database technology in either an Active-Standby or Active-Active methodology.
Mainframe Data Replication	Mainframe storage area network (SAN) replication recovery uses full asynchronous data replication between the production mainframe and a geographically dispersed hot standby disaster recovery mainframe.
Storage Replication	Distributed SAN replication recovery uses full asynchronous data replication of production storage pools for distributed systems (UNIX and Wintel) and failover of production processing to geographically dispersed nonproduction systems for processing. Other storage replication technologies are used in specialized areas such as with VMware Site Recovery Manager (SRM) or IBM iSeries replication.
Failover and Restoration	Some distributed systems employ a cold recovery solution with failover of production to geographically separate nonproduction systems using data restoration from virtual tape.
Disaster Recovery Plan	Each application identified as critical within national BCPs has a disaster recovery plan refreshed and tested annually.
Key Risk Indicators	Key risk indicators (KRIs) are metrics used to derive the "health" of our EDR program.

Scenario-Based Planning for Disaster Resiliency and Recovery

In our disaster recovery plan, we address risks identified through scenario-based planning of threat and business interruptions. UnitedHealth Group's strategy focuses on preventing a disaster from disabling systems. Scenario-specific risk management includes these disaster scenarios and the corresponding ER&R plan:

- **Scenario:** Central computer installation and resident software are destroyed or damaged | **ER&R Plan:** Planning for the common types of disasters and designing solutions to address them is the foundation of our EDR program. Disaster protection addresses recovery from most probable disaster scenarios and worst-case scenarios.

- **Scenario:** System interruption or failure due to network, operating hardware, software, communications infrastructure or operational errors that:
  - *compromises transaction integrity* active in live system at the time of outage | **ER&R Plan:** To minimize impact of threats identified, UnitedHealth Group has implemented redundancies in its network, hardware and software implementation.
  - *compromises data integrity* active in live system at time of the outage | **ER&R Plan:** Per policy, we maintain two copies of operational backups at secured technology centers. We maintain a backup copy at the primary data center for daily operational recovery purposes in case of data corruption or accidental deletion. A second copy of the backup is then electronically transmitted to another location in our geographically dispersed data center(s).
  - *does not compromise transaction or data integrity* maintained in a live or archival system *but prevents access to the system* (e.g., causes unscheduled system unavailability) | **ER&R Plan:** Our data centers and technology are self-managed and UnitedHealth Group IT has instituted a formal ITIL-based service delivery model.
- **Scenario:** Projected recovery times and data loss for mission-critical systems | **ER&R Plan:** Critical business functions generally provide for near immediate failover of core services via reroutes to geographically dispersed redundant operations and maintain recovery time objectives identified in the Emergency Management Plan.

Business Continuity Plans for Critical Business Functions

Our business continuity plans (BCPs) are part of UnitedHealth Group's overall program designed and structured to respond to disaster events, restore critical business function processes, resume normal business function operations in a prioritized manner and to mitigate impact to our customers. Our plans address all types of disasters and are used in conjunction with our event management and disaster recovery process. We achieve recovery from anything less than complete interruption by implementing appropriate portions of the plan.

The BCP includes a variety of strategies to effectively respond to the inability to use critical resources, which, if lost, would impede service continuity for members or providers, as described in the following table:

BCP Elements	Loss Description
Loss of Facility	Complete interruption of facilities without access to its equipment, local data and content. The interruption may affect a single site or multiple sites in a geographic region.
Loss of Critical People	Complete interruption with 100% loss of personnel within the first 24 hours and 50% loss of personnel long term. The interruption may affect a single site or multiple sites in a geographic area.
Loss of Technology	Complete interruption and access of critical systems and data located at the various UnitedHealth Group data centers for an extended period of time.
Loss of Vendor	Complete interruption in a service or supply provided by a third-party vendor.

If a Mississippi office is at risk, inaccessible or disabled, we first move affected staff to other Mississippi offices where they have access to all systems or can access our systems securely from home. If alternate Mississippi offices is not a viable solution, we route operations and have staff work from home or a safe remote site.

Employee Training on Emergency Preparedness, Natural Disaster and Recovery

All recovery team members are educated on the BCP. Senior managers receive training annually. In turn, they educate other established staff members, providing updated instruction and appropriate preparedness training. Refresher training is required annually.

[END OF RESPONSE]