SFY25 EMERGENCY CONTRACTUAL AGREEMENT
BETWEEN
THE DIVISION OF MEDICAID
IN THE OFFICE OF THE GOVERNOR
AND
MOLINA HEALTHCARE OF MISSISSIPPI, INC.
A COORDINATED CARE ORGANIZATION (CCO)

(Mississippi Coordinated Access Network (MSCAN) Program)

THIS EMERGENCY CONTRACTUAL AGREEMENT (hereinafter "Emergency Contract" or "Agreement")**,** made and entered into by and between the **DIVISION OF MEDICAID IN THE OFFICE OF THE GOVERNOR,** an administrative agency of the **STATE OF MISSISSIPPI,** hereinafter referred to as "DOM," and **MOLINA HEALTHCARE OF MISSISSIPPI, INC.,** a corporation qualified to do business in Mississippi, hereinafter referred to as "Contractor," and collectively hereinafter referred to as "Parties," for the provision of prepaid comprehensive health care services as defined in 42 C.F.R. § 438.2 for the benefit of certain Medicaid beneficiaries.

WHEREAS, DOM is charged with the administration of the Mississippi State Plan for Medical Assistance in accordance with the requirements of Title XIX of the Social Security Act of 1935, as amended, (the "Act") and Miss. Code Ann. § 43-13-101 et seq. (1972, as amended);

WHEREAS, Contractor is an entity eligible to enter into a full risk capitated contract in accordance with Section 1903(m) of the Social Security Act and 42 C.F.R. § 438.6(b) and is engaged in the business of providing prepaid comprehensive health care services as defined in 42 C.F.R. § 438.2. The Contractor is licensed appropriately as defined by the Department of Insurance of the State of Mississippi pursuant to Miss. Code Ann. § 83-41-305 (1972, as amended);

WHEREAS, DOM entered into a full risk capitated contract (herein referenced as "Base MSCAN Contract") with Contractor on July 1, 2017 for Contractor to provide prepaid comprehensive health care services pursuant to state and federal requirements;

WHEREAS, the original term of the Base MSCAN Contract began on July 1, 2017 and ended on June 30, 2023 with no further options for renewal;

WHEREAS, on December 10, 2021, DOM issued a Request for Qualifications No. 20211210 (RFQ) from qualified offerors to provide services for the statewide administration of DOM's Coordinated Care Organization Program consisting of the Mississippi Coordinated Access Network (MSCAN) and the Mississippi Children's Health Insurance Program (CHIP) for services to begin July 1, 2023;

WHEREAS, DOM received five (5) responses to the RFQ and, on August 10, 2022, issued its Notice of Intent to Award to three (3) offerors;

WHEREAS, on August 17, 2022, DOM received protests of the Notice of Intent to Award from two (2) offerors not selected for award. Since that date, DOM, PPRB, and the five (5) RFQ offerors have been and are still currently involved in these protests which have prevented PPRB from approving and DOM from executing the RFQ awarded contracts;

WHEREAS, Any Contracts executed pursuant to the RFQ will contain an inital implementation period of up to 18 months for each vendor to implement the following program components to include, but not be limited to: information technology, administrative services, Provider Network management, and medical management. At the conclusion of this implementation, each vendor must undergo a Readiness Review with CMS, Medicaid's federal oversight agency, and be approved by CMS before that vendor may delivery any managed care services. All services and activities during implementation and Readiness Review are performed at no cots to DOM;

WHEREAS, The vendors awarded contracts under the RFQ cannot deliver actual Medicaid services during the 18-month implementation period until each vendor's Readiness Review has been approved by CMS, DOM is required to enter into Emergency Contracts with the existing managed care vendors to deliver managed care services until such time as the awarded vendors can deliver services. ; and,

WHEREAS, through its written determination to the Mississippi Public Procurement Review Board (PPRB) Office of Personal Service Contract Review (OPSCR), DOM identified the continuing need for MSCAN Program Services to Medicaid beneficiaries on an emergency basis with the aforementioned Contractor pursuant to Sections 3-207 and 7-111 of PPRB OPSCR Rules and Regulations;

WHEREAS, DOM has determined that it is in the best interest of the State to enter into an Emergency Contract with Contractor to continue provision of Managed Care services as required herein for SFY25 and Contractor has agreed to render said services to DOM in accordance with this Agreement.

NOW THEREFORE, in consideration of the mutual covenants contained herein and subject to the terms and conditions hereinafter stated, it is hereby understood and agreed by the Parties hereto as follows:

I. ENTIRE AGREEMENT AND INCORPORATION: This Emergency Contractual Agreement for SFY25 (Emergency Contract) between DOM and Contractor shall consist of: (1) this Emergency Contract, inclusive of any amendments hereto; (2) the SFY24 MSCAN Emergency Contract, inclusive of any amendments thereto; and (3) the Base MSCAN Contract. The Parties hereby agree that the SFY24 MSCAN Emergency. The Parties hereby agree that the SFY24 MSCAN Emergency Contract (inclusive of any amendments

thereto) and the Base MSCAN Contract (inclusive of any amendments thereto) shall be collectively referred to herein as the "Previous Contract." The Parties agree to be bound by all terms and conditions of the Previous Contract which are incorporated herein by reference as Attachment A, unless those terms are specifically modified or overridden through this Emergency Contract.

Any ambiguities, conflicts, disputes, or questions of interpretation of this Emergency Contract shall be resolved pursuant to the following order of priority:

(1) This Emergency Contract; and
(2) The Previous Contract.

II. PERIOD OF PERFORMANCE: The term of this Emergency Agreement shall commence on July 1, 2024 and shall expire on June 30, 2025, unless this Agreement is terminated pursuant to the termination related provisions of this Contract.

III. SCOPE OF WORK: Contractor shall continue to provide prepaid comprehensive health care services pursuant to this Emergency Contract for SFY25in accordance with the Previous Contract and any modified provisions to the Previous Contract as follows:

1. Section 1.L., GENERAL PROVISIONS, Data Exchange Requirements is hereby amended to read as follows:

L. <u>Data Exchange Requirements</u>

The Contractor must be able to receive, maintain, and utilize data extracts from the Division and/or its Agents. These data extract files will be used for obtaining necessary information to properly identify members, reimburse providers for services rendered, and/or to reconcile records accordingly. The Contractor must systematically update its database within five (5) calendar days of receipt of the files and shall ensure that its Subcontractors update within five (5) calendar days of receipt of the files, unless otherwise directed by the Division to update more frequently.

Data extract files include but are not limited to the following:

1. Daily Active Provider Extract;
2. Weekly Provider Affiliation Details Extract;
3. 834 Enrollment Files;
4. 835 Claims Payment Remittance Advice Transaction;

5. 277 Claims Acknowledgement;
6. Third Party Liability (TPL) Resource/Policy Information File, etc.;
7. Claims History Extracts;
8. Prior Authorization Extracts;
9. Denials Report;
10. Any files related to pharmacy and/or drug benefits and/or services as directed by and in a timeframe determined by the Division; and
11. Beneficiary Health Management Program (BHMP) to include but not be limited to: beneficiary, prescriber, and pharmacy lock-in information as requested by the Division's Office of Program Integrity.

The Contractor shall utilize the most current version of the Division's Universal Preferred Drug List (PDL). The Division or its designee will continue to send to Contractor a weekly Formulary Drug file. The Contractor will have access to the Division's up-to-date PDL through the Division's website.

The Division may impose liquidated damages under Section 16, Default and Termination, of the Previous Contract for non-compliance with these requirements.

All other language not modified as stated herein for Section 1.L shall remain unchanged and in full force and effect.

2. Section 2.A., DEFINITIONS, Definitions is hereby amended to replace definition Numbers 78, 79, and 82 with the following, and to add the below additional definitions for "Pharmacy Benefit Administrator (PBA)" and "Beneficiary Health Management Program (BHMP)":

78. **Pharmacy Benefit Manager (PBM)**: A business that administers the prescription drug portion of covered services on behalf of the Contractor in accordance with Miss. Code Ann. § 73-21-179.
79. **Physician-Administered Drugs and Implantable Drug System Devices (PADs)**: These products are typically billed on medical claims and are included in the definition of Covered Outpatient Drugs within Section 1927 of the Social Security Act.
82. **Universal Preferred Drug List (PDL)**: A medication list recommended to the Division of Medicaid by the Pharmacy & Therapeutics Committee and approved by the Executive Director of the Division of Medicaid for use in the Fee-for-Service delivery system and

MISSISSIPPI DIVISION OF MEDICAID

the MississippiCAN Program. A medication becomes a preferred drug based first on safety and efficacy, then on cost-effectiveness. Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug. The Contractor is required to follow the guidance provided in the PDL.

119. **Pharmacy Benefits Administrator (PBA):** A business that administers prior authorization, claims management, and pharmacy provider management for prescription drug services on behalf of the Division.
120. **Beneficiary Health Management Program (BHMP):** the program implemented by the Division to: (1) closely monitor program usage and to identify beneficiaries who may be potentially over utilizing or misusing their Medicaid services and benefits; (2) restrict beneficiaries whose utilization of medical and/or pharmacy services is documented at a frequency or amount that is not medically necessary; and (3) prevent beneficiaries from obtaining non-medically necessary quantities of prescribed drugs through multiple visits to physicians and pharmacies.

All other language not modified as stated herein for Section 2.A shall remain unchanged and in full force and effect.

3. Section 2.B., DEFINITIONS, Acronyms is hereby amended to add the following acronyms:

60. BHMP – Beneficiary Health Management Program
61. BIN/PCN – Bank Identification Number/Processor Control Number. A BIN/PCN may also be recognized within the industry as "IIN" – Issuer Identification Number.

All other language not modified as stated herein for Section 2.B shall remain unchanged and in full force and effect.

4. Section 5.A., COVERED SERVICES AND BENEFITS, Covered Services is hereby amended to read as follows:

A. <u>Covered Services</u>

The Contractor shall provide all Medically Necessary covered services allowed under the MississippiCAN Program. The contractor shall ensure that all covered services are sufficient in the amount, duration, and scope to reasonably achieve its purpose as set forth in 42 C.F.R. § 440.230 and that no incentive is provided, monetary or otherwise, to Providers for withholding Medically Necessary coved services from a Member. The Contractor shall make available accessible facilities, service locations, and personnel sufficient to provide covered services consistent with the requirements specified in this Contract.

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

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

The Division will annually review the cost and utilization of high-cost medications to determine whether such medications should be excluded from the capitation rate or included in the Pharmacy High-Cost Drug Risk Corridor. Any high-cost medications designated as covered benefits that are excluded from the capitation rate and not covered by Division's PBA based on the Division's annual review, may be reimbursed outside of the monthly capitation payment or reimbursed through the High-Cost Drug Risk Corridor reconciliation.

MISSISSIPPI DIVISION OF MEDICAID

All other language not modified as stated herein for Section 5.A shall remain unchanged and in full force and effect.

5. Section 5.F., COVERED SERVICES AND BENEFITS, Prescription Drugs, Physician-Administered Drugs, and Implantable System Devices is hereby redesignated and amended to read as follows:

F. <u>Prescribed Drugs, Physician-Administered Drugs and Implantable Drug System Devices</u>

1. Requirements Prior to Effective Date of Live Operations of Division PBA

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

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

   The Contractor shall establish/maintain a unique Banking Identification Number/Processor Control Number (BIN/PCN) number for the processing of pharmacy claims for the purpose of separating the Contractor's third-party private pharmacy provider claims and CHIP claims from MississippiCAN Medicaid claims. A unique network reimbursement ID must also be established and maintained for MississippiCAN Medicaid claims. The remittance advice statements must adhere to industry standards and be in a user-friendly format defined and approved by the Division.

   The Contractor is restricted from requiring Members to utilize a pharmacy that ships, mails, or delivers prescription drugs or devices. However, the Contractor may implement a mail- order pharmacy program in accordance with State and Federal law. The Contractor shall not reject claims for any drug billed by a Mississippi Medicaid pharmacy Provider for the purpose of redirecting the prescription to the Contractor's mail order pharmacy and/or contracted specialty pharmacy.

   The Contractor shall provide PADs to Members enrolled in the MississippiCAN program pursuant to the requirements of Mississippi Administrative Code, Title 23, Part 203.

   The Contractor must use the most current version of the MS DOM Universal Preferred Drug List (PDL), which is subject to periodic changes. The Contractor must use the Medicaid PDL developed by the Division or its Agent and may not develop and use its own PDL. The Contractor will be

provided opportunities to offer feedback on the PDL to the Division. A pharmacy representative from the plan shall attend the P&T committee meetings as a guest and will be offered the opportunity to contribute in an evaluative and educational capacity in post P&T committee meetings. The Executive Director of the Division has final authority on drugs with preferred and non-preferred status on the PDL. The Contractor shall follow the same PA criteria of that of FFS for drugs requiring PA on the PDL. The Contractor shall not promote any preferred drugs over other preferred drugs.

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

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

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

The Contractor is not authorized to negotiate rebates for preferred products. The Division or its Agent will negotiate rebate agreements. If the Contractor or its Subcontractor has an existing rebate agreement with a

MISSISSIPPI DIVISION OF MEDICAID

manufacturer, all Medicaid outpatient drug claims, including Provider-administered drugs, must be exempt from such rebate agreements.

Covered outpatient drugs dispensed to Members eligible for medical assistance who are enrolled with the Contractor shall be subject to the same rebate requirements as the Division is subject under Section 1927 of the Act and the Division shall collect such rebates from manufacturers.

The Contractor and its Subcontractor or delegated vendors must follow the Division's current reimbursement methodology to reimburse pharmacy providers for pharmacy point of sale claims. The Contractor must include a written description of assurances, procedures, and policies under the proposed PBM Subcontract such as an independent audit to ensure no conflicts of interest exist and ensure the confidentiality of proprietary information. The Contractor must provide a plan documenting how it will monitor these Subcontractors. The assurances, procedures, and policies must be submitted for the Division's review and approval thirty (30) calendar days prior to initiating any PBM Subcontract.

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

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

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

MISSISSIPPI DIVISION OF MEDICAID

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

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

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

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

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

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

MISSISSIPPI DIVISION OF MEDICAID

The Contractor must have a drug utilization review (DUR) program to conduct prospective and retrospective utilization review of prescriptions. The DUR program must comply with 42 C.F.R. § 438. The Contractor must submit an annual report to the Division that provides a detailed description of its DUR program activities both prospective and retrospective reviews.

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

Please refer to Mississippi Administrative Code, Title 23, Part 203. The Contractor shall report information specified by the Division to enable the collection of rebates by the Division, as described in Section 11, Reporting Requirements, of this Contract.

The Contractor shall provide the Division, and other designated staff as specified by the Division, electronic access and viewing rights of the contracted Pharmacy Benefits Manager's real-time pharmacy point-of-sale claims processing system as well as testing rights in the PBM's pharmacy point-of-sale test environment.

The Division, including the Division's Office of Program Integrity, must be informed of all Pharmacy-related audits, whether desk audits or onsite. The Contractor must complete all audits of a Provider clean claim within a timeframe consistent with state law. If the audit indicates that the Contractor is due a refund from the Provider, the Contractor must send the Provider written notice of the basis and specific reasons for the request. The Contractor must give the Provider an opportunity to appeal.

2. Requirements Beginning on the Effective Date of Live Operations of Division PBA and continuing thereafter

   Beginning on the effective date of live operations of the Division PBA and continuing thereafter, the Division will use a single PBA for the administration of pharmacy claims benefits for MississippiCAN Members.

   The Division PBA will be responsible for claims management and payment, prior authorization, and pharmacy provider management for all Members.

The Contractor is required to cooperate with the Division PBA fully in all aspects of pharmacy administration. The Division PBA will share all Member claims with the Contractor for the purposes of Care Management and pharmacy claim payment amount(s) processed. The Division will provide the Contractor with additional information and requirements regarding its obligation to cooperate with the PBA throughout the life of this Contract.

Any PAD that is billed on an outpatient medical claim, instead of pharmacy claim, will still be the responsibility of the Contractor. The Contractor will not implement any strategy or policy that will intend to shift medication coverage of these drugs to the pharmacy benefit. The Division will provide forty-five (45) calendar days advance written notice to the Contractor prior to removing pharmacy coverage for any physician administered drugs that may be also covered on the pharmacy benefit, to allow the Contractor time to provide impacted members advance notice to ensure continuity of care.

Contractor shall maintain its PBM to perform claims processing/encounter submissions for pharmacy and PADs claims submitted with dates of service prior to the effective date of live operations of the Division PBA. Contractor is required to maintain its PBM for a period of time to allow all timely filing and timely processing periods to expire with regard to such claims. The Contractor shall maintain the same unique BIN/PCN number in effect prior to July 1, 2024 for the processing of pharmacy claims for the purpose of separating the Contractor's third-party private pharmacy provider claims from MississippiCAN Medicaid claims. Contractor must also maintain the same unique network reimbursement ID for MississippiCAN Medicaid claims.

The Contractor shall process claims for PADs to Members enrolled in the MississippiCAN Program as defined in the Mississippi Administrative Code, Title 23, Part 203. These claims shall be submitted on CMS 1500 and UB-40 claim types.

The Contractor must use the most current version of the MS DOM Universal PDL, which is subject to periodic changes. The Contractor must use the Medicaid PDL developed by the Division or its Agent and may not develop

and use its own PDL. The Contractor will be provided opportunities to offer feedback on the PDL to the Division. A pharmacy representative from Contractor shall attend the P&T committee meetings as a guest and will be offered the opportunity to contribute in an evaluative and educational capacity in post P&T committee meetings. The Executive Director of the Division has final authority on drugs with preferred and non-preferred status on the PDL. The Contractor shall follow the same PA criteria of that of FFS for drugs requiring PA, regardless of PDL status. The Contractor shall not promote any preferred drugs over other preferred drugs.

The Contractor must refer to the Pharmacy Services page on the Division's website for a current listing of prescription drugs on the PDL to ensure continuity of care for Members. Pursuant to 42 C.F.R. § 438.10(i), Contractor, upon request by a Member or the Division PBA on behalf of a Member, must provide access to Members in paper and electronic form the following Preferred Drug List information: which medications are covered (generic and name brand), and the information must be made available on the MCOs website. The Contractor must make available a link to the Universal PDL on their website.

The Contractor may require Prior Authorization in accordance with Section 5.J of this Contract for drugs outside the PDL.

The Contractor shall ensure that prescribed drugs, and PADs are dispensed and/or administered in accordance with medically accepted indications and dosing limits supported by one (1) or more of the official compendia as designated by the Centers for Medicare and Medicaid Services (CMS). No payment may be made for services, procedures, devices, supplies or drugs which are still in clinical trials and/or investigative or experimental, cosmetic, or unproven in nature.

The Contractor is not authorized to negotiate rebates for preferred products.

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

MISSISSIPPI DIVISION OF MEDICAID

The Contractor shall continue to report drug utilization data that is necessary for the Division to bill manufacturers for rebates for PADs in accordance with section 1927(b)(1)(A) of the Act no later than thirty (30) calendar days after the end of each quarterly rebate period of the Division. Such utilization information must include, at a minimum, information on the total number of units of each dosage form, strength, the billing provider's NPI number and package size by National Drug Code of each covered outpatient drug dispensed or covered by the Contractor. Contractor must enforce the Division's billing requirements for 340B claim submissions billed by registered 340B covered entities.

The Contractor shall operate a retrospective drug utilization review (DUR) program that complies with the requirements described in Section 1927(g) of the Social Security Act and 42 C.F.R. Part 456, Subpart K. The Contractor shall maintain drug utilization review provisions as outlined in Section 1004 of the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act.

The Division shall oversee one common drug utilization review board for MississippiCAN and FFS beneficiaries. The Division requires the Contractor's pharmacy account managers to attend all drug utilization review board meetings and to participate with the Division in implementing drug utilization review board initiatives for MississippiCAN members.

MISSISSIPPI DIVISION OF MEDICAID

The Contractor must complete and submit an annual Abbreviated CMS DUR report to the Division as directed by the Division. As detailed in the Abbreviated CMS DUR report, the Contractor shall perform a minimum of the following activities related to DUR in coordination with the Division and/or PBA, to include, but not be limited to:

(1) Monitor opioid prescriptions (duplicate therapy, early refills, quantity limits, etc.).
(2) Automated retrospective claim reviews process to monitor opioid prescriptions exceeding State defined limitations.
(3) Monitor opioids and benzodiazepines being used concurrently.
(4) Monitor opioids and sedatives being used concurrently.

(5) Monitor opioids and antipsychotics being used concurrently.
(6) Maintain safety edits or perform automated retrospective claims reviews and/or provider education regarding beneficiaries with a diagnosis or history of opioid use disorder (OUD) or opioid poisoning diagnosis.
(7) Monitor MME total daily dose of opioid prescriptions dispensed.
(8) Monitor and manage appropriate use of naloxone to persons at risk of overdose.
(9) Manage or monitor the appropriate use of antipsychotic drugs in children.
(10) Manage or monitor the appropriate use of stimulant drugs in children.
(11) Manage or monitor the appropriate use of other psychotropic medication (antidepressants, mood stabilizers, antianxiety/sedative) in children.

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

Please refer to Mississippi Administrative Code, Title 23, Part 203. The Contractor shall report information specified by the Division to enable the collection of rebates by the Division, as described in Section 11, Reporting Requirements, of this Contract.

The Division, including the Division's Office of Program Integrity, must be informed of all Pharmacy-related audits for claims processed by the Contractor, whether desk audits or onsite. The Contractor must complete all audits of a Provider clean claim processed by the Contractor within a timeframe consistent with state law. For claims processed by the Contractor, if the audit indicates that the Contractor is due a refund from the Provider, the Contractor must send the Provider written notice of the basis and specific reasons for the request. The Contractor must give the Provider an opportunity to appeal.

All other language not modified as stated herein for Section 5.F shall remain unchanged and in full force and effect.

6. Section 5.J.4., COVERED SERVICES AND BENEFITS, Prior Authorizations is hereby amended to read as follows:

4. Pharmacy Claims

a. Requirements Prior to Effective Date of Live Operations of Division PBA

For claims processed by the Contractor prior to effective date of live operations of Division PBA, the Contractor must establish policies and procedures to comply with the Division's Prior Authorization criteria in accordance with the PDL guidance for the drugs listed on the PDL.

Drugs with manual prior authorization criteria are developed and maintained by the Division and can be found on the Division's website. When changes occur to these criteria, the Division will notify the Contractor. Updated criteria must be implemented upon receipt. Drugs with electronic prior authorization criteria (Smart PA) are addressed in Section 1.L. Data Exchange Requirements, of this Contract. The Contractor may approve non-preferred drugs when one of the following Prior Authorization criteria is satisfied:

i. Member experiences an adverse event(s) or reaction(s) to preferred medications; or
ii. Contraindications to preferred medications (i.e. drug interaction, existing medical condition preventing the use of preferred medications).
iii. The Contractor must establish criteria and coverage policies for drugs not listed on the PDL, which must be approved by the Division. The Contractor must ensure that decisions regarding policies and procedures for prescription drugs are made in a clinically sound manner.

The Division allows pharmacy providers thirty (30) calendar days to submit a request for reconsideration after receipt of a Prior Authorization denial. The Contractor and its Subcontractor or delegated vendors shall adhere to this time frame.

b. Requirements Beginning on the Effective Date of Live Operations of Division PBA and continuing thereafter

MISSISSIPPI DIVISION OF MEDICAID

Beginning on the effective date of live operations of the Division PBA and continuing thereafter, the Division PBA will handle and administer all Pharmacy Prior Authorizations.

The Contractor shall be responsible for Pharmacy appeals/grievances received, for Pharmacy services rendered and Pharmacy services and authorizations denied prior to the effective date of live operations of Division PBA.

All other language not modified as stated herein for Section 5.J.4 shall remain unchanged and in full force and effect.

7. Section 6.A., MEMBER SERVICES, Member Services Call Center, first paragraph is hereby amended as follows:

A. <u>Member Services Call Center</u>

The Contractor must maintain and staff a toll-free dedicated Member services call center to respond to Members' inquiries, issues, or referrals. Members will be provided with one (1) toll free number, and the Contractor's automated system and call center staff will route calls as required to meet Members' needs. Beginning on the effective date of live operations of Division's PBA and continuing thereafter, the Contractor's Member call center automated system shall provide a menu option including the phone number for the Division PBA call center, along with a statement that any pharmacy-related Member inquiries not related to PADs should be directed to the Division's PBA call center.

All other language not modified as stated herein for Section 6.A shall remain unchanged and in full force and effect.

8. Section 6.A.(4), MEMBER SERVICES, Member Services Call Center – Staff Training, is hereby amended as follows:

4. Staff Training

The Contractor's Member Services Call Center staff must receive trainings at least quarterly. Trainings must include education about Medicaid, the MississippiCAN Program, appropriate instances for transferring a Member to a Care Manager,

redirecting pharmacy-related calls to the Division PBA call center, and customer service. Contractor shall provide training to its Member Services Call center staff on the process for re-directing pharmacy-related Member calls not related to PADs to the Division's PBA call center. Staff must receive updates about continued Medicaid changes and requirements, including "Late Breaking News" articles, Provider Bulletins, State Plan Amendments, Administrative Code Filings, the Division's Provider Reference Guide and MississippiCAN Program updates. The Contractor will submit quarterly reports detailing the trainings conducted, topics covered, and the number and positions of staff completing the trainings.

All other language not modified as stated herein for Section 6.A shall remain unchanged and in full force and effect.

9. Section 6.C., MEMBER SERVICES, Member Identification Card is hereby amended to add the below language as an additional paragraph to the existing Section 6.C. language as follows:

C. <u>Member Identification Card</u>

The Contractor shall provide each Member notice of an identification card change effective upon live operations of Division PBA to change the pharmacy BIN/PCN. This change, which will be effective upon live operations of the Division's PBA, will change the pharmacy BIN/PCN from the Contractor's value to the BIN/PCN of the Division PBA. This notification should be sent to Members thirty (30) days prior to the Division PBA go-live date. The Contractor shall submit a plan to the Division for a replacement of existing Member ID Cards along with the normal monthly new member cards. The Contractor must submit and receive approval of the revised identification card from the Division fifteen (15) calendar days prior to production of the cards.

All other language not modified as stated herein for Section 6.C shall remain unchanged and in full force and effect.

10. Section 6.D., MEMBER SERVICES, Member Handbook is hereby amended to add the below language as an additional paragraph to the existing Section 6.D. language as follows:

MISSISSIPPI DIVISION OF MEDICAID

D. Member Handbook

The Contractor shall work with the Division to identify and revise specific documentation for Member Handbook and Provider Manuals related to go-live of Division PBA.

All other language not modified as stated herein for Section 6.D shall remain unchanged and in full force and effect.

11. Section 6.E., MEMBER SERVICES, Provider Directory is hereby amended to add the below language as an additional paragraph to the existing Section 6.E. language as follows:

E. Provider Directory

Effective upon live operations of the Division's PBA, the Contractor shall remove retail pharmacies from the Contractor's hard copy and web-based Provider Directories.

All other language not modified as stated herein for Section 6.E shall remain unchanged and in full force and effect.

12. Section 6.F., MEMBER SERVICES, Communication Standards is hereby amended to add the below language as an additional paragraph to the existing Section 6.F. language as follows:

F. Communication Standards

The Contractor shall coordinate with the Division to develop both content and distribution schedules for any Contractor member communications relative to live operations of the Division's PBA.

All other language not modified as stated herein for Section 6.F shall remain unchanged and in full force and effect.

13. Section 7.A., PROVIDER NETWORK, General Requirements is hereby amended to read as follows:

A. General Requirements

1. Requirements Prior to Live Operations of the Division's PBA

MISSISSIPPI DIVISION OF MEDICAID

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

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

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

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

2. Requirements Beginning on the Effective Date of Live Operations of Division PBA and continuing thereafter

   The Contractor and its Subcontractor or delegated vendors shall recruit and maintain a Provider Network, using Provider contracts as approved by the Division. The Contractor must comply with federal regulations regarding

Provider Network adequacy as stated in 42 C.F.R. §§ 438.68, 438.206, 438.207; and must comply with state regulations regarding reconsideration of inclusion per Miss. Code Ann. § 83-41-409 (e).

The Contractor is solely responsible for providing a network of physicians, specialty pharmacies for the dispensing and billing of PADs, facilities, and other health care Providers, excluding retail pharmacies, through whom it will provide the items and services included in covered services.

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

In establishing its Provider Network, the Contractor shall contract with FQHCs and RHCs. The Contractor must contract with as many FQHCs and RHCs as necessary to permit Member access to participating FQHCs and RHCs without having to travel a significantly greater distance than the location of a non-participating FQHC or RHC. If the Contractor cannot satisfy this standard for FQHC and RHC access at any time, the Contractor must allow its Medicaid Members to seek care from non-contracting FQHCs and RHCs and must reimburse these Providers at Medicaid fees.

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

All other language not modified as stated herein for Section 7.A shall remain unchanged and in full force and effect.

14. Section 7.H.(1), PROVIDER NETWORK, Provider Services – Provider Services Call Center is hereby amended to add the below language as an additional paragraph to the existing Section 7.H.(1) language as follows:

MISSISSIPPI DIVISION OF MEDICAID

1. Provider Services Call Center

   Beginning on the effective date of live operations of the Division's PBA and continuing thereafter, the Contractor's Provider call center automated system shall provide a menu option including the phone number for the Division PBA call center, along with a statement that any pharmacy-related Provider inquiries not related to PADs should be directed to Division PBA.

All other language not modified as stated herein for Section 7.H.(1) shall remain unchanged and in full force and effect.

15. Section 7.H.(3), PROVIDER NETWORK, Provider Services – Provider Education and Training is hereby amended to add the below language as an additional paragraph to the existing Section 7.H.(3) language as follows:

3. Provider Education and Training

   Prior to July 1, 2024, Contractor shall provide training to its Provider services call center staff on the process for re-directing pharmacy-related Provider calls not related to PADs to the Division PBA.

All other language not modified as stated herein for Section 7.H.(1) shall remain unchanged and in full force and effect.

16. Section 10.V., QUALITY MANAGEMENT – Quality Withhold Measurements and Targets, is hereby amended to add the following for SFY25:

V. Quality Withhold Measurements and Targets:

[SFY25 Incentive/Withhold Targets Chart continued on next page]

MISSISSIPPI DIVISION OF MEDICAID

CCO MSCAN SFY 2025 Incentive/Withhold Targets		
Quality Measure	**Sub Measure**	**Target**
**** Well Child Visits - First 30 Months of Life (W30)**	***children 15 months of age with 6+ visits***	58.34%
	children 30 months of age with 2+ visits	NA
Immunizations for Adolescents (IMA)	***Combination 2***	22.52%
Anti-Depressant Management	***Effective Acute Phase Treatment***	55.59%
Follow up After Hospitalization for Mental Illness	***30 Days - Ages 6 to 17***	71.36%
Timeliness of Prenatal Care		94.92%
Comprehensive Diabetes Care - CDC (SPD)	***Hemoglobin A1c Control for Patients with Diabetes (<8%)***	50.12%
Comprehensive Diabetes Care - CDC (SPD)	***Blood Pressure Control for Patients with Diabetes***	60.83%
Comprehensive Diabetes Care - CDC (SPD)	***Eye Exams for Patients with Diabetes***	51.09%
Adults & Children: Asthma ages 5-64	***(AMR) Total***	72.89%

Adults: Pharmacotherapy Management of COPD Exacerbation (PCE)	***Systemic Corticosteroid***	53.84%
Reduction in C-Section Rate		2 percentage point improvement over CY 2021 Individual CCO Rate
QIPP PPHR A/E Ratio		2% improvement over Baseline Years of CY 2020 and 2021 (If a/e ratio >1.0)

All other language not modified as stated herein for Section 10.V. shall remain unchanged and in full force and effect.

17. Section 10, QUALITY MANAGEMENT, is hereby amended to add the following new sub-section:

W. Value-Based Payment Program (VBP)

The Mississippi Division of Medicaid Value-Based Payment Program (MSDOM VBP) consists of measures and payment amounts, as determined and defined by DOM, that promote quality in the delivery of services. In exchange for incentives created through the MSDOM VBP, CCOs, hospitals, and providers must collaborate with one another, utilizing care management and other available tools to ensure that targets set by DOM are met. Targets will be measured using metrics defined by DOM and will be set on a State Fiscal Year basis. Failure to meet a target will result in no incentive being paid for that target. There will be no partial incentive payments awarded.

Monetary incentives will be split among CCOs, hospitals, and other providers as applicable and in proportions as set by DOM. At DOM's discretion, additional incentives for CCOs may include priority in CCO autoenrollment, with higher

performing CCOs having the potential to be assigned auto-enrolled members at a higher percentage rate.

DOM will promulgate a MSDOM VBP Work Plan on a State Fiscal Year basis, which is incorporated via reference to this contract. The Work Plan will include metrics, requirements, and any other information relevant to CCOs and providers for the implementation and operationalization of the MSDOM VBP. The Contractor will be required to comply with the final Work Plan promulgated by the Division, as well as produce and disseminate reports as outlined within that Work Plan. The Work Plan will comply with all applicable provisions of state law and 42 C.F.R. §438.6(c). DOM has the right to alter the MSDOM VPB Program and Work Plan at any time, at its discretion. CCOs will have sixty (60) calendar days' notice prior to the required implementation date of any ad hoc changes made by DOM. Changes made on the State Fiscal Year calendar are to be expected by the CCO.

18. Section 11.F., REPORTING REQUIREMENTS - Pharmacy Lock-In Program is hereby deleted in its entirety, re-designated as "Beneficiary Health Management Program (BHMP)", and replaced with the following:

F. <u>Beneficiary Health Management Program (BHMP)</u>

The Contractor shall administer and monitor a beneficiary health management program (BHMP) in which beneficiaries who may over utilize medical and/or pharmacy benefits will be assigned to a prescriber or a pharmacy, or both, in accordance with 42 CFR § 431.54. The Contractor's program shall follow the same policies, procedures, and criteria as set by the DOM Office of Program Integrity for establishing the need for lock-in or restriction of medical and/or pharmacy benefits. The continued need for lock-in for any Member shall be re-evaluated by the Contractor at the end of the lock-in period .

In utilizing a BHMP, the following policies must be observed:

1. Members must be notified and given the opportunity for a hearing (in accordance with procedures established by the Division) before imposing restrictions;

2. The Contractor ensures that the member has reasonable access (taking into account geographic location and reasonable travel time) to services of adequate quality;
3. The restrictions do not apply to emergency services furnished to the member. For pharmacy, a seventy-two (72)-hour emergency supply of medication at pharmacies other than the designated lock-in pharmacy shall be permitted to assure the provision of the necessary medication required in an interim/urgent basis when the assigned pharmacy does not immediately have the medication;
4. Members must be permitted to choose or change providers for good cause. Good cause is defined as:

    a. death, retirement, or closing of the specified provider,
    b. change in geographical location of the beneficiary or provider,
    c. Provider discontinues participation in the Medicaid Program, or
    d. Provider is terminated from participation in the Medicaid Program.

5. Care management and education reinforcement of appropriate medication/provider use shall be provided to Members. A Plan for an education program for members shall be developed and submitted for review and approval by the Division's Office of Program Integrity.
6. RESERVED.
7. When finalizing member BMHP decisions, the Contractor shall take into consideration the member's prior BMHP experiences with the Medicaid-Fee-For- Service Program and those of other Medicaid-participating CCOs, utilizing BMHP data made available by the Division. The contractor may be required to BMHP members at the request of DOM.
8. The Contractor will provide Medium to High Risk Care Management services to all lock-in members, specifically members with substance use disorders, as outlined in Section 7, PROVIDER NETWORK of the Contract.

In administering a BHMP, Contractor shall utilize the criteria found in Administrative Code Title 23 Medicaid Part 305, Program Integrity, Chapter 2, Beneficiary Health Management.

The Contractor shall submit a monthly report providing information on the BMHP in a manner or format established by the Division.

Prior to live operations of the Division's PBA, the Contractor will be required to provide a file of active pharmacy lock-in data.

All other language not modified as stated herein for Section 11 shall remain unchanged and in full force and effect.

19. Section 11.S.1 and 11.S.3., REPORTING REQUIREMENTS, Member Encounter Data – Data Format & Member Encounter Data Provision, Submissions, and Processing Requirements is hereby amended to read as follows with all other sub sections within this section unchanged:

S. <u>Member Encounter Data</u>

1. Data Format

For claims processed by the Contractor, the Contractor must provide Member Encounter Data in the format required by the Division to support comprehensive financial reporting and utilization analysis necessary for capitation rate development, program oversight, and reporting requirements. The Contractor must submit Member Encounter Data to the Division's Agent using established protocols. The Contractor shall be able to receive, maintain and utilize data extracts from the Division and its contractors, e.g., pharmacy data from the Division or its PBM.

The Contractor must comply with state and federal requirements, including the Division's Encounter Companion Guide for Professional, Institutional, Dental, and Pharmacy encounter claims guide posted on the Division's managed care website. The Division may change the Member Encounter Data Transaction requirements in the system companion guide. The Contractor shall be given a minimum of sixty (60) calendar days' written notice of any new edits or changes that the Division intends to implement regarding Member Encounter Data. The Contractor shall, upon notice from the Division, communicate these same changes to Subcontractors.

The Contractor shall provide Member Encounter Data files electronically to the Division. The Contractor's system shall conform to the following HIPAA-compliant standards for information exchange. Batch transaction types include, but are not limited to the following:

MISSISSIPPI DIVISION OF MEDICAID

a. ASC X12N 837P Professional Claim/Encounter Transaction;
b. ASC X12N 837I Institutional Claim/Encounter Transaction:
c. ASC X12N 837D Dental Claim/Encounter Transaction;
d. ASC X12N 834 Benefit Enrollment and Maintenance;
e. ASC X12N 835 Claims Payment Remittance Advice Transaction;
f. ASC X12N 277 Claims Status Response; and
g. NCPDP Version D.0 Pharmacy.

3. Member Encounter Data Provision, Submissions, and Processing Requirements

A. Requirements Prior to the Effective Date of Live Operations of Division'sPBA

The Contractor shall submit Member Encounter Data that meets established Division data quality standards. These standards are defined by the Division to ensure receipt of complete and accurate data for program administration and will be closely monitored and strictly enforced. The Division will revise and amend these standards as necessary to ensure continuous quality improvement. The Contractor shall make changes or corrections to any systems, processes or data transmission formats as needed to comply with the Division's data quality standards as originally defined or subsequently amended. The Contractor shall comply with industry-accepted Clean Claim standards for all Member Encounter Data, including submission of complete and accurate data for all fields required on standard billing forms, or electronic claim formats to support proper adjudication of a claim. The Contractor shall be required to submit all data relevant to the adjudication and payment of claims in sufficient detail in order to support comprehensive financial reporting and utilization analysis.

The level of detail in the Member Encounter Data provided by the Contractor to the Division shall be equivalent to the level of detail associated with that Member Encounter Data when it is submitted to and adjudicated by Contractor for claims payment. The Contractor must collect and maintain sufficient Member Encounter Data to identify the provider who delivers any item(s) or service(s) to Members. The Provider's National Provider Identifier (NPI) shall be used when submitting required

MISSISSIPPI DIVISION OF MEDICAID

Member Encounter Data. Member Encounter Data elements must include all of the data the Division is required to report to CMS under 42 C.F.R. § 438.818 including but not limited to:

a. Accurate enrollee and provider identifying information;
b. Date of service;
c. Procedure and diagnosis codes;
d. Allowed amount and Paid amount;
e. Third party liability amounts;
f. Claim received date;
g. Claim adjudication date; and
h. Claim payment dates.

The Member Encounter Data files shall contain settled claims and claim adjustments processed during that payment cycle, as well as encounters processed during that payment cycle from providers with whom the Contractor has a capitation arrangement. These settled claims and claims adjustments include, but are not limited to: (a) adjustments necessitated by administrative payments or recoupments, (b) program integrity recoupments, (c) lump sum payments, and (d) payment errors. Submissions shall be comprised of encounter records or adjustments to previously submitted records, which the Contractor has received and processed from provider encounter or claim records of all contracted services rendered to the Member in the current or preceding months.

For pharmacy encounter claims, the Contractor shall submit complete and accurate Member Encounter Data processed by the Contractor's Subcontractor within fifteen (15) calendar days following the date of adjudication.

Within two (2) business days of the end of a payment cycle the Contractor shall generate Member Encounter Data files for that payment cycle from its claims management system(s) and/or other sources. If the Contractor has more than one (1) payment cycle within the same calendar week, the Member Encounter Data files may be merged and submitted within two (2) business days of the end of the last payment cycle during the calendar week. In no event, may Member Encounter Data be submitted by the

MISSISSIPPI DIVISION OF MEDICAID

Contractor or Subcontracts more than thirty (30) calendar days after the date of adjudication.

The Contractor shall submit Member Encounter Data according to HIPAA X12 transaction standards and formats as defined by the Division, including those referenced in the companion Guide(s), complying with standard code sets and maintaining integrity with all reference data sources including provider and member data. All Member Encounter Data submissions will be subjected to systematic data quality edits and audits on submission to verify not only the data content but also the accuracy of claims processing. Any batch submission which contains fatal errors that prevent processing or that does not satisfy defined threshold error rates defined in Section 16.E of this Contract will be rejected and returned to the Contractor for immediate correction. When the Division or its Agent rejects a file of encounter claims, the rejected files must be resubmitted with all of the required data elements in the correct format by the Contractor within thirty (30) calendar days from the date the Agent rejected the file. The Division may impose liquidated damages or other available remedies under Section 16, Default and Termination, of this Contract for non-compliance with these requirements.

The Contractor shall be able to receive, maintain, and utilize data extracts and data files from the Division and its Contractors. Based on the data extracts and data files received from the Division, the Contractor shall correct and resubmit rejected Encounter Records as an adjustment within the time frame referenced above.

MISSISSIPPI DIVISION OF MEDICAID

The Division provides a listing of encounter claim edits to the Contractor, which includes a comprehensive listing of edits such as X12, FFS, and other agency edits, to ensure quality encounter data. Corrections and resubmissions must pass all edits before they are accepted for processing in electronic form in the MMIS system by the Division's Agent. Only accepted encounters are used for evaluation of rate development, risk adjustment, and quality assurance.

Member Encounter Records that deny due to the Division's Agent's edits are returned to the Contractor and the Contractor must make the requested corrections, if possible.

The Contractor must make an adjustment to encounter claims when the Contractor discovers the data is incorrect, no longer valid, or some element of the claim not identified as part of the original claim needs to be changed. If the Division or its Agent discovers errors or a conflict with a previously adjudicated encounter claim the Contractor shall be required to adjust or void the encounter claim within thirty (30) calendar days of notification by the Division. The Division may impose liquidated damages or other available remedies under Section 16, Default and Termination, of this Contract for non-compliance with these requirements.

Encounter records shall be submitted such that payment for discrete services which may have been submitted in a single claim can be ascertained in accordance with the Contractor's applicable reimbursement methodology for that service.

An encounter claim rejection occurs before the claim is processed in the MMIS system and most often results from incorrect data. The Contractor shall correct and resubmit rejected Encounter Records within the time frame referenced above. Corrections and resubmissions must pass all edits before they are accepted for processing in electronic form in the MMIS system by the Division's Agent.

The Contractor shall ensure that the payment information on the Subcontractors' Member Encounter Data reflect the date and the amount paid to the provider by the Subcontractor. The Claim Received Date shall reflect the Subcontractor received the claim from the Provider. This Claim Received Date shall not reflect the date that the Contractor received the encounter claim from the Subcontractor.

Failure of Subcontractors to submit Member Encounter Data timely shall not excuse the Contractor of noncompliance with this requirement, and the Division may impose liquidated damages or other available remedies under Section 16, Default and Termination, of this Contract for non-compliance.

B. Requirements Beginning on the Effective Date of Live Operations of Division PBA and continuing thereafter

The Contractor shall continue to receive, process, pay, and submit all non-pharmacy Member Encounter Data as defined in 3.A. Requirements Prior to the Effective Date of Live Operations of Division's PBA.

The Contractor shall continue to receive, process, and pay pharmacy claims and adjustments for any dates of service prior to Division PBA go-live. These settled claims and claims adjustments include, but are not limited to: (a) adjustments necessitated by administrative payments or recoupments, (b) program integrity recoupments, (c) lump sum payments, and (d) payment errors. Submissions with dates of service prior to Division PBA go-live shall be comprised of encounter records or adjustments to previously submitted records, which the Contractor has received and processed from provider encounter or claim records of all contracted services rendered to the Member in the current or preceding months.

The Contractor shall receive Member Pharmacy Claim Data from the Division PBA that meets established Division data quality standards. The Contractor shall make changes or corrections to any systems, processes or data transmission formats received or submitted as needed to comply with the Division's data quality standards as originally defined or subsequently amended.

The Contractor will receive Member Pharmacy Claim Data and Prior Authorization Data daily as incrementally received. The Contractor must utilize Member Pharmacy Claim Data and Prior Authorization Data in all aspects of Care Management for all Members.

The Division PBA shall provide a summary of the daily Member Pharmacy Claim Data files to the Contractor weekly following the PBA payment cycle, which will contain the financial data for the settled claims and claim adjustments processed during that payment cycle. The Division PBA shall provide a summary of the daily Prior Authorization Data to the Contractor weekly.

For adjustments of pharmacy encounters processed by Contractor's PBM prior to live operations of the Division's PBA, failure of Contractor's PBM to submit Member Pharmacy Encounter Data timely shall not excuse

MISSISSIPPI DIVISION OF MEDICAID

Contractor's noncompliance with this requirement, and the Division may impose liquidated damages or other available remedies under Section 16, Default and Termination, of this Contract for non-compliance.

All other language not modified as stated herein for Section 11.S shall remain unchanged and in full force and effect.

20. Section 13.A.9., FINANCIAL REQUIREMENTS - Capitation Payments – Capitation Rates, is hereby amended to add the following updated Capitation Rate language and rates for SFY25:

The table below includes Capitation Rates of this Contract, which are the capitation rates per member per month (PMPM) varying by region and Rate Cell. Each Contractor will be paid based on the distribution of Members they have in each Rate Cell. The Non-Newborn SSI/Disabled, MA Adult, MA Children and Quasi-CHIP rate cells will be risk adjusted. These four Rate Cells have a Risk Adjustment factor, calculated on a prospective basis using CDPS+RX, applied to each rate re-calculated based on each Contractor's actual risk scores. The Foster Care Rate Cell will also be risk adjusted on a concurrent basis using a members' eligibility for either state or federal financial assistance to assign a risk score.

The table below establishes the CCO Capitation Rates per member per month (PMPM) for MSCAN. These rates are effective for the following Rate Cells: Non- Newborn SSI/Disabled; Foster Care; Breast and Cervical Cancer; SSI/Disabled Newborn; MA Adults; Pregnant Women; and Non-SSI Newborns. Additionally, Capitation Rates are included for MA Children and Quasi-CHIP Children, and Mississippi Youth Programs Around the Clock (MYPAC) rate cells. Capitation rates are for the period of State Fiscal Year 2025 (July 1, 2024 through June 30, 2025).

These rates exclude MHAP FSA, QIPP, MAPS, TREAT, Rural Hospital Ambulatory Payment Classification (APC) Opt-Out Payments, and HIF (as applicable); however, the MHAP FSA, QIPP, MAPS, TREAT, Rural Hospital Ambulatory Payment Classification (APC) Opt-Out Payments will be paid separately monthly as a financial transaction. Rates are prior to the application of a 1.00 percent Quality Withhold.

Molina Health Plan, Inc. MississippiCAN Capitation Rates State Fiscal Year 2025 (SFY 25) Capitation Rates PMPM (excluding Risk Scores) Effective July 1, 2024– June 30, 2025			
Rate Cell	**North**	**Central**	**South**
Non- Newborn SSI-Disabled	**$764.62**	**$905.24**	**$954.92**
Breast/Cervical Cancer	**$2,874.53**	**$3,403.17**	**$3,589.93**
MA Adults	**$360.00**	**$372.10**	**$356.35**
Pregnant Women	**$624.32**	**$645.30**	**$618.00**
SSI-Disabled Newborn	**$6,839.33**	**$7,219.49**	**$6,129.93**
Non-SSI Newborns 0-2 Months	**$2,382.83**	**$2,515.27**	**$2,135.67**
Non-SSI Newborns 3-12 Months	**$317.43**	**$335.08**	**$284.51**
Foster Care	**$635.41**	**$670.73**	**$569.50**
MYPAC	**$3,439.78**	**$3,630.97**	**$3,082.99**
MA Children	**$209.12**	**$220.75**	**$187.43**
Quasi-CHIP	**$205.57**	**$217.00**	**$184.25**

*Capitation rates per the June 4, 2024 Actuarial Report attached as Exhibit 1 to this MSCAN SFY25 Emergency Agreement. Rates are prior to the application of a 1.00% quality withhold or VBP.
Rates exclude MHAP FSA, QIPP, MAPS, TREAT, and Rural Hospital Ambulatory Payment Classification (APC) Opt-Out Payments.

The Contractor is not allowed to affect the assignment of risk scores through any post-billing claims review process for the assignment of additional diagnosis codes. Diagnosis codes may only be recorded by the provider at the time of the creation of the medical record and may not be retroactively adjusted except to correct errors.

21. Section 13.A.10, FINANCIAL REQUIREMENTS – Capitation Payments – Risk Corridor, is hereby amended to add the following for SFY25:

*The Program Wide Risk Corridor will not be applicable or utilized for State Fiscal Year 2025.

MISSISSIPPI DIVISION OF MEDICAID

Risk Corridor for Pharmacy High-Cost Drugs - State Fiscal Year (SFY) 2025

Some Medicaid members have conditions requiring very expensive drug treatments. These members are infrequent and not evenly distributed among the CCOs. To help mitigate the CCO's risk, the Division is introducing a pharmacy high-cost drug risk corridor for SFY 2025, subject to CMS approval. The pharmacy high-cost drug risk corridor is applicable to total drug spend of $250,000 or more per year at a member level. The capitation rates include a PMPM estimate of the costs that will be covered in the pharmacy high-cost drug risk corridor specific to each Rate Cell. The actual costs from the CCOs will be compared to these estimated costs for the final settlement calculation.

The pharmacy high-cost drug risk corridor outlined below has been developed in accordance with generally accepted actuarial principles and practices. The table below summarizes the share of gains and losses relative to the estimated pharmacy high-cost drug costs for each party.

Mississippi Division of Medicaid Risk Corridor Parameters for Pharmacy High-Cost Drugs SFY 2025		
Contractor Gain/Loss	**Contractor Share of Gain/Loss in Corridor**	**Division Share of Gain/Loss in Corridor**
Less than -6.0%	0%	100%
-6.0% to -3.0%	50%	50%
-3.0% to +3.0%	100%	0%
+3.0% to +6.0%	50%	50%
Greater than +6.0%	0%	100%

The pharmacy high-cost drug risk corridor will be implemented using the following provisions:

(1) Estimated high-cost pharmacy drug costs will be calculated separately for each Rate Cell based on the expected mix of high-cost products.

(2) Each Rate Cell's actual pharmacy high-cost drug costs will include payments made for the following:

(a) All pharmacy claims with an NDC code billed to and paid through the Contractor. Pharmacy claims paid through the Division's PBA are excluded.

(b) All drugs billed as medical claims with a HCPCS code that starts with the letter "J"

(c) Inpatient stays for select gene therapies and other select products. The estimated pharmacy costs included in the pharmacy high-cost drug risk corridor include the following; however, DOM will monitor and revise the list of approved products if additional products are covered by DOM for use during SFY 2025.

i) lovotibeglogene autotemcel (lovo-cel)
ii) exagamglogene autotemcel (exa-cel)
iii) Zynteglo

(d) Applicable script limits will be applied and the costs for those services will not be counted toward total member spend during that time period.

(3) The timing of the pharmacy high-cost drug risk corridor settlements will occur as follows:

(a) The initial settlement will occur after the contract year is closed, using six months of runout.

(b) The final settlement will occur once the MLR audit has been completed. MLR audits are usually completed 12 to 18 months after the close of the SFY.

(4) The 91.3% minimum MLR provision (Federal MLR definition) in the CCO contract will apply after the risk corridor settlement calculation.

All other language not modified as stated herein for Section 13.A.10 shall remain unchanged and in full force and effect.

22. Section 13.B., FINANCIAL REQUIREMENTS – State Directed Payments, is hereby amended to add the following additional sub-provision:

5. Rural Hospital Ambulatory Payment Classification (APC) Opt-Out Payments

The Rural Hospital Ambulatory Payment Classification APC Opt-Out Program (Rural APC Opt-Out) is a state directed payment arrangement based on Miss. Code Sec. 43-13-117(A)(2)(c) which requires the Division of Medicaid (DOM) to "give rural hospitals that have fifty (50) or fewer licensed beds the option to not be reimbursed for outpatient hospital services using the APC methodology, but reimbursement for outpatient hospital services provided by those hospitals shall be based on one hundred one percent (101%) of the rate established under Medicare for outpatient hospital services."

Rural APC Opt-Out payments shall be made annually upon the completion of DOM's review of the hospital cost report and calculation of any reimbursement due under the directed payment arrangement. When the Contractor receives payment of Rural APC Opt-Out payments, it shall be paid to the provider within five (5) business days

of receipt. The Contractor shall distribute the Rural APC Opt-Out funds with no amount withheld for administrative cost.

23. Section 13.J., FINANCIAL REQUIREMENTS – Value Based Payment, is hereby amended to read as follows:

J. <u>Value Based Payment</u>

Effective with the beginning of SFY 2025, the Contractor is required to contract with an entity in the state of Mississippi providing a state-wide health information exchange (HIE) which must have the capability to receive admit, discharge and transfer (ADT) information from hospitals and transmit that information to the Contractor, Medicaid and/or its designee. The ADT information is expected to be received by the Contractor as a part of the contract with the HIE to utilize the information in real-time in conjunction with the Division's Value Based Payment Program. The Division expects the Contractor to utilize the ADT information within the timeframe as required by the Value Based Payment Program.

Effective July 1, 2024, the Mississippi Division of Medicaid (DOM) will implement the Value-Based Payment Incentive Program (MSDOM VBP) as part of the MississippiCAN (MSCAN) contract in support of the State's quality strategy aims.

The program consists of associated quality measures, payment arrangements and amounts, as determined and defined by DOM, that promote quality in the delivery of services. This is in keeping with the purpose of a value-based payment program to link enhanced provider payments to improved performance by health care providers.

MSDOM VBP may include structural, process and outcomes measures during the performance period. The program is expected to be phased in such that a portion of incentives may be tied to implementation of redesigned systems (i.e., structural measures), pay for reporting and pay for performance. Pay for performance incentives will be based on statewide performance targets. Targets will be measured using quality metrics defined by DOM and will be set on a State Fiscal Year basis. Failure to meet a target will result in no incentive being paid for that target. There will be no partial incentive payments awarded.

The Contractor will be eligible to receive additional funds over and above base capitation rates. Monetary incentives will not exceed one-half percent (0.5%) above the capitation payment and as such will not be in excess of 105 percent of the approved capitation payments in accordance with 42 C.F.R. § 438.6(b). Monetary incentives will be split among MSCAN Coordinated Care Contractors, hospitals, and other providers as applicable and in proportions as set by DOM. In exchange for incentives created through the MSDOM VBP, CCOs, hospitals, and other providers must collaborate with one another, utilizing care management and other available tools to ensure that targets set by DOM are met. At DOM's discretion, additional incentives for CCOs may include priority in CCO auto-enrollment, with higher performing CCOs having the potential to be assigned auto-enrolled members at a higher percentage rate.

DOM will promulgate a MSDOM VBP Work Plan on a State Fiscal Year basis, which is incorporated via reference to this contract. The Work Plan will include metrics, performance periods, payment processes, requirements, and any other information relevant to CCOs and providers for the implementation and operationalization of the MSDOM VBP. The Contractor will be required to comply with the final Work Plan promulgated by the Division, as well as produce and disseminate reports as outlined within that Work Plan. The Work Plan will comply with all applicable provisions of state law and 42 C.F.R. §438.6(c). DOM has the right to alter the MSDOM VPB Program and Work Plan at any time, at its discretion. CCOs will have sixty (60) calendar days' notice prior to the required implementation date of any ad hoc changes made by DOM. Changes made for each new State Fiscal Year are to be expected by the CCO.

24. Section 13, FINANCIAL REQUIREMENTS is hereby amended to add the following as new sub-section:

H. <u>Pharmacy Payment Through Division PBA</u>

The Contractor will use an existing or newly established bank account for the purpose of receiving the funds from the Division and processing the payment of PBA invoices. All PBA invoices must be paid by Contractor on the business day following Contractor's receipt of the funds, and the payment to the PBA must be made in a manner that will make the funds fully available to the Division within one (1) business day of receipt of the funds. If the funds from the PBA are received

by the Contractor on a holiday, the Contractor is still required to make payment on the first business day after receipt of the funds.

25. Section 15, SUBCONTRACTUAL RELATIONSHIPS AND DELEGATION, is hereby amended to add the following as a new sub-section:

D. <u>Pharmacy Subcontracts</u>

Prior to Contractor terminating any of its pharmacy subcontracts or engaging in any new pharmacy subcontracts, Contractor shall provide to the Division, at least sixty (60) days prior to termination or execution of a new subcontract, unless otherwise approved by the Division in writing, a report of its pharmacy subcontracts that identifies the subcontracting entity and the responsibilities of that subcontractor relative to Contractor's pharmacy operations prior to July 1, 2024.

26. EXHIBIT C: MEDICAL LOSS RATIO (MLR) REQUIREMENTS is hereby amended and replaced with "EXHIBIT C: MEDICAL LOSS RATIO (MLR) REQUIREMENTS" as attached and incorporated herein by reference to this Emergency Contract.

27. EXIBIT H: REPORTING REQUIREMENTS is hereby amended and replaced with "EXHIBIT H: REPORTING REQUIREMENTS" as attached and incorporated herein by reference to this SFY25 Emergency Contract.

MISSISSIPPI DIVISION OF MEDICAID

IV. COST FOR SERVICES: DOM shall remit payment to Contractor as a monthly capitation fee pursuant to Section 13 – FINANCIAL REQUIREMENTS of the Previous Contract as amended herein for the term of this Emergency Contract.

V. APPLICABLE LAW: The contract shall be governed by and construed in accordance with the laws of the State of Mississippi, excluding its conflicts of laws provisions, and any litigation with respect thereto shall be brought in the courts of the State. Contractor shall comply with applicable federal, state, and local laws and regulations.

[remainder of this page left intentionally blank]

IN WITNESS WHEREOF, the parties have caused this Emergency Agreement to be executed by their duly authorized representatives as follows:

Mississippi Division of Medicaid

By: _____
Drew L. Snyder
Executive Director

Date: 6/28/24

Molina Healthcare of Mississippi, Inc.

By: _____
Bridget Galatas
President & Chief Executive Officer

Date: 06.25.2024

STATE OF MISSISSIPPI

COUNTY OF Hinds

THIS DAY personally came and appeared before me, the undersigned authority, in and for the aforesaid jurisdiction, the within named, **Drew L. Snyder,** in his official capacity as the duly appointed **Executive Director of the Division of Medicaid in the Office of the Governor,** an administrative agency of the State of Mississippi, who acknowledged to me, being first duly authorized by said agency that he signed and delivered the above and foregoing written Contractual Agreement for and on behalf of said agency, and as its official act and deed on the day and year therein mentioned.

GIVEN under my hand and official seal of office on this the 28th day of June, A.D., 2024.

NOTARY PUBLIC

MY COMMISSION EXPIRES:

09-23-2024

STATE OF MISSISSIPPI
NOTARY PUBLIC
ID # 64864
SHELBY J. BERRYMAN
Commission Expires
Sept. 23, 2024
MADISON COUNTY

STATE OF Mississippi
COUNTY OF Hinds

THIS DAY personally came and appeared before me, the undersigned authority, in and for the aforesaid jurisdiction, the within named, **Bridgete Galatas,** in her respective capacity as **President & Chief Executive Officer of Molina Healthcare of Mississippi, Inc.,** who acknowledged to me, being first duly authorized by said corporation that she signed and delivered the above and foregoing written Contractual Agreement for and on behalf of said corporation and as its official act and deed on the day and year therein mentioned.

GIVEN UNDER MY HAND and official seal of office on this the 25th day of June, A.D., 2024

NOTARY PUBLIC
Hinds County
My Commission Expires
July 20, 2027

NOTARY PUBLIC

MY COMMISSION EXPIRES:

July 20, 2027

Milliman

17335 Golf Parkway
Suite 100
Brookfield, WI 53045
USA
Tel +1 262 784 2250

milliman.com

June 4, 2024

Jennifer Wentworth
Deputy Executive Director, Finance
Mississippi Division of Medicaid
550 High Street, Suite 1000
Jackson, MS 39201
Sent via email: jennifer.wentworth@medicaid.ms.gov

Re: Report10 State Fiscal Year 2025 MississippiCAN Preliminary Rate Calculation and Certification - DRAFT

Dear Jennifer:

The Mississippi Division of Medicaid (DOM) has retained Milliman to develop actuarially sound capitation rates for state fiscal year (SFY) 2025 for Mississippi Coordinated Access Network (MississippiCAN), a coordinated care program for Medicaid beneficiaries.

This report documents the preliminary capitation rates for all populations enrolled in MississippiCAN. Overall, the SFY 2025 capitation rates in this report are 2.4% lower than the SFY 2024 capitation rates issued on December 19, 2023 (when compositing rates using calendar year (CY) 2022 membership). This report assumes ultimate approval of the preprints submitted to CMS for directed payments and directed fee schedules.

Rates will be retroactively adjusted and recertified for the following items:

- Payments for the Mississippi Hospital Access Program (MHAP) Quality Incentive Payment Program (QIPP).
- Payments for the MHAP fee schedule adjustment (FSA) amounts.
- Payments for the Mississippi Medicaid Access to Physician Services (MAPS) program.
- Payments for the Transforming Reimbursement for Emergency Ambulance Transportation (TREAT) program.
- Payments for the ambulatory payment classification (APC) opt out program.

This recertification will be done at one time for capitation rates for the entire SFY 2025 period. This recertification is anticipated to happen two quarters following the end of SFY 2025.

There are many considerations taken in the development of SFY 2025 capitation rates to reflect impacts of COVID-19 and the unwinding of the continuous coverage requirement (CCR) in the Families First Coronavirus Act (FFCRA). Explicit adjustments for COVID-19 are made in the rate development for the following:

- **Base Period Data:** The SFY 2025 capitation rates use CY 2022 data as the basis for projections. Under normal circumstances, SFY 2025 capitation rates would be based on CY 2022 and CY 2021 experience for smaller rate cells. However, given the large population and member behavior changes in CY 2021, we do not find this experience to be a credible basis for SFY 2025 projections. Therefore, we use a single year of experience data for all populations as the basis for our SFY 2025 projections.

- **Acuity Adjustments:** MississippiCAN enrollment fluctuated significantly throughout CY 2022 due to the CCR and DOM policies shifting members between MississippiCAN and fee-for-service (FFS). Under the continuous coverage requirement DOM could not disenroll members who would normally lose eligibility during the public health emergency (PHE), as declared by the Department of Health and Human Services (HHS). However, beginning in June 2021, and continuing through late CY 2022, DOM transitioned individuals for whom Medicaid eligibility would have lapsed absent the CCR from coordinated care organizations (CCOs) into FFS Medicaid.

  Per the Consolidated Appropriations Act, 2023 (CAA), the continuous coverage requirement, which was previously tied to the federal PHE ended on March 31, 2023. Additional guidance from the Centers for Medicare and Medicaid Services (CMS) indicated that states had 14 months after this date to complete

redeterminations for affected enrollees. Within the options outlined by CMS, DOM began eligibility redeterminations starting in April 2023 and began disenrolling Mississippi Medicaid recipients who were no longer eligible in July 2023 and throughout the following year. We have been monitoring membership and population acuity changes as of a result of the end of the continuous coverage requirements and have applied an acuity adjustment in preliminary SFY 2025 capitation rates for certain populations based on the most recent data available as of March 2024.

- **COVID-19 / Influenza / RSV Adjustment:** We developed an adjustment for the estimated difference in costs included in the CY 2022 base period data and projected SFY 2025 costs for testing, vaccination, and treatment for influenza, respiratory syncytial virus (RSV), and COVID-19. These population specific adjustments reflect an expected decrease in COVID-19, influenza, and RSV costs from CY 2022 to SFY 2025.

This preliminary report does not include projected costs for the following reimbursement and program changes currently anticipated for SFY 2025. We will amend the capitation rates accordingly in a subsequent release for these items.

- Final charge trends for inpatient, outpatient, and certain physician services provided by DOM's payment methodology development vendor.
- Population adjustments related to procedural changes in presumptive eligibility or passive enrollment starting in SFY 2025.
- The removal of diabetic supplies, which will be paid through DOM's pharmacy benefits administrator (PBA) in SFY 2025.

❖ ❖ ❖ ❖ ❖

Jennifer, please call us at 262 784 2250 if you have questions. We look forward to discussing this report with you and the CCOs.

Sincerely,

Jill A. Bruckert, FSA, MAAA
Principal and Consulting Actuary

Katarina N. Lorenz, FSA, MAAA
Consulting Actuary

JAB/KNL/crl

Attachments

MILLIMAN REPORT

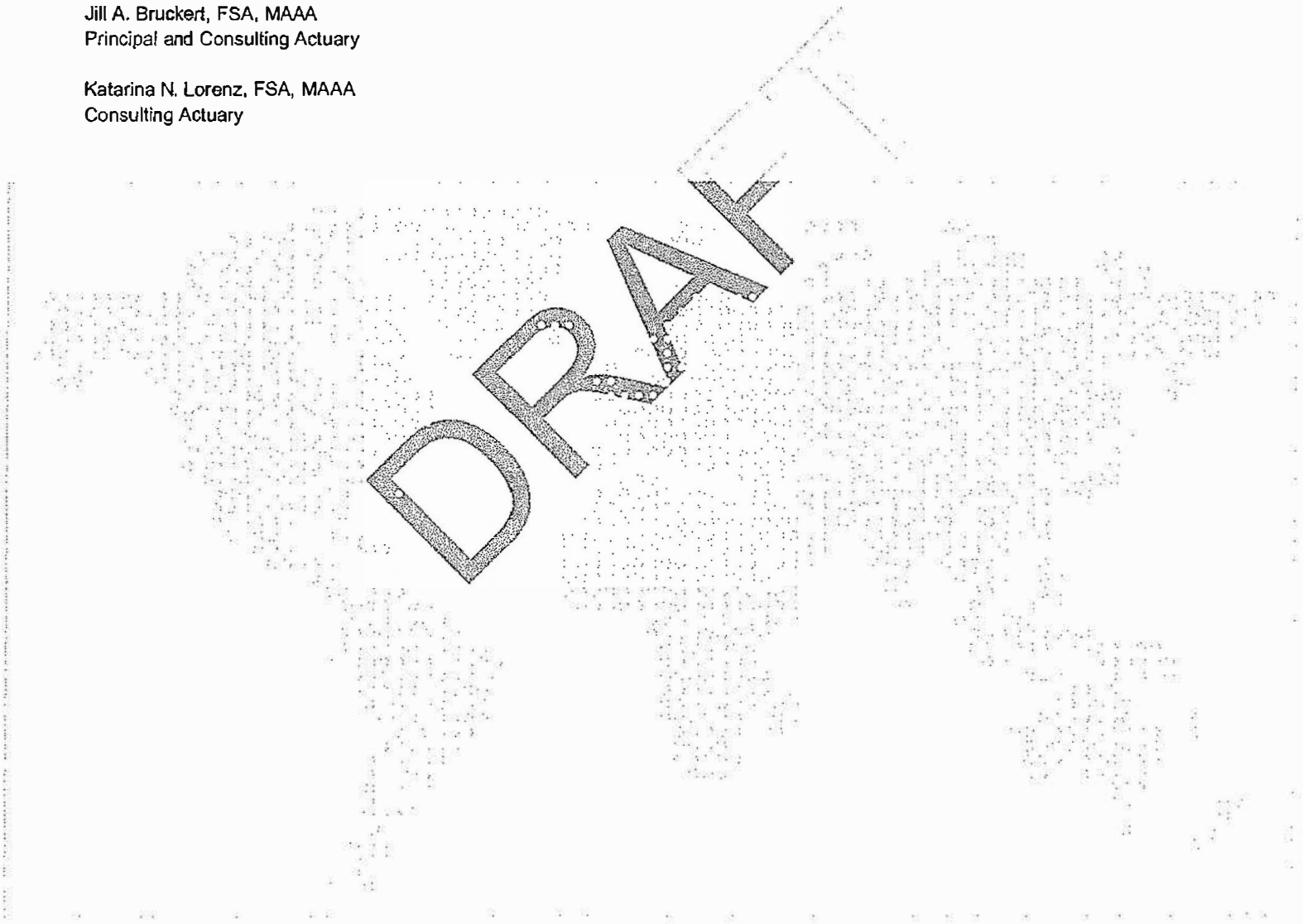
State of Mississippi Division of Medicaid

State Fiscal Year 2025 MississippiCAN Preliminary Rate Calculation and Certification - DRAFT

June 4, 2024

Jill A. Bruckert, FSA, MAAA
Principal and Consulting Actuary

Katarina N. Lorenz, FSA, MAAA
Consulting Actuary



17335 Golf Parkway
Suite 100
Brookfield, WI 53045
USA
Tel +1 262 784 2250

milliman.com

Milliman

Table of Contents

EXHIBITS (Provided in Excel format only)

Capitation Rate Development

Capitation Rate Support

Expenditure Projection

Risk Corridor Calculations

This report assumes the reader is familiar with the State of Mississippi's MississippiCAN program, its benefits, and rate setting principles. The report was prepared solely to provide assistance to DOM to set SFY 2025 capitation rates for the MississippiCAN program. It may not be appropriate for other purposes. Milliman does not intend to benefit, and assumes no duty or liability to, other parties who receive this work. This material should only be reviewed in its entirety.

Table of Contents *(continued)*

APPENDICES

Supporting Documentation

DRAFT

I. SUMMARY AND DISCUSSION OF RESULTS

The Mississippi Division of Medicaid (DOM) retained Milliman to calculate, document, and certify to capitation rates for Mississippi Coordinated Access Network (MississippiCAN), a coordinated care program for targeted Medicaid beneficiaries, effective for state fiscal year (SFY) 2025. This report provides preliminary SFY 2025 capitation rates and documents their development. This report is structured as follows:

- Section I includes a high-level overview of the change in capitation rates relative to the July 1, 2023 to June 30, 2024 (SFY 2024) capitation rates.
- Section II provides a short background of the MississippiCAN program.
- Section III documents the development of the base data.
- Section IV documents the rate setting process for SFY 2025 capitation rates.
- Appendices A and B contain additional details on the SFY 2025 rate cell definitions and base period data sources and processing.
- Appendix C provides responses to the CMS managed care rate setting guide for all rate cells. ***This is intentionally blank for the draft report.***
- Appendix D contains an Actuarial Certification for all MississippiCAN rate cells. ***This is intentionally blank for the draft report.***
- Appendix E documents our reliance on DOM for data and other assumptions in the development of the capitation rates. ***This is intentionally blank for the draft report.***

SFY 2025 CAPITATION RATES

Table 1 includes per member per month (PMPM) preliminary capitation rates effective for SFY 2025 that will be paid to the Coordinated Care Organizations (CCOs) on a monthly basis (excluding all directed payments and any payments earned through the new value-based payment (VBP) incentive program) to provide medical and certain pharmacy services to their enrolled beneficiaries. Each CCO will be paid based on the distribution of members enrolled in each rate cell. In addition, CCO capitation payments will vary based on their members' county of residence. We assigned each county to one of the following regions: North, Central, or South, as shown in Appendix A.

Table 1
Mississippi Division of Medicaid
MississippiCAN Capitation Rates
Per Member Per Month (PMPM)[1]
Effective SFY 2025

Rate Cell	North	Central	South
Non-Newborn SSI / Disabled	$764.62	$905.24	$954.92
Breast and Cervical Cancer	$2,874.53	$3,403.17	$3,589.93
MA Adult	$360.00	$372.10	$356.35
Pregnant Women	$624.32	$645.30	$618.00
SSI / Disabled Newborn	$6,839.33	$7,219.49	$6,129.93
Non-SSI Newborns 0 to 2 Months	$2,382.83	$2,515.27	$2,135.67
Non-SSI Newborns 3 to 12 Months	$317.43	$335.08	$284.51
Foster Care	$635.41	$670.73	$569.50
MYPAC	$3,439.78	$3,630.97	$3,082.99
MA Children	$209.12	$220.75	$187.43
Quasi-CHIP	$205.57	$217.00	$184.25

[1] *Capitation rates in Table 1 exclude MHAP, MAPS, TREAT, and are prior to the application of the quality withhold or VBP.*

This report assumes the reader is familiar with the State of Mississippi's MississippiCAN program, its benefits, and rate setting principles. The report was prepared solely to provide assistance to DOM to set SFY 2025 capitation rates for the MississippiCAN program. It may not be appropriate for other purposes. Milliman does not intend to benefit, and assumes no duty or liability to, other parties who receive this work. This material should only be reviewed in its entirety.

In addition, there are multiple directed payments that are paid outside of the monthly capitation rates and excluded from Table 1. The estimated cost for each directed payment is included as a PMPM amount in the preliminary SFY 2025 capitation rates. These PMPM amounts will be retrospectively adjusted on a CCO-specific basis to reflect final payments made for each program.

- The Mississippi Hospital Access Program (MHAP) hospital fee schedule adjustment (FSA) payments are paid outside of the capitation rates on a monthly basis. This amount varies by rate cell on a PMPM basis based on projected utilization of inpatient and outpatient services and actual membership. The MHAP FSA payments are projected to be $733.3 million in SFY 2025. Please see Section IV of this report for additional details on the MHAP FSA.

- Payments for the MHAP quality incentive payment program (QIPP) are paid outside of the capitation rates on a quarterly basis. The MHAP QIPP payments are projected to be $832.5 million in SFY 2025. Please see Section IV of this report for additional details on the MHAP QIPP.

- The Mississippi Medicaid Access to Physician Services (MAPS) program in MississippiCAN enhances payments to physicians who are employed by a qualifying hospital or who assigned Mississippi Medicaid payments to a qualifying hospital. The MAPS payments are estimated to be $32.9 million in SFY 2025. Please see Section IV of this report for additional details on the MAPS program.

- The Payments for the Transforming Reimbursement for Emergency Ambulance Transportation (TREAT) program in MississippiCAN for SFY 2025 enhances payments to eligible emergency ambulance providers. The TREAT payments are estimated to be $25.3 million in SFY 2025. Please see Section IV of this report for additional details on the TREAT program.

In addition, we expect that DOM will be filing a preprint with CMS for payments made to providers that opt out of the ambulatory payment classification (APC) payment model for outpatient services. The amount and structure of those payments are still under development at this time, but we will update the rate certification with the appropriate information once available.

In addition, the capitation rates will be adjusted on a CCO-specific basis for the following rate adjustments:

- Quality Withhold: As in SFY 2024 rates, DOM will apply a quality withhold to MississippiCAN payments in SFY 2025 based on metrics reported by the CCOs. The PMPM capitation rates in Table 1 are prior to the application of this quality withhold. Please see Section IV for more information on the quality withhold for SFY 2025.

- Value-Based Payment Program (VBP): Starting in SFY 2025, DOM is implementing a value-based payment program where CCOs can earn up to a 0.5% incentive payment. Please see Section IV for more information on this program.

- Risk Adjustment: The capitation rates for the Non-Newborn SSI / Disabled, MA Adult, MA Children, and Quasi-CHIP rate cells will be risk adjusted for each CCO using the combined Chronic Illness and Disability Payment System and Medicaid Rx risk adjuster (CDPS + Rx). The CDPS + Rx risk adjuster will be used to adjust for the acuity differences between the enrolled populations of each CCO and will be budget-neutral to DOM. The CDPS + Rx demographic and disease category weights will be calculated using Mississippi FFS and encounter data for the populations enrolled and services provided during SFY 2025.

  The capitation rates for the Foster Care rate cell will be risk adjusted using a custom risk adjustment model developed for this population. This custom model uses a member's eligibility for either state or federal financial assistance to assign a risk score. The risk adjustment for the Foster Care rate cell will be applied on a concurrent basis.

  Please see Section IV for more information on the application of risk adjustment to the applicable rate cells.

- High-Cost Pharmacy Risk Corridor: Similar to SFY 2024, a high-cost pharmacy risk corridor will be applied to recognize the uncertainty in determining rate setting assumptions for the impact of current and anticipated high-cost medications.

This report assumes the reader is familiar with the State of Mississippi's MississippiCAN program, its benefits, and rate setting principles. The report was prepared solely to provide assistance to DOM to set SFY 2025 capitation rates for the MississippiCAN program. It may not be appropriate for other purposes. Milliman does not intend to benefit, and assumes no duty or liability to, other parties who receive this work. This material should only be reviewed in its entirety.

Please see Section IV for more information on how the High-Cost Pharmacy Risk Corridor settlement will be calculated.

This report includes preliminary capitation rates for SFY 2025. These rates will be updated for the following. It is anticipated that all adjustments will be made during the rating period.

- Final charge trends for inpatient, outpatient, and certain physician services provided by DOM's vendor.
- Population adjustments related to procedural changes in presumptive eligibility or passive enrollment starting in SFY 2025.

Our Actuarial Certification of the SFY 2025 MississippiCAN capitation rates will be included as Appendix D in the final capitation rate report. **Appendix D is omitted in this draft release.** It should be emphasized that capitation rates are a projection of future costs based on a set of starting data and assumptions. Actual costs will be dependent on each contracted CCO's situation, experience, and enrolled population.

SELECTION OF BASE DATA

Under normal circumstances, data from calendar year (CY) 2022 would be used as the primary base data for SFY 2025 capitation rates with data from CY 2021 used to supplement CY 2022 data for rate cells with fewer than 150,000 member months. Due to the emergence of COVID-19 in early 2020, and related enrollment changes occurring throughout CY 2021, the CY 2021 encounter data shows different utilization and cost patterns when compared with more recent time periods. We expect claims and member behavior in SFY 2025 to be more similar to adjusted CY 2022, rather than earlier time periods. Therefore, we did not incorporate CY 2021 data for the lower membership rate cells and CY 2022 data was used as our sole base data source for all rate cells in development of the SFY 2025 capitation rates, regardless of membership.

While CY 2022 encounter data is the primary data source for SFY 2025 capitation rates, emerging data from CY 2023 is also used in the development of several rate adjustments, such as seasonal virus impacts, population acuity adjustments, and trend assumptions.

In October 2022 a new MMIS vendor began processing all data for the Mississippi Medicaid and CHIP programs. In order to have consistency in the data for all months, the CY 2022 encounter data that serves as the basis for SFY 2025 capitation rates is supplied by DOM's new MMIS vendor, including restated months of data prior to October 2022. Milliman has worked closely with DOM and their MMIS vendor to refine our data process and validate the CY 2022 data.

CATEGORIES OF SERVICE

For SFY 2025 capitation rate development, the CY 2022 base data was categorized using a more granular category of service methodology in which inpatient, outpatient, and physician services are further subset into more specific sub-categories of service. We believe that these additional breakouts will allow for greater transparency when developing the SFY 2025 capitation rates. Table 2 below shows the comparison between the categories of service for the SFY 2024 and the SFY 2025 capitation rates.

The SFY 2024 capitation rate exhibits displayed costs for the MA Adult and Pregnant Women rate cells separately for delivery and non-delivery related costs. With the addition of maternity and delivery category of service breakouts for inpatient and physician services, we have adjusted our exhibits to show the MA Adult and Pregnant Women costs without this additional breakout as any delivery-specific adjustments will now be reflected in those categories of service.

Starting in July 2024, DOM expects to enter into an arrangement with their Pharmacy Benefits Administrator (PBA) in which certain pharmacy claims will be paid through the PBA. As such, we identified and removed the associated pharmacy claims from the CY 2022 base data for the purpose of developing SFY 2025 capitation rates. Please see Appendix B for a further description of the associated pharmacy services.

This report assumes the reader is familiar with the State of Mississippi's MississippiCAN program, its benefits, and rate setting principles. The report was prepared solely to provide assistance to DOM to set SFY 2025 capitation rates for the MississippiCAN program. It may not be appropriate for other purposes. Milliman does not intend to benefit, and assumes no duty or liability to, other parties who receive this work. This material should only be reviewed in its entirety.

Table 2 Mississippi Division of Medicaid SFY 2024 & SFY 2025 Categories of Service	
SFY 2024 Category	**SFY 2025 Category**
Inpatient Hospital	Inpatient Hospital Services - Maternity / Deliveries
	Inpatient Hospital Services - Psychiatric / Substance Abuse
	Inpatient Hospital Services - All Other
Outpatient Hospital	Outpatient Hospital Services - Emergency Room
	Outpatient Hospital Services - Pharmacy
	Outpatient Hospital Services - All Other
Physician	Physician Services - Maternity / Deliveries
	Physician Services - Psychiatric / Substance Abuse
	Physician Services - All Other
Pharmacy	N/A
Dental	Dental - All Services
Other	All Other Services

PHE UNWIND AND COVID-19 CONSIDERATIONS IN SFY 2025 RATE DEVELOPMENT

Several adjustments were made in the SFY 2025 capitation rates to reflect changes as a result of COVID-19 and the unwinding impacts of the associated CCR, including:

- Acuity adjustments: Enrollment information through March 2024 was utilized as part of a risk score analysis to estimate changes in population acuity between the base period (CY 2022) and SFY 2025 for certain populations. Please see Section IV (Step 2) for more information on this adjustment.
- Seasonal virus adjustments: Adjustments are made in the rate development to account for estimated changes in seasonal virus loads (including COVID-19, RSV, and influenza) between CY 2022 and SFY 2025. Please see Section IV (Step 1) for more information on this adjustment.

CAPITATION RATE CHANGE SUMMARY

Table 3 summarizes the change in capitation rates from SFY 2024 to SFY 2025. This comparison is shown excluding the impact of directed payments, the quality withhold, and any payments earned through the VBP program, and is composited across all rate cells using CY 2022 membership. Table 3 also summarizes changes excluding the impact of program changes (noted by footnote 2 in Table 3), which increase or decrease total program costs concurrently with revenue for the CCOs and excluding the impact of COVID-19 adjustments (noted by footnote 3 in Table 3).

DRAFT

This report assumes the reader is familiar with the State of Mississippi's MississippiCAN program, its benefits, and rate setting principles. The report was prepared solely to provide assistance to DOM to set SFY 2025 capitation rates for the MississippiCAN program. It may not be appropriate for other purposes. Milliman does not intend to benefit, and assumes no duty or liability to, other parties who receive this work. This material should only be reviewed in its entirety.

Table 3
Mississippi Division of Medicaid
MississippiCAN Capitation Rates
Summary of SFY 2025 Rate Change Components[1]

	Aggregated with CY 2022 Membership
SFY 2024 Capitation Rate - Including Pharmacy Services	**$518.94**
Remove Non-Physician Administered Pharmacy Services	0.748
SFY 2024 Capitation Rate - Excluding Pharmacy Services	**$388.42**
Shift CGT Estimates from Pharmacy to Physician	1.046
SFY 2024 Capitation Rate - Excluding Pharmacy Services with CGT Shift	**$406.37**
Base Period Data Update	0.993
Restate CY 2022 to SFY 2024 Trends	1.003
Restate SFY 2024 Hemophilia Population Carve-In[2]	1.000
Restate SFY 2024 Cell / Gene Therapy Coverage[2]	0.975
Remove SFY 2024 Population Acuity Adjustment[3,4]	0.976
Other Restated SFY 2024 Assumptions	0.998
Updates Relative to SFY 2024 Assumptions	**0.946**
SFY 2024 to SFY 2025 Utilization Trends	1.027
SFY 2024 to SFY 2025 Unit Cost Trends	1.007
SFY 2025 Population Acuity Adjustment[3]	1.006
SFY 2025 Seasonal Virus Adjustment[3]	1.005
SFY 2025 Hemophilia Population Carve-In[2]	1.001
SFY 2025 Postpartum Coverage Extension[2]	0.993
SFY 2024 to SFY 2025 Restorative Dental Reimbursement Change[2]	1.001
Update SFY 2025 Admin	0.999
Remove SFY 2025 PBA Pharmacy Admin[2]	0.993
Preliminary SFY 2025 Rate Change	**0.976**
SFY 2025 Rate Change - Excluding Program Changes[2]	**1.013**
SFY 2025 Rate Change - Excluding COVID-19 Adjustments[3]	**0.990**

[1] Rate changes exclude MHAP, MAPS, TREAT, the quality withhold, and the VBP.
[2] Program change that increases or decreases total program costs outside of the control of the CCOs.
[3] COVID-19 adjustments include the population acuity adjustments and seasonal virus adjustment.
[4] The final SFY 2024 Population Acuity Adjustment is still outstanding and will be updated in the next iteration of SFY 2024 rates.

The values quoted below are all based on the program wide impact using CY 2022 membership to composite the rate cells. **The rate change components are based on SFY 2024 rates excluding pharmacy services and adjusted to show cell and gene therapy (CGT) costs as part of the physician service category (rather than pharmacy as originally projected in SFY 2024 rate development).**

- As discussed previously, SFY 2024 capitation rates were developed to project total medical and pharmacy costs, including those that will be covered by DOM's PBA for SFY 2025. For comparison purposes, we include the SFY 2024 rates with and without the PBA-eligible pharmacy services. The impact of removing estimated pharmacy category of service from the SFY 2024 rates decreases overall costs by about 25.2%.

  The estimated SFY 2024 pharmacy category of service costs were developed using CY 2021 base period experience and trended to SFY 2024, including adding cost estimates for new CGT treatments to the pharmacy category of service. Based on our current understanding of how these claims will be paid in SFY 2025, these services will be paid in physician category of services. Therefore, we restated the SFY 2024 rates with CGT costs included in the physician service category for a more direct comparison to the SFY 2025 capitation rates. This change increases the SFY 2024 rates without PBA-eligible pharmacy services by 4.6%. The net impact of these two adjustments for the removal of PBA eligible pharmacy services (excluding CGTs) is a decrease of about 21.7%.

This report assumes the reader is familiar with the State of Mississippi's MississippiCAN program, its benefits, and rate setting principles. The report was prepared solely to provide assistance to DOM to set SFY 2025 capitation rates for the MississippiCAN program. It may not be appropriate for other purposes. Milliman does not intend to benefit, and assumes no duty or liability to, other parties who receive this work. This material should only be reviewed in its entirety.

- The development of SFY 2025 capitation rates is a ground-up approach where the base data and each assumption is evaluated separate from the SFY 2024 capitation rates. However, for the purposes of explaining the rate change from SFY 2024 to SFY 2025, we isolate the impact of rebasing the data and assumptions that we updated relative to the data or assumptions used to develop the SFY 2024 values. Overall, this rebasing decreased the projection of SFY 2024 costs by 5.4% from costs projected in the SFY 2024 capitation rates. This change contains the following sub-components:

  - As stated above, SFY 2024 rates used CY 2021 data as the basis for capitation rate development. For SFY 2025, we rely on CY 2022 encounter data as the basis for rate development. The impact of changing our base data (including the associated impact of restating IBNR, TPL, missing data, and non-covered services) decreased projected costs by 0.7%.

  - Milliman restated CY 2022 to SFY 2024 trend assumptions. This included the recalculation of annual trend assumptions based on reviewing restated data, and the recalculation of fee schedule impacts based on base data for CY 2022 (rather than CY 2021); all topics are discussed in Section IV. Overall, this trend restatement resulted in a 0.3% increase to capitation rates.

  - Starting January 1, 2024, eligible members with Hemophilia or Von Willebrand disease transitioned from FFS into MississippiCAN. Historically this population was carved-out of MississippiCAN due to the relatively high medical costs associated with these conditions, as well as the infrequent and non-uniform distribution of members across the CCOs. Milliman restated the estimated costs of adding this population to MississippiCAN based on enrollment extracts provided by DOM (which increased the total number of expected members) and an updated effective date of January 1, 2024. Previously this change was assumed to be effective July 1, 2023. Across all rate cells, this restatement has a negligible impact due to the offsetting impact of more members but for a shorter coverage period.

  - Several high-cost gene therapies are currently available or will become available during SFY 2025. Restating anticipated medical and non-PBA eligible pharmacy costs associated with these treatments, as well as the carve-in of Zolgensma from FFS, decreased rates by 2.5%. To date, the actual utilization of these high-cost gene therapies has been very low and the SFY 2025 estimates reflect this reduction in anticipated utilization for SFY 2025. Ultimate utilization levels are likely to be greater than or less than the estimates included in the SFY 2025 capitation rates. A high-cost drug risk corridor has been implemented for SFY 2025 to mitigate the uncertainty in the estimation of utilization of these therapies and other high-cost pharmaceuticals.

  - The population acuity previously applied to reflect the impact of moving members over to FFS as part of eligibility redeterminations during CY 2021 and CY 2022 was removed now that CY 2022 data is used as the base period for SFY 2025 capitation rates. A separate adjustment is applied to reflect population acuity changes between CY 2022 and SFY 2025. This reduces capitation rates by 2.4% overall.

  - Various other assumptions were restated, most notably the application of the preventative and diagnostic dental reimbursement increases occurring on July 1, 2021 and July 1, 2022. Now that we are utilizing CY 2022 base period data (instead of CY 2021), we no longer need to apply an adjustment for the July 1, 2021 change, and the July 1, 2022 adjustment is dampened to only apply to half the year. Relying on actual data vs. our prior assumptions reduced overall rates by approximately 0.2% across all rate cells.

- Composite utilization trend assumptions from SFY 2024 to SFY 2025 increased projected costs 2.7%. Please see Section IV for more information on trend assumptions included in SFY 2025 capitation rates.

- Composite unit cost trend assumptions from SFY 2024 to SFY 2025 increased projected costs 0.7%. This change includes physician administered drug (PAD) trends and any fee schedule changes not modeled by DOM's payment methodology development (PMD) vendor. **This does not include the impacts of fee schedule changes modeled by DOM's PMD vendor for inpatient, outpatient, and certain physician services. We will update capitation rates for these changes once the data is available.** Please see Section IV for more information on the fee schedule changes currently modeled.

- Throughout CY 2022, DOM transitioned individuals for whom Medicaid eligibility would have lapsed absent the CCR from the CCOs into FFS Medicaid. In addition, the continuous coverage requirement ended on March 31, 2023 and DOM started redeterminations in April 2023, with disenrollments of ineligible recipients

This report assumes the reader is familiar with the State of Mississippi's MississippiCAN program, its benefits, and rate setting principles. The report was prepared solely to provide assistance to DOM to set SFY 2025 capitation rates for the MississippiCAN program. It may not be appropriate for other purposes. Milliman does not intend to benefit, and assumes no duty or liability to, other parties who receive this work. This material should only be reviewed in its entirety.

starting in July 2023. During the official redetermination for individuals, there were multiple beneficiaries that had been moved from the CCOs into FFS initially that maintained Medicaid eligibility and subsequently were moved back into MississippiCAN, resulting in steady CCO enrollment increases throughout CY 2023 and into CY 2024. Given the changes in historical enrollment, Milliman developed a population acuity adjustment based on population risk scores to estimate the relative acuity of the base period to the projected SFY 2025 population. Across all rate cells, this population acuity adjustment increased capitation rates by 0.6%. Please see Section IV for a further description of the population acuity adjustment.

- SFY 2024 capitation rates included an adjustment reflecting estimated changes in testing, treatment, and vaccination costs for COVID-19, influenza, and RSV. We performed a similar analysis for SFY 2025 capitation rates reviewing actual experience during CY 2023 to inform our new baseline costs for COVID-19, influenza, and RSV. The change to use these new adjustments increased the overall rate by 0.5%, as shown in Table 3.

- Starting January 1, 2024, eligible members with Hemophilia or Von Willebrand disease transitioned from FFS into MississippiCAN. Historically this population was carved-out of MississippiCAN due to the relatively high medical costs associated with these conditions, as well as the infrequent and non-uniform distribution of members across the CCOs. The SFY 2025 capitation rates include the estimated costs of adding this population to MississippiCAN for a full year (rather than six months as reflected in the restated SFY 2024 capitation rate described above). Across all rate cells, this restatement increased capitation rates by approximately 0.1%.

- Per SB 2212, postpartum coverage extended from 60 days to 12 months for members who gave birth on or after April 1, 2023, such that the first enrollment month under the coverage extension was July 2023. An adjustment to account for the estimated cost differential between the prior coverage and the additional 10 months of postpartum coverage was included in the SFY 2024 capitation rates. Milliman updated this analysis for SFY 2025 and the resulted in an overall decrease in SFY 2025 capitation rates by 0.7% on a PMPM basis across all rate cells due to a higher percentage of membership in SFY 2025 in these newly covered postpartum months compared to SFY 2024 when this additional coverage was ramping up throughout the year.

- Per HB657, SFY 2025 MississippiCAN restorative dental services will be reimbursed at a rate 5.0% greater than in SFY 2024. Across all rate cells, this amounts to a slight increase to capitation rates.

- Changes to administrative expenses on a PMPM basis result in a decrease to the rate of approximately 0.1%, based upon CCO administrative expenses for CY 2022 trended to SFY 2025. A positive rate change in Table 3 indicates that the administrative costs increased as a percentage of the overall rate (i.e., administrative costs trended at a higher percentage than the overall rate). The overall PMPM for administrative expenses decreased 3.3% from the SFY 2024 allowance, comprised of a fixed administrative expense decrease from $11.17 PMPM in the SFY 2024 rate to $10.81 PMPM in the SFY 2025 rate, and a variable administrative expense decrease from $26.07 in the SFY 2024 rate to $25.21 in the SFY 2025 rate.

- As mentioned above, certain pharmacy expenses are expected to be paid by DOM's PBA rather than the CCOs. As these services will not be administered by the CCOs, Milliman reduced the SFY 2025 administrative cost levels to account for this change, based on splits of PBM related costs provided by DOM and the CCOs, which show that approximately 15% of prior PBM costs are related to duties that will be retained by the CCOs in SFY 2025. The change decreased overall capitation rates by 0.7% or an additional 7.5% ($2.72) on a PMPM basis when aggregated using CY 2022 member months.

The rate change included in Table 2 does not include the impact of changes in directed payments from SFY 2024 to SFY 2025. The following changes in directed payments are expected for SFY 2025:

- The total MHAP payment across all MississippiCAN members increases from $1.522 billion in SFY 2024 to $1.566 billion in SFY 2025.

- The total MAPS payment decreases from $39.4 million in SFY 2024 to $32.9 million in SFY 2025.

- The TREAT payment amount increases from $20.6 million in SFY 2024 to $25.3 million in SFY 2025.

Please see Section IV of this report for more information on changes to the directed payments for SFY 2025.

This report assumes the reader is familiar with the State of Mississippi's MississippiCAN program, its benefits, and rate setting principles. The report was prepared solely to provide assistance to DOM to set SFY 2025 capitation rates for the MississippiCAN program. It may not be appropriate for other purposes. Milliman does not intend to benefit, and assumes no duty or liability to, other parties who receive this work. This material should only be reviewed in its entirety.

CAPITATION RATE CHANGE BY RATE CELL

Rate changes vary by capitation rate cell as shown in Table 4, which compares SFY 2025 capitation rates to SFY 2024 capitation rates, on a similar basis as Table 3. The level of detail for the rate change included in Table 3 above is shown by rate cell in Exhibit 5.

Table 4
Mississippi Division of Medicaid
MississippiCAN Capitation Rates
Summary of Statewide SFY 2025 Rate Change[1]

Rate Cell	Overall Rate Change	Excluding Program Changes[2]	Excluding COVID-19 Adjustments[3]
Non-Newborn SSI / Disabled	-5.6%	2.2%	-4.8%
Breast and Cervical Cancer	17.4%	18.0%	18.1%
MA Adult	-11.9%	-11.2%	-3.0%
Pregnant Women	-19.7%	-3.7%	-22.6%
SSI / Disabled Newborn	-12.2%	-11.7%	-14.1%
Non-SSI Newborns 0 to 2 Months	3.5%	4.0%	1.4%
Non-SSI Newborns 3 to 12 Months	12.9%	10.0%	12.2%
Foster Care	1.7%	2.3%	-1.4%
MYPAC	-5.7%	-5.2%	-9.3%
MA Children	4.0%	4.9%	6.3%
Quasi-CHIP	3.8%	4.6%	6.5%
Total - Aggregated with CY 2022 MMs	**-2.4%**	**1.3%**	**-1.0%**

[1] Rate changes exclude MHAP, MAPS, TREAT, and are prior to the application of the quality withhold or VBP.
[2] PDL and dental reimbursement changes have been excluded from this calculation.
[3] COVID-19 adjustments include the acuity change resulting from the member shift to FFS and seasonal viruses.

DATA RELIANCE AND IMPORTANT CAVEATS

Milliman has developed certain models to estimate the values included in this report. The intent of the models was to estimate SFY 2025 capitation rates. We have reviewed the models, including their inputs, calculations, and outputs for consistency, reasonableness, and appropriateness to the intended purpose and in compliance with generally accepted actuarial practice and relevant actuarial standards of practice (ASOPs).

The models rely on data and information as input to the models. We used CCO encounter data and CCO financial reporting for January 2022 to December 2022 with runout through June 2023, historical and projected reimbursement information, fee schedules, and other information from DOM, MississippiCAN CCOs, Gainwell Technologies, Myers and Stauffer, and CMS to calculate the preliminary MississippiCAN capitation rates shown in this report. If the underlying data used is inadequate or incomplete, the results will be likewise inadequate or incomplete. Please see Appendix E for a full list of the data relied upon to develop the SFY 2025 base data.

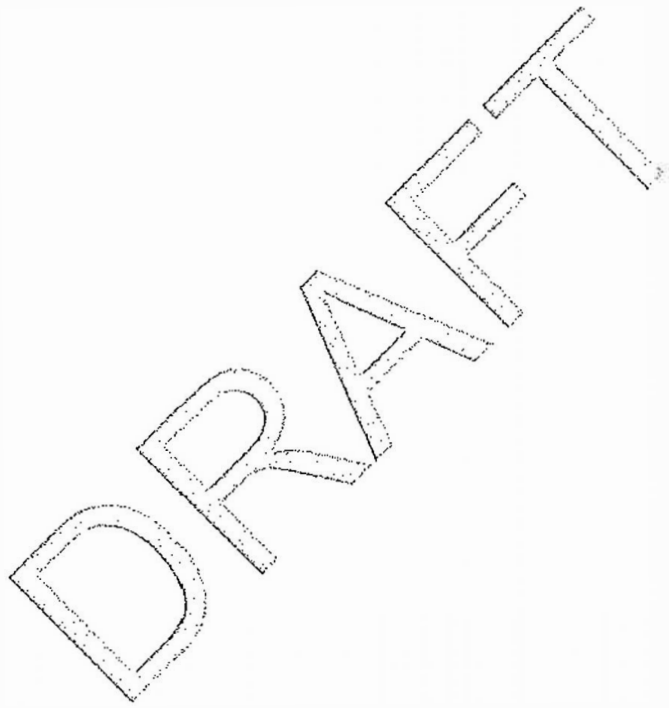
Differences between the capitation rate and actual experience will depend on the extent to which future experience conforms to the assumptions made in the capitation rate calculations. It is certain that actual experience will not conform exactly to the assumptions used. Actual amounts will differ from projected amounts to the extent that actual experience is better or worse than expected.

Our report is intended for the internal use of DOM to review the preliminary MississippiCAN capitation rates for SFY 2025. The report and the models used to develop the values in this report may not be appropriate for other purposes. We anticipate the report will be shared with contracted CCOs and other interested parties. Milliman does not intend to benefit, and assumes no duty or liability to, other parties who receive this work. It should only be distributed and reviewed in its entirety. These capitation rates may not be appropriate for all CCOs. Any CCO considering participating in MississippiCAN should consider their unique circumstances before deciding to contract under these rates.

The results of this report are technical in nature and are dependent upon specific assumptions and methods. No party should rely on these results without a thorough understanding of those assumptions and methods. Such an understanding may require consultation with qualified professionals.

This report assumes the reader is familiar with the State of Mississippi's MississippiCAN program, its benefits, and rate setting principles. The report was prepared solely to provide assistance to DOM to set SFY 2025 capitation rates for the MississippiCAN program. It may not be appropriate for other purposes. Milliman does not intend to benefit, and assumes no duty or liability to, other parties who receive this work. This material should only be reviewed in its entirety.

Jill Bruckert and Katarina Lorenz are consulting actuaries for Milliman, members of the American Academy of Actuaries, and meet the Qualification Standards of the Academy to render the actuarial opinion contained herein. To the best of their knowledge and belief, this report is complete and accurate and has been prepared in accordance with generally recognized and accepted actuarial principles and practices.



This report assumes the reader is familiar with the State of Mississippi's MississippiCAN program, its benefits, and rate setting principles. The report was prepared solely to provide assistance to DOM to set SFY 2025 capitation rates for the MississippiCAN program. It may not be appropriate for other purposes. Milliman does not intend to benefit, and assumes no duty or liability to, other parties who receive this work. This material should only be reviewed in its entirety.

II. MISSISSIPPICAN BACKGROUND

MississippiCAN, a Coordinated Care Program for Mississippi Medicaid beneficiaries, was designed to address the following goals:

- Improve access to needed medical services – This goal is accomplished by connecting the targeted beneficiaries with a medical home, increasing access to providers, and improving beneficiaries' use of primary and preventive care services.
- Improve quality of care – This goal is accomplished by providing systems and supportive services, including disease state management and other programs that will allow beneficiaries to take increased responsibility for their health care.
- Improve efficiencies and cost effectiveness – This goal is accomplished by contracting with CCOs on a capitated basis to provide services through an efficient, cost-effective system of care.

TARGET POPULATION

MississippiCAN was implemented in all 82 counties in the State of Mississippi for all eligible beneficiaries beginning January 1, 2011 for targeted, high cost Medicaid beneficiaries defined by these categories of eligibility (COEs):

- COE001 – SSI via SDX
- COE019 – Disabled children at home
- COE025 – Working Disabled
- COE026 – DHS CWS Foster Care
- COE027 – Breast-Cervical

On December 1, 2012 the eligible population of MississippiCAN was expanded to include all Foster Care children, Non-SSI Newborns 0 to 12 months, MA Adults, and Pregnant Women, as defined by the following categories of eligibility and age requirements:

- COE003 – DHS-IV-E-Medicaid
- COE075 – Parents / Caretakers of minor children
- COE088 – Pregnant Women, 185% FPL – Ages 8+
- Non-SSI Newborns – Ages 0 to 12 months
  - COE003 – DHS IV-E Medicaid
  - COE026 – DHS Foster Care
  - COE071 – Newborn age 0 to 1 with income at or below 185% FPL
  - COE088 – Pregnant Women, 185% FPL

Effective December 1, 2012, all MississippiCAN populations were mandatory enrolled except SSI children, disabled children at home, Foster Care children, and members of the Mississippi Band of Choctaw Indians.

Between December 2014 and July 2015, the eligible population of MississippiCAN was expanded again to include children as defined by the following categories of eligibility, age, and income requirements:

- COE072 – Children age 1 to 5 with income at or below 133% FPL
- COE073 – Children age 6 to 19 with income at or below 100% FPL
- COE074 – Children age 6 to 19 with income between 100% and 133% FPL who would have qualified for CHIP under pre-Affordable Care Act rules

Effective January 1, 2014, COE074 children previously eligible for CHIP with income eligibility between 100% and 133% FPL became Medicaid eligible rather than CHIP eligible due to income eligibility outlined in the Affordable Care Act. These children were moved into MississippiCAN effective December 1, 2014 and referred to as "Quasi-CHIP" children.

This report assumes the reader is familiar with the State of Mississippi's MississippiCAN program, its benefits, and rate setting principles. The report was prepared solely to provide assistance to DOM to set SFY 2025 capitation rates for the MississippiCAN program. It may not be appropriate for other purposes. Milliman does not intend to benefit, and assumes no duty or liability to, other parties who receive this work. This material should only be reviewed in its entirety.

The children covered under the above COEs previously covered in the Medicaid program are called "MA Children." DOM phased in enrollment from FFS into MississippiCAN by July 2015, with most children transitioned between May 2015 and July 2015.

Effective December 1, 2015, in conjunction with the movement of inpatient services into MississippiCAN, enrollment procedures were changed to enroll newborns in MississippiCAN on the day of their birth. Previously, newborns were not enrolled until, on average, their second month of life due to a delay in assigning a Medicaid identification number and the process to enroll them in a CCO.

Starting October 1, 2018, Severely Emotionally Disturbed (SED) Children were covered by MississippiCAN. These children are identified with the lock-in code of "SED," which is effective for one year after determination. To receive Mississippi Youth Program Around the Clock (MYPAC) services, a child must have an SED lock-in code. This population was referred to as "SED Children" prior to SFY 2021. Starting in SFY 2021, this population is referred to as the "MYPAC" rate cell.

Effective July 1, 2023, postpartum coverage extends from 60 days to 12 months. Previously, at 60 days postpartum individuals in the Pregnant Women rate cell had their Medicaid eligibly redetermined and unless they had a qualifying reason to remain in Medicaid (such as meeting eligibility qualifications for the MA Adult rate cell) the member was disenrolled from MississippiCAN. After July 1, 2023 this redetermination will not occur until the end of the 12 months of postpartum coverage.

Throughout this report, we frequently apply the same adjustments to rate cells with similar demographics. The rate cell groups summarized in Table 5 identify the rate cells contained within each grouping referenced throughout this report.

Table 5
Mississippi Division of Medicaid
MississippiCAN Capitation Rates
Rate Cell Groupings

Rate Cells	Rate Cell Grouping
Non-Newborn SSI / Disabled	SSI
Breast and Cervical Cancer	SSI
MA Adult	Adults
Pregnant Women	Adults
SSI / Disabled Newborn	Children
Non-SSI Newborns 0 to 2 Months	Children
Non-SSI Newborns 3 to 12 Months	Children
Foster Care	Children
MYPAC	Children
MA Children	Children
Quasi-CHIP	Children

COVERED SERVICES

When MississippiCAN was first established in January 2011, three key services were initially excluded from the program. Over time, each has been moved from being covered by FFS to MississippiCAN as follows:

- Behavioral health services – Rolled into MississippiCAN effective December 1, 2012
- Non-emergent transportation services – Rolled into MississippiCAN effective July 1, 2014
- Inpatient services – Rolled into MississippiCAN effective December 1, 2015

Effective October 1, 2018, MississippiCAN included costs for psychiatric residential treatment facility (PRTF) stays. Historically, these costs were carved out of MississippiCAN, although members were not dis-enrolled from MississippiCAN.

Starting July 1, 2019, services provided at institutions for mental disease (IMD) are covered as part of the MississippiCAN program.

This report assumes the reader is familiar with the State of Mississippi's MississippiCAN program, its benefits, and rate setting principles. The report was prepared solely to provide assistance to DOM to set SFY 2025 capitation rates for the MississippiCAN program. It may not be appropriate for other purposes. Milliman does not intend to benefit, and assumes no duty or liability to, other parties who receive this work. This material should only be reviewed in its entirety.

Effective January 1, 2024, members diagnosed with Hemophilia or Von Willebrand disease are included in the MississippiCAN program. These members were previously carved out to the FFS program.

Effective July 1, 2023, Zolgensma will be included as a covered treatment for members with spinal muscular atrophy. Previously this drug was carved out and CCOs were reimbursed for any incurred costs.

Effective July 1, 2024 pharmacy services will no longer be paid by the CCOs and will instead be paid through DOM's PBA.

CCOs historically have not provided services not covered under MississippiCAN "in lieu of" covered services.

ENROLLMENT PERIOD

All beneficiaries have the ability to choose the CCO in which to enroll. Enrolled beneficiaries will have an open enrollment period during the 90 days following their initial enrollment in a CCO, during which they can enroll in a different CCO "without cause" and an open enrollment period from October to December of each year. During this time period, beneficiaries may choose to change their CCO.

Various "for cause" reasons for disenrollment at other times incorporate federal requirements, such as: providers that do not (for religious or moral reasons) offer needed services; not all related services are available in the plan's network; or the plan lacks providers experienced in dealing with the enrollee's health care needs.

Eligibility criteria for MississippiCAN are the same as the eligibility criteria for Mississippi Medicaid. To receive enhanced federal funding during the COVID-19 PHE, DOM paused disenrollment of members from the Mississippi Medicaid program who normally would no longer be eligible for Medicaid services. Where readily identifiable (e.g., individuals aging out of the program eligibility requirements or pregnant women reaching 60 days postpartum), individuals who would have lost normal Medicaid eligibility in the MississippiCAN program were transitioned to FFS for the remainder of the CCR. Beginning in June 2021, DOM began transitioning individuals for whom Medicaid eligibility would have lapsed absent the CCR from CCOs into FFS Medicaid. Following the end of the CCR, these members Medicaid eligibility will be redetermined; members may be re-enrolled in managed care or may be disenrolled from Medicaid entirely. These redeterminations began in SFY 2023 and continue through SFY 2024.

The CCOs do not have the ability to directly market to targeted beneficiaries. DOM provides information about choice of CCOs and enrolls the beneficiaries into their chosen CCO. The Medicaid Fiscal Agent provides some specific services of an enrollment broker to accomplish these tasks.

DRAFT

This report assumes the reader is familiar with the State of Mississippi's MississippiCAN program, its benefits, and rate setting principles. The report was prepared solely to provide assistance to DOM to set SFY 2025 capitation rates for the MississippiCAN program. It may not be appropriate for other purposes. Milliman does not intend to benefit, and assumes no duty or liability to, other parties who receive this work. This material should only be reviewed in its entirety.

III. BASE DATA DEVELOPMENT

This section of the report describes the development of the base data used for the preliminary SFY 2025 MississippiCAN capitation rates.

METHODOLOGY OVERVIEW

The base data for the SFY 2025 capitation rates was developed by summarizing eligibility, encounter claims, and financial claim data for CY 2022 MississippiCAN enrollees. Exhibit 9 contains databooks summarizing encounter data for CY 2022 for all rate cells. Please note, the total and PMPM costs shown in the 2022 databook include missing data. The total and PMPM costs in the 2022 databooks tie to the starting totals on Exhibit 1 if missing data is removed from the databook.

The remainder of this section is a high-level description of the processing for eligibility, encounter claim data, and financial claim data for CY 2022 MississippiCAN enrollees. In addition, any adjustments made to the raw data are discussed in this section and shown in Exhibit 1. Please refer to Appendices A and B of this report for additional information on the validation and processing of these data sources.

Membership

Member months by rate cell and region in CY 2022 were summarized from the detailed Medicaid eligibility data, excluding populations not covered by MississippiCAN and individuals that opted out of the program (where applicable). These enrollment counts were validated against enrollment information provided by the CCOs. In total, the enrollment in the eligibility files is 0.4% lower than reported by the CCOs.

Adjustments are applied to the starting enrollment records to reflect changes resulting from several adjustments described below, including:

- IMD removal: Per CMS guidelines, eligibility and claims are removed for members with IMD stays of over 15 days in a given month.
- MYPAC membership reallocation: Some members were not correctly assigned a 'SED' lock-in code during CY 2022. Although this does not impact overall enrollment, membership is shifted from other children rate cells to the MYPAC rate cell.
- SSI Children Formerly Moved to FFS Due to PRTF Stay: Membership and claims information for these members was pulled from FFS data and added to the CY 2022 MississippiCAN eligibility and encounter claims data.

Row (a) of Exhibit 1 includes the adjusted CY 2022 member months included in base data development.

Claim Data

DOM and Milliman go through extensive data validation processes to review CCO submitted encounter data. DOM regularly monitors encounter claims compared to cash disbursement journals (CDJs) to ensure the timeliness and completeness of submitted encounters and works with Myers and Stauffer to identify the correct original or final claim to keep in each claim string. Milliman relied on this claim status identification process to remove duplicates and identify denied claims that are anticipated to be resubmitted and accepted, as described in Appendix B.

As part of rate development, Milliman requests financial reporting data from each CCO. This financial reporting data was reconciled to each CCO's 2022 audited NAIC financial statement. After several rounds of questions to clarify, adjust, and confirm understanding of the reported financial information, Milliman compared the encounter data to the financial reporting data, for paid claims and subcapitated claims. This comparison excludes estimates for incurred but not reported (IBNR) claims and adjusts for any claims that were identified as missing from the processed encounter data. To align the financial templates and encounter data on a comparable basis, we performed this reconciliation exercise using CY 2022 data with run-out through June 2023.

This report assumes the reader is familiar with the State of Mississippi's MississippiCAN program, its benefits, and rate setting principles. The report was prepared solely to provide assistance to DOM to set SFY 2025 capitation rates for the MississippiCAN program. It may not be appropriate for other purposes. Milliman does not intend to benefit, and assumes no duty or liability to, other parties who receive this work. This material should only be reviewed in its entirety.

As discussed above, DOM transitioned to a new data vendor during CY 2022. In the process of reviewing the CY 2022 data from the new data vendor, Gainwell, we noted several issues, including duplicate claims. We are still working with DOM and Gainwell to determine a possible resolution for this issue. Therefore, this base data report includes an adjustment to calibrate encounters to CCO reported financial levels at a high-level service category level. This adjustment is discussed in more detail below.

Additionally, starting on July 1, 2024, DOM expects to enter into an arrangement with their PBA in which certain pharmacy claims will be paid through the PBA. As such, we identified and removed the associated pharmacy claims from the CY 2022 base data for the purpose of developing SFY 2025 capitation rates. Please see Appendix B for a further description of the associated pharmacy services.

Encounter to Financial Adjustment

In the development of the base data the following items are noted:

- As the CY 2022 financial data was reported using the SFY 2024 categories of service definitions, we compared financial to encounter data utilizing the SFY 2024 level of granularity, and the following notes reflect this classification.
- Overall, the paid amounts in the encounters reconcile reasonably well to the paid amounts shown in the CCO financial reporting for the MississippiCAN populations, particularly for inpatient, outpatient, physician, and other services. As Table 6 shows, in total encounter data was 0.32% higher than financial data.
- At a category of service and rate cell level, there was a greater variance between encounter data and financial reporting, particularly for the inpatient and dental categories of service, which may be most impacted by the duplicate claim issues noted above. Therefore, when calculating and applying the financial to encounter data adjustments we applied separate adjustments for inpatient and dental services. All other service categories receive the same adjustment.

Table 6
Mississippi Division of Medicaid
SFY 2025 MississippiCAN Capitation Rate Development
Comparison of Financial and Encounter Data

Difference of Encounters and Financials (% of Encounters)	
OP / Physician / Other Services	0.69%
IP Services	-2.13%
Dental Services	-2.92%
All Services	**-0.32%**

Encounter data for all three CCOs is combined to summarize CY 2022 claim experience for MississippiCAN enrollees. The financial reporting expenditures for all CCOs were combined to perform the encounter validation outlined above, as well as to develop the following adjustments to apply to the encounter data:

- Removal of costs that would be paid or recouped through a third party.
- Addition of IBNR expenses not yet included in encounters.
- Addition of claims paid by the CCOs that are not yet reflected in the encounter system.

All experience used to develop the base period data for the SFY 2025 capitation rates is on a net basis and excludes any member cost sharing.

Row (b) of Exhibit 1 includes the CY 2022 total service costs from the encounter data. Row (c) converts the total service costs to a PMPM basis. To reflect the differences between claims in the financial reporting and the encounter data, the financial to encounter data adjustments are applied on row (e) of Exhibit 1. Given duplicate claims and other encounter data issues noted by Gainwell and DOM, this adjustment calibrates overall encounter claims to levels reported in the financial templates.

This report assumes the reader is familiar with the State of Mississippi's MississippiCAN program, its benefits, and rate setting principles. The report was prepared solely to provide assistance to DOM to set SFY 2025 capitation rates for the MississippiCAN program. It may not be appropriate for other purposes. Milliman does not intend to benefit, and assumes no duty or liability to, other parties who receive this work. This material should only be reviewed in its entirety.

MYPAC Member Identification Adjustment

Beginning in July 2021, the assignment of the "SED" lock-in flag was applied inconsistently for some members. The lock-in flag is the primary means of identifying members in the MYPAC rate cell, and as such, using our current rate cell methodology, as outlined in Appendix A, some members were not assigned to the MYPAC rate cell and instead assigned to other children rate cells. We queried our enrollment records and claims data to identify members who should have been identified via the "SED" lock-in flag but were not and reassigned them accordingly. We reassigned membership and corresponding claims amounts for 3,819 member months totaling approximately $9.7 million from other children rate cells to the MYPAC rate cell.

The member months shown in row (a) of Exhibit 1 reflects the reassignment of these member months.

The adjustment to reassign the costs between rate cells is shown in Exhibit 1 in row (d).

Missing Data Adjustment

A separate adjustment was made to account for payments made by the CCOs that are not reflected in the detailed encounter data or cannot be reasonably applied to a specific claim (e.g., provider bonuses or settlements). These claim amounts are not included in the detailed encounter data after the processing outlined in Appendix B. Each CCO provided separate financial reporting to support and validate the amounts reported for claims not appearing in encounters. As the CY 2022 financial data was reported using the SFY 2024 categories of service definitions, we developed the adjustments utilizing the financial data at the SFY 2024 level of granularity and applied the resulting adjustment factors to all corresponding breakout categories of service. The detailed financial reporting provided by the CCOs included splits by region and rate cell, which were used to allocate missing data on Exhibit 1.

Overall, the base data is increased 0.5% on a PMPM basis for missing data.

The aggregate adjustment for all missing data described above is shown in Exhibit 1 in row (f).

IBNR Adjustment

The adjustment for IBNR claims as of June 30, 2023 uses the best estimate IBNR claims provided by each of the CCOs in their financial reporting. As the CY 2022 financial data was reported using the SFY 2024 categories of service definitions, we developed the adjustments utilizing the financial data at the SFY 2024 level of granularity and applied the resulting adjustment factors to all corresponding breakout categories of service.

We performed the following high-level reasonability checks to validate these estimates:

- Data, including IBNR estimates, was reported on a quarterly basis by each CCO. We reviewed the reported IBNR by quarter to determine that there was a reasonable pattern throughout the year (i.e., IBNR amounts held for Q1 2022 were significantly lower than Q4 2022).
- IBNR estimates among the CCOs were reviewed to validate that they were approximately the same as a percentage of total claims, where appropriate.
- IBNR estimates by category of service are approximately the same as a percentage of total claims as IBNR adjustments applied to the MississippiCAN data in prior years after accounting for differences in runout period between years.

Overall, the base data increased by 0.7% on a PMPM basis for IBNR claims.

This adjustment is shown in Exhibit 1 in row (g).

Non-Covered Services

As noted above, Milliman is aware of a known data issue related to identifying some non-covered physician services. Due to this known issue, we developed an estimate for CY 2022 non-covered physician services using percentages from the CY 2021 encounter data.

This report assumes the reader is familiar with the State of Mississippi's MississippiCAN program, its benefits, and rate setting principles. The report was prepared solely to provide assistance to DOM to set SFY 2025 capitation rates for the MississippiCAN program. It may not be appropriate for other purposes. Milliman does not intend to benefit, and assumes no duty or liability to, other parties who receive this work. This material should only be reviewed in its entirety.

Additionally, Milliman summarized the costs of home health services exceeding CY 2022 service limits in the encounter data using the definitions provided by DOM, as detailed in Appendix B.

The combined amount for physician and home health services estimated to exceed CY 2022 service limits, which totaled approximately 0.2% of CY 2022 MississippiCAN service costs, were removed from CY 2022 base data at the rate cell level of detail. Service limits do not apply up to age 21, thus, base period costs were not adjusted for these members.

The adjustment to remove estimated non-covered services in CY 2022 is shown in Exhibit 1 in row (h).

Zolgensma Removal

In CY 2022, Zolgensma, a gene therapy used to treat Spinal Muscular Atrophy, was carved-out of managed care and reimbursed separately by DOM on a case-by-case basis. We removed three Zolgensma claims totaling approximately $6.5 million from the CY 2022 base data as the CCOs were not at-risk for these claims in CY 2022. Across all rate cells, this reduced base data by 0.4%.

The adjustment to remove Zolgensma treatments in CY 2022 is shown in Exhibit 1 in row (i).

Please note that starting on July 1, 2023, the Zolgensma carve-out was reversed and CCOs are at-risk for these treatments, subject to the High-Cost Pharmacy Risk Corridor. We include estimates of projected Zolgensma treatments as part of the gene therapy drug coverage adjustment in Exhibit 2, which is detailed in Section IV of this report.

Third-Party Liability (TPL) Recoveries

The CCOs provided Milliman with a summary of recoveries for TPL payments related to claims incurred in CY 2022 and recovered through December 2022. Using CY 2019 through CY 2021 data, Milliman reviewed the portion of total CY 2019 through CY 2021 recoveries recovered after the end of each year. The recovery patterns looked noticeably different in CY 2020 and CY 2021, possibly because of the COVID-19 pandemic. Therefore, we relied on CY 2019 data to estimate total claim recoveries for services incurred in CY 2022, but not yet reflected in the CY 2022 base data. It is assumed that these outstanding TPL recoveries will reduce ultimate CY 2022 paid totals.

We removed the total TPL amounts as a percentage of total paid claims across all rate cells and categories of services from the CY 2022 base data. Across all rate cells, these TPL recoveries amounted to a 0.2% reduction to CY 2022 base data. We do not have information to apply this estimate at either a rate cell or category of service level, and therefore apply a uniform adjustment for the estimate of TPL recoveries.

This adjustment is shown in Exhibit 1 in row (j).

IMD (Institution for Mental Disease) Stays Beyond 15 Days

Per CMS regulations, services rendered at an IMD beyond 15 days in a given month for individuals aged 21 to 64 cannot be covered by Medicaid. CMS requires all claims (not just IMD claims) incurred by members and the enrollment records for those same months be removed from base data for the month with the IMD stay exceeding 15 days. The enrollment shown in row (a) of Exhibit 1 is after the removal of these 93 member months. An additional adjustment was made to remove all claims for these members in the impacted months, resulting in approximately a 0.1% reduction to the CY 2022 encounter data.

This adjustment is shown in Exhibit 1 in row (k).

IMD Unit Cost Adjustment

Some IMD stays for 15 days or fewer for individuals aged 21 to 64 will be covered under MississippiCAN. We adjusted the unit cost for similar claims in the CY 2022 experience to use DOM's fee schedule for these services. These unit cost adjustments resulted in a cost increase of approximately $700 in total.

This adjustment is shown in Exhibit 1 in row (l).

This report assumes the reader is familiar with the State of Mississippi's MississippiCAN program, its benefits, and rate setting principles. The report was prepared solely to provide assistance to DOM to set SFY 2025 capitation rates for the MississippiCAN program. It may not be appropriate for other purposes. Milliman does not intend to benefit, and assumes no duty or liability to, other parties who receive this work. This material should only be reviewed in its entirety.

SSI Children Formerly Moved to FFS Due to PRTF Stay

From October 2018 through May 2022, DOM moved certain SSI children from COE 001 to COE 005, which is not a MississippiCAN covered population, due to a psychiatric residential treatment facility (PRTF) stay. In SFY 2025, these members will remain in COE 001 during their PRTF stay, and MississippiCAN CCOs will be responsible for expenses incurred during these stays.

We reviewed the encounter data along with a supplemental enrollment extract provided by DOM identifying the members impacted during CY 2022 and found 63 members totaling 316 member months that were moved to COE 005 from January to May 2022. The enrollment shown in row (a) of Exhibit 1 reflects the inclusion of these member months. An additional adjustment was made to add claims for these members in the impacted months to the Non-Newborn SSI / Disabled rate cell. Overall, the base data increased by 0.3% on a PMPM basis for this adjustment.

This adjustment is shown in Exhibit 1 in row (m).

Adjusted CY 2022 PMPM Costs

Total 2022 base period PMPM costs by rate cell are shown in the final row of Exhibit 1.

DRAFT

This report assumes the reader is familiar with the State of Mississippi's MississippiCAN program, its benefits, and rate setting principles. The report was prepared solely to provide assistance to DOM to set SFY 2025 capitation rates for the MississippiCAN program. It may not be appropriate for other purposes. Milliman does not intend to benefit, and assumes no duty or liability to, other parties who receive this work. This material should only be reviewed in its entirety.

IV. PROJECTED SFY 2025 CAPITATION RATES

Many adjustments must be applied to the base period data to develop SFY 2025 capitation rates. This section describes the adjustments applied to the base period data described in Section III to develop SFY 2025 capitation rates. These adjustments are applied in eight steps:

1. Trend costs from base period to SFY 2025.
2. Apply adjustments for population, program, and reimbursement methodology changes.
3. Include an allowance for CCO non-service expenses.
4. Adjust rates to reflect differences in geographic area by rate cell.
5. Apply quality withhold.
6. Adjust for CCO specific risk scores (if applicable).
7. Retrospectively adjust for directed payments.
8. Calculate risk corridor settlements.

Step 1: Trend Costs from Base Period to SFY 2025

Starting with the blended base data developed in Section III, we apply trend adjustments to project the base period to SFY 2025. Below, we describe each trend adjustment shown on Exhibit 2. The adjustments for non-pharmacy and pharmacy services for which the CCOs are responsible (physician administered drugs) are developed using differing methodologies, and therefore described separately in this section.

Non-Pharmacy Trend Overview

Our general approach to trend development for non-pharmacy categories of service is to consider known recent changes in provider reimbursement, along with historical PMPM trend values. We then develop utilization / service mix trends that produce targeted PMPM trends. We utilize this approach because it is frequently difficult to directly measure changes in utilization for services other than inpatient hospital and pharmacy over time due to differences in counting utilization "units."

Exhibits 7A to 7E include a historical trend summary of PMPM costs from January 2019 through September 2023 for each high-level population type and in total for the MississippiCAN program. This data has been normalized for the following to put it on a consistent basis across time:

- IBNR from the financial templates was added to the encounter data to review PMPM trends on a completed basis.
- Estimates of the impact of the following material program or reimbursement changes were removed for the applicable time periods. These changes are accounted for in separate adjustments in this report, and therefore, should not be included in data analyzed for trends.
  - Removal of Zolgensma claims
  - 5% assessment removal for OPPS services
  - Implementation of 5% assessment on non-OPPS services
  - OPPS reimbursement changes not related to the 5% assessment
  - PAD reimbursement changes
  - PRTF services
  - OP dental reimbursement change
  - GME carve out
  - NET reimbursement adjustment
  - Provider settlements
  - Financial to encounter adjustments
  - Emergency ambulance reimbursement increases

This report assumes the reader is familiar with the State of Mississippi's MississippiCAN program, its benefits, and rate setting principles. The report was prepared solely to provide assistance to DOM to set SFY 2025 capitation rates for the MississippiCAN program. It may not be appropriate for other purposes. Milliman does not intend to benefit, and assumes no duty or liability to, other parties who receive this work. This material should only be reviewed in its entirety.

- PMPMs at a rate cell level were aggregated using September 2023 membership into higher level population groupings and MississippiCAN in total. This removes the impact of membership mix changes across rate cells over time on the aggregate PMPMs.

- No adjustments were made to account for population acuity changes over time.

Table 7 below shows the annualized utilization trends assumed in SFY 2025 capitation rates. Please see Exhibit 12 for a summary of unit cost changes for each service category and rate cell. For the MYPAC rate cell, utilization trends for physician services are dampened relative to the trends shown for other children rate cells to reflect the high proportion of physician services obtained through the MYPAC providers, for which flat utilization trends were assumed. The impact of MYPAC reimbursement changes is reflected through a separate MYPAC fee schedule adjustment, shown on Exhibit 12.

Table 7
Mississippi Division of Medicaid
MississippiCAN Capitation Rates
CY 2022 to SFY 2025 Utilization Trends (Annualized)

	Population				
Service Category	SSI	BCCP	Adults	Children	Newborn
Inpatient Hospital - Maternity / Deliveries	1.0%	1.0%	1.0%	1.0%	1.0%
Inpatient Hospital - Psychiatric / Substance Abuse	5.0%	3.0%	2.0%	3.0%	0.0%
Inpatient Hospital - Other	5.0%	3.0%	2.0%	3.0%	0.0%
Outpatient Hospital - Emergency Room	0.0%	0.0%	0.0%	0.0%	0.0%
Outpatient Hospital - Pharmacy	2.0%	2.0%	1.5%	2.5%	2.5%
Outpatient Hospital - Other	5.0%	3.0%	2.0%	3.0%	3.0%
Physician - Maternity / Deliveries	1.0%	1.0%	1.0%	1.0%	1.0%
Physician - Psychiatric / Substance Abuse	6.0%	3.0%	2.0%	3.0%	3.0%
Physician - Other	5.5%	5.5%	2.0%	3.0%	2.0%
Dental	4.0%	4.0%	4.0%	4.0%	4.0%
Other	3.0%	3.0%	3.0%	3.0%	3.0%

The development of the utilization and unit cost trend assumptions is described below.

Utilization Trend for Non-Pharmacy Costs

Utilization trend reflects expected changes in:

- Demand for medical services
- Intensity or mix of medical services
- Provider practice patterns
- Provider coding changes

The following data sources were used to develop the utilization trend assumptions:

- Historical MississippiCAN specific trends as shown in Exhibits 7A through 7E, with limited credibility applied to trends during the COVID-19 pandemic.

- Emerging Q1 through Q3 2023 experience as reported by the CCOs was additionally summarized to review recent claim trend patterns by population. We adjusted the emerging experience for the following:

  - Acuity changes between Q1 through Q3 2023 and the final acuity projected for SFY 2025 (based on enrollment as of March 2024) for the MA Adult, MA Children, and Quasi-CHIP rate cells.

  - Reimbursement changes effective July 1, 2023 and projected reimbursement changes effective July 1, 2024 were applied to put reimbursement on a SFY 2025 basis.

- Experience from similar programs in other states.

This report assumes the reader is familiar with the State of Mississippi's MississippiCAN program, its benefits, and rate setting principles. The report was prepared solely to provide assistance to DOM to set SFY 2025 capitation rates for the MississippiCAN program. It may not be appropriate for other purposes. Milliman does not intend to benefit, and assumes no duty or liability to, other parties who receive this work. This material should only be reviewed in its entirety.

Table 8 below shows the adjusted Q1 through Q3 2023 PMPM costs for the largest population groups, as reported by the CCOs in their emerging CY 2023 financial template data. As described above, this data was adjusted to reflect the expected acuity of the population currently enrolled (as of March 2024) and adjusted to be on a SFY 2025 reimbursement basis. To help assess the reasonability of the trend assumptions selected above, we compared the adjusted Q1 to Q3 2023 PMPM costs for the largest populations to the projected service costs in SFY 2025 and the implied PMPM trend on an annualized basis between the emerging CY 2023 experience and projected SFY 2025 costs. The results are summarized below in Table 8.

Table 8
Mississippi Division of Medicaid
CY 2023 Emerging Experience

Rate Cell	Q1 2023 PMPM[1]	Q2 2023 PMPM[1]	Q3 2023 PMPM[1]	SFY 2025 PMPM[2,3]	Implied Annualized Trend From Q1 2023	Implied Annualized Trend From Q2 2023	Implied Annualized Trend From Q3 2023
Non-Newborn SSI / Disabled	$687.15	$725.24	$723.76	$737.34	3.8%	1.0%	1.4%
MA Adult	$301.85	$303.95	$306.02	$312.93	1.9%	1.8%	1.6%
MA Children / Quasi-CHIP	$163.52	$154.77	$164.99	$168.88	1.7%	5.5%	1.7%

[1] Adjusted for acuity, reimbursement, and program changes.
[2] Adjusted to remove estimated CGT costs and the impact of extended postpartum coverage for pregnant women.
[3] SFY 2025 PMPMs include estimated reimbursement changes from CY 2022 to SFY 2024, but do not include reimbursement changes from SFY 2024 to SFY 2025 in these preliminary rates."

The adjustment resulting from the selected utilization trends is shown in Exhibit 2A in row (b).

Unit Charge Trends for Non-Pharmacy Costs

The hospital inpatient, hospital outpatient, physician, and dental Medicaid FFS fee schedules are updated each year consistent with the following sources. DOM does not mandate provider reimbursement levels other than to require that reimbursement be at least as great as FFS for network providers. We assume that CCO reimbursement levels will move in tandem with changes to FFS reimbursement. Pursuant to SB2799 that was passed into Mississippi law on April 19, 2021, changes in reimbursement after July 1, 2021 will require legislative notification. HB657 was subsequently signed into law on April 19, 2022, allowing for changes in reimbursement rates as long as the payment methodology remains consistent. Based on direction from DOM, we are modeling fee schedule changes for each service category as noted below. Coverage for new codes and prohibition for billing on discontinued codes is allowed. We assumed the net impact of these latter two issues will be budget neutral but will reevaluate once data is available and adjust capitation rates, if needed. Unless otherwise noted, the fee schedule changes for prior years remained unchanged.

- Inpatient: DOM reimburses hospital inpatient claims using an APR-DRG methodology based upon the 3M grouper, which will be updated to reflect changes effective on July 1, 2024. The simulated impact of this change is not yet available from Myers and Stauffer (DOM's payment methodology vendor), but in aggregate the updates are expected to be budget neutral to overall program costs. In the interim, the unit cost trends continue to rely on the simulations provided by Conduent for SFY 2024 capitation rates showing the estimated impact of payment rate changes effective July 1, 2022 and July 1, 2023 using an underlying mix of CY 2021 claims. Given the updated base period for SFY 2025 capitation rates is CY 2022, which already includes the fee schedule updates effective July 1, 2022 for half the year, we dampened the impact of the projected July 1, 2022 fee schedule changes to apply to January to June 2022 claims only.

  The new simulations will be developed using a base data set of CY 2022 claims and we will have the ability to apply the unit cost trends at the new granular categories of service first introduced in the SFY 2025 rates. Once these new simulations are available, we will update the unit cost trends included in the SFY 2025 capitation rates.

  Table 9 below shows the assumed annualized inpatient charge trends from CY 2022 to SFY 2025 by rate cell grouping assuming a 0% change for July 1, 2024.

This report assumes the reader is familiar with the State of Mississippi's MississippiCAN program, its benefits, and rate setting principles. The report was prepared solely to provide assistance to DOM to set SFY 2025 capitation rates for the MississippiCAN program. It may not be appropriate for other purposes. Milliman does not intend to benefit, and assumes no duty or liability to, other parties who receive this work. This material should only be reviewed in its entirety.

Table 9 Mississippi Division of Medicaid Inpatient Unit Cost Trends for CY 2022 to SFY 2025	
Population	**Inpatient**
SSI	-1.83%
Adult	1.54%
Newborn[1]	3.34%
Children[2]	-1.04%

[1] Newborn include SSI / Disabled Newborns and Non-SSI Newborns 0 to 2 Months.
[2] Children include all other children rate cells.

PRTFs are not paid using the APR-DRG methodology and instead rely on a separate fee schedule with per diem payment rates for each facility. To calculate the impact of payment rate changes between the base period and SFY 2025 we applied the increased payment rates for each facility to the applicable time periods. Please see Exhibit 12 for more information about the percentage of base period data impacted and the annualized trend applied as a result of these fee schedule updates.

- **Outpatient:** DOM reimburses hospital outpatient claims using the Medicare APC methodology updated on July 1 of each year. Similar to inpatient services, the simulation of reimbursement changes for OPPS services effective July 1, 2024 is not yet available from Myers and Stauffer, but we expect the impact to be budget neutral for the MississippiCAN program overall. In the interim, the unit cost trends continue to rely on the simulations provided by Conduent for SFY 2024 capitation rates showing the estimated impact of payment rate changes effective July 1, 2023 using an underlying mix of CY 2021 claims. No payment change was made for July 1, 2022 due to the payment rate freeze.

  The new simulations will be developed using a base data set of CY 2022 claims, and we will have the ability to apply the unit cost trends at the new granular categories of service first introduced in the SFY 2025 rates. Once these new simulations are available, we will update the unit cost trends included in the SFY 2025 capitation rates.

  Not all services included in our outpatient service category are billed using the OPPS payment methodology, and therefore we dampened the impact of the OPPS reimbursement changes to apply to applicable services only. Fee schedule changes for home health and some ambulatory surgical center (ASC) services are also included in the outpatient service category.

  Table 10 shows the assumed annualized outpatient charge trends for non-pharmacy services from CY 2022 to SFY 2025 by rate cell grouping, assuming a 0% increase for the OPPS payment rate changes effective July 1, 2024. Similar to the process described above for PRTF, fee schedule changes for these services are reflected as a charge trend calculated by comparing the fee schedules in place during the base period and projection periods, weighted by the applicable procedure codes. Please see Exhibit 12 for more information about the percentage of base period data impacted and the annualized trend applied as a result of these fee schedule updates.

Table 10 Mississippi Division of Medicaid Outpatient Unit Cost Trends for CY 2022 to SFY 2025	
Population	**Outpatient**
SSI	1.38%
Adult	2.04%
Newborn[1]	2.54%
Children[2]	2.54%

[1]Newborn include SSI / Disabled Newborns and Non-SSI Newborns 0 to 2 Months.
[2]Children include all other children rate cells.

This report assumes the reader is familiar with the State of Mississippi's MississippiCAN program, its benefits, and rate setting principles. The report was prepared solely to provide assistance to DOM to set SFY 2025 capitation rates for the MississippiCAN program. It may not be appropriate for other purposes. Milliman does not intend to benefit, and assumes no duty or liability to, other parties who receive this work. This material should only be reviewed in its entirety.

- **Physician:** DOM generally reimburses physician services as a percentage of Mississippi Medicare fee schedules and updates the FFS fee schedules on July 1 of each year for the Medicare fee schedule changes from January 1 of the given year. The simulated impact of fee schedule changes for July 1, 2024 is not yet available from Myers and Stauffer, and therefore not included in preliminary SFY 2025 capitation rates. In the interim, the unit cost trends continue to rely on the simulations provided by Conduent for SFY 2024 capitation rates showing the estimated impact of payment rate changes effective July 1, 2022 and July 1, 2023 using an underlying mix of CY 2021 claims.

  The new simulations will be developed using a base data set of CY 2022 claims and we will have the ability to apply the unit cost trends at the new granular categories of service first introduced in the SFY 2025 rates. Once these new simulations are available, we will update the unit cost trends included in the SFY 2025 capitation rates.

  Given the updated base period for SFY 2025 capitation rates is CY 2022, which already includes the fee schedule updates effective July 1, 2022 for half the year, we dampened the impact of the projected July 1, 2022 fee schedule changes to apply to January to June 2022 claims only. The majority of these increases are associated with evaluation and management codes, which received a large increase in the 2021 Medicare fee schedule but were not implemented in Mississippi until July 1, 2022. It is our understanding that Conduent's simulations included laboratory, physician (medical and surgical), radiology, and vaccine services, and excluded any services not listed above and those that were not anticipated to have a fee change between CY 2021 and SFY 2024.

  The per-encounter FQHC and RHC reimbursement is included in the MississippiCAN capitation rates to provide a steadier cash flow to the RHCs and FQHCs that serve the MississippiCAN population. The CCOs are expected to reimburse FQHCs and RHCs at DOM's per-encounter rates. DOM will monitor the utilization of services at FQHCs and RHCs under MississippiCAN to ensure services are not diverted from FQHCs and RHCs to other providers. Approximately 12% of costs in the high-level physician category of service are for FQHCs and RHCs. Rate increases of 2.1% and 3.8% were applied to FQHC and RHC per-encounter rates effective January 1, 2023 and January 1, 2024, respectively. We assumed the per-encounter rate increase effective January 1, 2025 will be 2.9%, based on the average increase from the prior two years.

  We assumed that reimbursement for all other services that were not included in Conduent's simulations remain flat from CY 2022 to SFY 2025.

  Table 11 below shows the combined physician unit cost trends incorporating the Conduent simulated changes, flat unit cost trends for services with no anticipated changes, and the appropriate trends for FQHC and RHC services. These trends are applied to the physician maternity, psychiatric, and the portion of the other physician trends not related to PADs. The total physician other trend is a blend of these trends and PAD trends.

Table 11
Mississippi Division of Medicaid
Physician Unit Cost Trends for CY 2022 to SFY 2025

Population	Physician
SSI	1.03%
Adult	1.37%
Newborn[1]	0.32%
Children[2]	1.47%

[1]Newborn include SSI / Disabled Newborns and Non-SSI Newborns 0 to 2 Months.
[2]Children include all other children rate cells.

In addition to the physician unit costs trends included in Table 11, fee schedule changes for autism spectrum disorder (ASD), prescribed pediatric extended care (PPEC), and some ASC services are also included in the physician service category. These charge trends were calculated by comparing the CY 2022 payment rates with those currently expected to be in place during SFY 2025, composited based on the mix of services during CY 2022. See Exhibit 12 for additional details regarding the base period costs and applied trend.

This report assumes the reader is familiar with the State of Mississippi's MississippiCAN program, its benefits, and rate setting principles. The report was prepared solely to provide assistance to DOM to set SFY 2025 capitation rates for the MississippiCAN program. It may not be appropriate for other purposes. Milliman does not intend to benefit, and assumes no duty or liability to, other parties who receive this work. This material should only be reviewed in its entirety.

- **Dental:** Dental reimbursement changes due to SB2799 and HB657 are incorporated as a separate adjustment to rates. A 10% increase effective October 1, 2023 for certain orthodontia services is included in the dental unit cost trends. No additional dental fee schedule changes are anticipated for July 1, 2024.

- **Other:** Certain fee schedules remain unchanged, and thus no changes were implemented to the fee schedules between CY 2022 and SFY 2025 except for the services noted below:

  - Durable Medical Equipment (DME) / Medical Supplies
  - Ambulance
  - Private Duty Nursing (PDN)

  The simulated impact of fee schedule changes for July 1, 2024 is not yet available, and therefore, not included in preliminary SFY 2025 capitation rates. As described above, Conduent performed a simulation of the impact of changes in the fee schedules effective July 1, 2022 and July 1, 2023 for SFY 2024 capitation rates based on CY 2021 costs. Based on this analysis, we included unit cost trends ranging from approximately 1.0% to 1.7% by rate cell to other services for the applicable services included in Conduent's simulation. These trends include the dampening impact of only applying the July 1, 2022 reimbursement change to services incurred from January to June 2022. The simulation provided by Conduent included DME, medical supplies, and ambulance services, and excluded any services that were not anticipated to have a fee change between CY 2021 and SFY 2024.

  To calculate the impact of the PDN fee schedule change we applied the 15.0% fee schedule increase effective October 2022 to all claims with a service data prior to October 2022, assuming that CCO payments will increase alongside FFS payment increases.

  Row (c) in Exhibit 2A includes the aggregate unit cost adjustment factors from CY 2022 to SFY 2025.

Physician Administered Drug Trends

We developed physician administered drug (PAD) trends using the following sources:

- ***MississippiCAN-Specific Data*** – We analyzed completed January 2022 to December 2023 experience for pharmacy claims administered in a medical setting, also referred to in this report as physician administered drugs (PADs). We analyzed historical experience in CY 2022 and CY 2023 by high level population and drug type.

- ***Industry Research*** – We reviewed recent drug trend reports from PBMs to benchmark the prospective list price and utilization trends used in our detailed modeling of MississippiCAN-specific data. Additionally, we conducted industry research to adjust trends for anticipated market events, including but not limited to, recent average sales price (ASP) price change, biosimilars, novel brand drugs, expanded treatable population for approved drugs (e.g., new indication or age expansion), and drug mix in MississippiCAN medical experience.

- ***FDA Drug Approvals*** – When developing prospective PAD trends, we consider the FDA approval of various new therapies. However, building explicit additional trend into capitation rates for these products is difficult due to a lack of information on expected pricing and uptake among the various populations. Therefore, we build in modest additional trend to reflect the expansion of new approvals for each population. We note, the historical experience reviewed in trend development also reflects the impact of FDA approvals that were new during those periods. For select high-cost pharmaceuticals we build explicit adjustments into the capitation rates, as outlined in Step 2, rather than incorporating into the PAD trend assumption.

Based on our analyses, we estimate annualized utilization and unit cost trends from CY 2022 to SFY 2025 shown in Table 12. Difference in aggregate trends by population in Table 12 are due to each population's historical trends and drug mix.

This report assumes the reader is familiar with the State of Mississippi's MississippiCAN program, its benefits, and rate setting principles. The report was prepared solely to provide assistance to DOM to set SFY 2025 capitation rates for the MississippiCAN program. It may not be appropriate for other purposes. Milliman does not intend to benefit, and assumes no duty or liability to, other parties who receive this work. This material should only be reviewed in its entirety.

Table 12 Mississippi Division of Medicaid Pharmacy Trends for CY 2022 to SFY 2025				
	SSI	Adult	Children	Newborn
Annualized Unit Cost Trends	2.00%	1.50%	2.50%	2.50%
Annualized Utilization Trends	2.00%	1.50%	2.50%	2.50%

Seasonal Virus Trend Adjustment

We continue to monitor costs associated with COVID-19 (testing, treatment, and vaccinations), as well as costs associated with influenza and respiratory syncytial virus (RSV). We queried CY 2022 MississippiCAN costs associated with COVID-19, influenza, and RSV by population and compared them to similar costs in emerging CY 2023 data (adjusted for CCO reported IBNR claim amounts). We expect that seasonal virus costs in SFY 2025 will be more similar to levels observed in CY 2023, which is further removed from the height of the COVID-19 PHE than the base period experience in CY 2022. We observe material decreases in costs related to COVID-19, influenza, and RSV in CY 2023 compared to CY 2022 levels.

Therefore, we applied high-level dampening adjustments to apply to CY 2022 COVID-19, influenza, and RSV costs to decrease them in line with observed CY 2023 levels. These dampening adjustments were calculated separately by population and for COVID-19 vs. influenza and RSV and the final resulting dampened cost is included in Table 13 below. The PMPM cost adjustments are scaled across service categories based on the historical cost distribution.

Table 13 Mississippi Division of Medicaid Seasonal Virus Trend Adjustment				
	CY 2022 PMPM Cost	CY 2023 PMPM Cost	Adjustment	CY 2022 Dampened Cost PMPM
SSI				
COVID-19	$18.98	$7.73	-60.0%	$7.59
Flu / RSV	$5.73	$4.24	-25.0%	$4.29
Total	**$24.70**	**$11.98**		**$11.89**
Newborn				
COVID-19	$18.72	$11.95	-35.0%	$12.17
Flu / RSV	$28.40	$28.98	0.0%	$28.40
Total	**$47.12**	**$40.93**		**$40.56**
Children				
COVID-19	$8.33	$4.50	-45.0%	$4.58
Flu / RSV	$6.15	$4.56	-25.0%	$4.61
Total	**$14.47**	**$9.05**		**$9.19**
Adults				
COVID-19	$14.89	$4.71	-70.0%	$4.47
Flu / RSV	$3.34	$2.22	-25.0%	$2.50
Total	**$18.22**	**$6.93**		**$6.97**

Row (d) in Exhibit 2 shows the adjustment for seasonal viruses.

Step 2: Apply Adjustments for Population, Program, and Reimbursement Methodology Changes

The following adjustments are applied to reflect changes in expected costs due to changes between the base period and rating period.

This report assumes the reader is familiar with the State of Mississippi's MississippiCAN program, its benefits, and rate setting principles. The report was prepared solely to provide assistance to DOM to set SFY 2025 capitation rates for the MississippiCAN program. It may not be appropriate for other purposes. Milliman does not intend to benefit, and assumes no duty or liability to, other parties who receive this work. This material should only be reviewed in its entirety.

- Population Changes: Change in the mix of individuals already enrolled in MississippiCAN
- Program Changes: Changes to populations and / or services included in MississippiCAN
- Reimbursement Methodology Changes: Updates to Medicaid FFS reimbursement methodologies (assumes a parallel impact on MississippiCAN reimbursement), or changes in CCO reimbursement

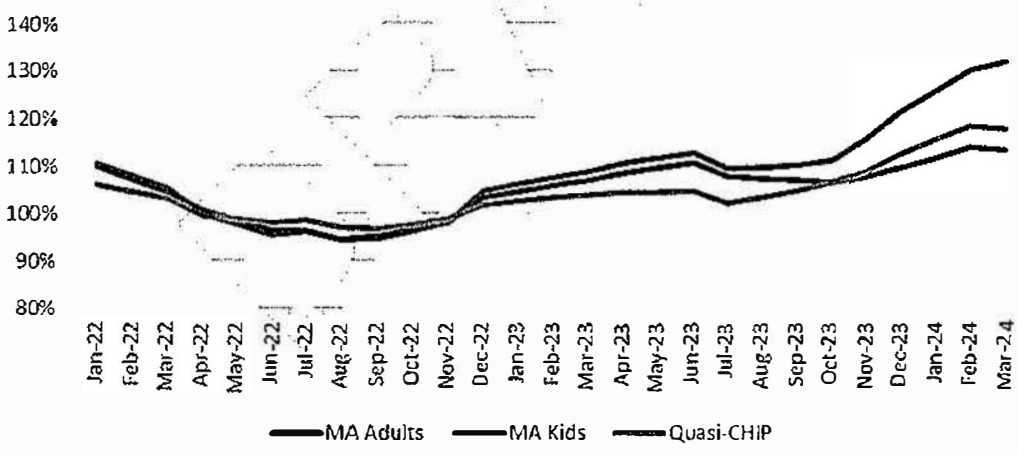
Exhibit 10 summarizes the program, population, and reimbursement changes discussed in this section, the impacted rate cells for each change, and where the change is reflected in the rate development.

Population Acuity Adjustment

Beginning in June 2021, DOM began transitioning individuals for whom Medicaid eligibility would have lapsed absent the CCR from the CCOs into FFS Medicaid. This transition from the CCOs into FFS Medicaid was concentrated in several populations where members commonly churn in and out of the Medicaid population or transition between rate cells due different income eligibility at different ages, including the MA Adults, MA Children, and Quasi-CHIP children. These transitions continued well into CY 2022, impacting the CY 2022 membership mix included in the base data used to develop SFY 2025 capitation rates.

In addition, the CCR ended on March 31, 2023, and DOM initiated eligibility redeterminations in April 2023, with disenrollments of ineligible recipients starting in July 2023 and continuing over the next 12 months. During the redetermination process, beneficiaries that had been moved from the CCOs into FFS initially that maintained Medicaid eligibility were moved back into MississippiCAN, resulting in steady CCO enrollment increases throughout CY 2023 and into CY 2024. Figure 1 shows this change in monthly enrollment compared to the average enrollment in CY 2022 for each rate cell (e.g., a ratio of 110% indicates that month's enrollment is 10% higher than the average enrollment during the CY 2022 base data).

Figure 1: Monthly MSCAN CCO Enrollment / Average CY 2022 Enrollment



To estimate the change in acuity due to population changes between the CY 2022 base period data and the population we expect to be enrolled during SFY 2025, we performed a risk score-based acuity analysis. We calculated risk scores for two distinct time frames:

1. CY 2022 (CY 2021 diagnoses and CY 2022 enrollment).
2. March 2024 (CY 2023 diagnoses and March 2024 enrollment used as a proxy for the population enrolled during SFY 2025).

This report assumes the reader is familiar with the State of Mississippi's MississippiCAN program, its benefits, and rate setting principles. The report was prepared solely to provide assistance to DOM to set SFY 2025 capitation rates for the MississippiCAN program. It may not be appropriate for other purposes. Milliman does not intend to benefit, and assumes no duty or liability to, other parties who receive this work. This material should only be reviewed in its entirety.

Due to population and programmatic changes occurring in MississippiCAN since we last calculated Mississippi-specific risk scores, we did not use the custom Mississippi risk weights that have been used for risk adjustment in prior capitation rate periods. Instead, we relied on standard CDPS weights from the CDPS + Rx risk score model. We excluded pharmacy claims from the risk score model, as these claims are not included in the capitation rates for SFY 2025. Given the large changes in membership between CY 2022 and March 2024 we only looked at members that were able to be "scored," meaning they had at least 6 months of enrollment during the diagnosis period.

To calculate the acuity adjustments, we compared the average risk scores for March 2024 enrollment compared to the average risk score in CY 2022 for each population. The results were very similar for MA Children and Quasi-CHIP, so the same adjustment was applied to both rate cells. The final acuity adjustments applied are a downward adjustment of 1.5% for MA Adults and an upward adjustment of 2.5% for MA Children and Quasi-CHIP, as shown in Table 14

Table 14
Mississippi Division of Medicaid
SFY 2025 MississippiCAN Capitation Rate Development
Population Acuity Adjustment

	CY 2022 - Scored Members		March 2024 - Scored Members			
Cap Cell	Member Months	Average Risk Score	Member Months	Average Risk Score	Risk Score Change	Final Acuity Adjustment
MA Adult	405,835	1.020	47,891	1.006	0.986	0.985
MA Children	2,462,797	0.947	238,373	0.972	1.027	1.025
Quasi-CHIP	275,824	0.967	27,371	0.986	1.019	1.025

Additional information about the risk scores for members enrolled in MississippiCAN during CY 2022 and March 2024, including additional splits for various time periods are shown in Tables 15 (MA Adult) and 16 (MississippiCAN children) below.

For CY 2022 MississippiCAN scored members, we reviewed the risk scores separately by quarter to assess the impact on risk scores of ongoing member eligibility redeterminations during CY 2022 when members were moved to FFS. This shows that risk scores remain relatively stable during CY 2022 as membership declines.

We similarly reviewed monthly risk scores for each scored population from December 2023 to March 2024 where we saw large membership increases as a result of member eligibility redeterminations related to the unwinding of the PHE. Tables 15 and 16 show a steady increase in membership month over month for all populations, but the impact on risk score varies by population (risk scores decrease for adults and increase for children).

Table 15
Mississippi Division of Medicaid
Acuity Adjustment - MA Adult

	CY 2022 Risk Scores by Quarter				
	Q1 2022	Q2 2022	Q3 2022	Q4 2022	CY 2022
Scored Member Months	116,213	101,521	93,607	94,494	405,835
Average Monthly Enrollment	38,738	33,840	31,202	31,498	33,820
Risk Score	1.019	1.025	1.024	1.014	1.020

	December 2023 to March 2024 Risk Scores			
	December 2023	January 2024	February 2024	March 2024
Scored Members	42,388	44,399	46,263	47,891
Risk Scores	1.019	1.013	1.009	1.006

This report assumes the reader is familiar with the State of Mississippi's MississippiCAN program, its benefits, and rate setting principles. The report was prepared solely to provide assistance to DOM to set SFY 2025 capitation rates for the MississippiCAN program. It may not be appropriate for other purposes. Milliman does not intend to benefit, and assumes no duty or liability to, other parties who receive this work. This material should only be reviewed in its entirety.

Table 16 Mississippi Division of Medicaid Acuity Adjustment - MA Children and Quasi-CHIP					
	CY 2022 Risk Scores by Quarter				
	Q1 2022	Q2 2022	Q3 2022	Q4 2022	CY 2022
Scored Member Months	750,429	683,691	649,991	654,510	2,738,621
Average Monthly Enrollment	250,143	227,897	216,664	218,170	228,218
Risk Score	0.941	0.949	0.954	0.949	0.949
	December 2023 to March 2024 Risk Scores				
		December 2023	January 2024	February 2024	March 2024
Scored Members		237,899	247,128	257,521	265,744
Risk Scores		0.971	0.971	0.973	0.973

Row (e) in Exhibit 2 shows the population acuity adjustment.

Postpartum Coverage Extension

Per SB 2212, postpartum coverage extended from 60 days to 12 months effective July 1, 2023. Previously, at 60 days postpartum individuals in the Pregnant Women rate cell had their Medicaid eligibly redetermined and unless they had a qualifying reason to remain in Medicaid (such as meeting eligibility qualifications for the MA Adult rate cell) the member was disenrolled from MississippiCAN. After July 1, 2023, this redetermination will not occur until the end of the 12 months of postpartum coverage. While this program change has the largest impact on the Pregnant Women rate cell, other rate cells are also expected to have minor increases in enrollment due to extending the time until eligibility redetermination to 12 months postpartum (i.e., if someone would have been disenrolled during their annual redetermination they now will remain for the additional months until 12 months postpartum). We reviewed the impact of the coverage extension on all rate cells in the MississippiCAN program and believe the PMPM impact is minimal and did not include an adjustment for any rate cell except for the Pregnant Women rate cell, given its unique eligibility requirements and historical enrollment patterns. The projected membership in Exhibit 3 includes the impact of extending postpartum coverage for all rate cells.

While this program change will add membership and service costs to the Pregnant Women rate cell, these additional months of coverage are expected to be lower on a PMPM basis than the costs included in the CY 2022 base data. We developed separate adjustments to apply to the non-delivery costs and delivery costs included in Exhibit 2.

- Non-Delivery Costs: The estimated PMPM cost for months 3 through 12 postpartum was developed by reviewing the relativity of the non-pharmacy PMPMs for postpartum months 1 and 2 compared to months 3 through 12 for individuals that had a delivery while in the Pregnant Women rate cell in CY 2023 and were eligible for the extended coverage effective July 1, 2023. Given the limited amount of data available and limitations on claim runout we also compared this to the PMPM relativities used in SFY 2024 capitation rate development, which was calculated based on experience in the MA Adult rate cell during CY 2021. Both data sets showed a cost relativity of roughly 75%. We then applied this relativity to the PMPM cost for postpartum months 1 and 2 for the Pregnant Women rate cell in the CY 2022 base data.

- Delivery Costs: Additional delivery costs will not be incurred for the additional months of membership added to the Pregnant Women rate cell. Therefore, we dampen the delivery cost PMPM to spread across the increased membership basis. The adjustment for SFY 2025 is further dampened compared to the adjustment in SFY 2024 capitation rates because the extension of coverage will be in place for a full year at the start of SFY 2025 rather than a ramp-up of additional member months during SFY 2024. Therefore, we expect a higher percentage of non-delivery months in the pregnant women rate cell in SFY 2025 compared to SFY 2024.

Table 17 below demonstrates the development of the population change factors.

This report assumes the reader is familiar with the State of Mississippi's MississippiCAN program, its benefits, and rate setting principles. The report was prepared solely to provide assistance to DOM to set SFY 2025 capitation rates for the MississippiCAN program. It may not be appropriate for other purposes. Milliman does not intend to benefit, and assumes no duty or liability to, other parties who receive this work. This material should only be reviewed in its entirety.

Table 17 Mississippi Division of Medicaid SFY 2025 Capitation Rate Development Pregnant Women Rate Cell Postpartum Extension Adjustment			
		Non-Delivery Costs	Delivery Costs
Prior Eligibility: Prenatal through 60 Days Postpartum			
(A)	Member Months	96,821	96,821
(B)	Total Allowed	$31,518,325	$56,111,477
(C) = (B) / (A)	CY 2022 Allowed PMPM	$325.53	$579.54
New Eligibility: 3 through 12 Months Postpartum			
(D)	Member Months	104,491	104,491
(E)	Total Allowed	$17,134,718	$0
(F) = (E) / (D)	Allowed PMPM	$163.98	$0.00
Total Population			
(G) = (A) + (D)	Member Months	201,312	201,312
(H) = (B) + (E)	Total Allowed	$48,653,043	$56,111,477
(I) = (H) / (G)	Allowed PMPM	$241.68	$278.73
(J) = (I) / (C)	**Postpartum Population Change Factor**	**0.742**	**0.481**

Row (f) in Exhibit 2 shows this adjustment.

Hemophilia Population Carve-In

Starting on January 1, 2024, eligible members diagnosed with Hemophilia and Von Willebrand's disease transitioned from FFS to MississippiCAN. Historically this population has been carved-out of MississippiCAN due to the relatively high-cost associated with treatment and the infrequent and non-uniform distribution across the CCOs. DOM provided a list of 168 members with hemophilia that were transitioned from FFS to MississippiCAN on January 1, 2024. We identified 153 members in CY 2022. We included an adjustment to include these members' CY 2022 FFS claims and enrollment to their current rate cell. Additionally, we increased overall costs to reflect the additional 15 members not present in the CY 2022 and assumed these members have the same average PMPM cost as those members reflected in the CY 2022 base period data.

Row (g) in Exhibit 2 shows this adjustment.

Gene Therapy Coverage

There are several high-cost gene therapies that are currently available. We worked closely with our clinical team and the clinical team at DOM to identify eligible members and estimate potential treatment uptake percentages and total costs for treatment for each gene therapy by rate cell. Table 18 below details the assumptions and estimated SFY 2025 impact for each treatment. Additionally, please see Exhibits 14C and 14D for the full development of these amounts by rate cell.

Table 18 Mississippi Division of Medicaid SFY 2025 Capitation Rate Development Gene Therapy Estimates					
Condition	**Therapy**	**Number of Treatments**	**Pharmacy Cost per Treatment**	**Inpatient Cost per Treatment**	**Total Anticipated Treatment Cost**
Beta-Thalassemia	Zynteglo	1	$2,800,000	$200,000	$3,000,000
Duchene Muscular Dystrophy	Elevydis	1	$3,200,000	$0	$3,200,000
Hemophilia A	Roctavian	2	$2,500,000	$0	$5,800,000
Hemophilia B	Hemgenix	1	$3,500,000	$0	$3,500,000
Sickle Cell Disease	Lyfgenia / Casgevy	6	$2,650,000	$200,000	$17,100,000
Spinal Muscular Atrophy	Zolgensma	3	$2,254,412	$0	$6,763,236
Total		**14**	**$2,711,660**	**$100,000**	**$39,636,236**

This report assumes the reader is familiar with the State of Mississippi's MississippiCAN program, its benefits, and rate setting principles. The report was prepared solely to provide assistance to DOM to set SFY 2025 capitation rates for the MississippiCAN program. It may not be appropriate for other purposes. Milliman does not intend to benefit, and assumes no duty or liability to, other parties who receive this work. This material should only be reviewed in its entirety.

Row (h) in Exhibit 2 shows this adjustment.

Gene Therapy Coverage Savings

The gene therapies listed above are assumed to significantly reduce or eliminate symptoms of the underlying condition. We queried CY 2022 claims data for potential utilizers meeting the clinical profile for each gene therapy to analyze what historical costs looked like for these members. We reviewed this information with our clinical team and determined that a majority of costs associated with the underlying condition that are likely to be alleviated by the new gene therapies are related to pharmacy services. Since pharmacy claims not administered as part of the medical benefit are not included in capitation rates for SFY 2025, we have not applied a savings adjustment to the capitation rates reflecting a cost reduction.

Preventative and Diagnostic Dental Reimbursement Change

Per SB2799 signed into law on April 19, 2021, the payment rate for preventative and diagnostic dental services was increased by 5% effective on both July 1, 2022 and July 1, 2023. We determined the proportion of CY 2022 dental claims identified as preventative or diagnostic (defined as procedure codes D0100 through D1999.) We calculated the overall dental reimbursement change within each rate cell as a blend of a 5% reimbursement adjustment on preventative and diagnostic dental services with a 0% reimbursement adjustment on other dental services.

The cumulative preventive and diagnostic dental reimbursement change is shown in row (j) in Exhibit 2.

Restorative Dental Reimbursement Change

Per HB657 signed into law on April 19, 2022, DOM increased the payment rate for restorative dental services by 5% on both July 1, 2022 and July 1, 2023 and will increase by another 5% effective on July 1, 2024. We determined the proportion of CY 2022 dental claims identified as restorative (defined as procedure codes D2000 through D2999.) We calculated the overall dental reimbursement change within each rate cell as a blend of a 5% reimbursement adjustment on the restorative services with a 0% reimbursement adjustment on other dental services, after adjusting for the preventative and diagnostic reimbursement changes discussed above.

The cumulative restorative dental reimbursement change is shown in row (k) in Exhibit 2.

Immaterial Program, Population, and Reimbursement Methodology Changes

There are several program, population, and reimbursement changes between the base period experience and SFY 2025 that we did not build an explicit adjustment into rates for, given the projected budget neutral or immaterial impact. These changes are described below.

- Tobacco Cessation – effective July 1, 2023, coverage for smoking cessation counseling services was expanded to cover up to 12 sessions per year. It is estimated that the impact to capitation rates for this change is negligible, so no adjustment was applied.

Step 3: Non-Service Expense Allowance

Administrative Expenses, Premium Tax, and Targeted Margin

The administrative allowance included in the capitation rate is intended to cover administrative costs, including the following:

- Case management
- Utilization management
- Claim processing and other IT functions
- Customer service
- Provider contracting and credentialing
- TPL and program integrity
- Member grievances and appeals
- Financial and other program reporting
- Local overhead costs
- Corporate overhead and business functions (e.g., legal, executive, human resources)

This report assumes the reader is familiar with the State of Mississippi's MississippiCAN program, its benefits, and rate setting principles. The report was prepared solely to provide assistance to DOM to set SFY 2025 capitation rates for the MississippiCAN program. It may not be appropriate for other purposes. Milliman does not intend to benefit, and assumes no duty or liability to, other parties who receive this work. This material should only be reviewed in its entirety.

Exhibit 3 shows the build-up of the non-service expenses, comprised of the following components for SFY 2025:

- $9.99 PMPM for fixed administrative costs
- 6.15% of revenue less directed payments for variable administrative costs
- 1.80% of revenue less directed payments for target underwriting margin and cost of capital
- 3.00% for the Mississippi premium tax

Table 19 displays the non-service expense allowance included in the SFY 2025 rates. All percentages of revenue are shown excluding MHAP, MAPS, and TREAT revenue, which are ultimately not at risk to the CCOs.

Table 19
Mississippi Division of Medicaid
SFY 2025 MississippiCAN Non-Benefit Expenses

	% of Revenue	PMPM
Fixed Costs[1]	2.64%	$9.99
Variable Costs[2]	6.15%	$23.31
Premium Tax[2]	3.00%	$11.37
Margin[2]	1.80%	$6.82
Total	**13.59%**	**$51.49**

[1] Included in the rate as a PMPM, equivalent % of revenue shown.
[2] Included in the rate as a % of Revenue, equivalent PMPM is shown.

The administrative expense allowance for SFY 2025 was developed by trending the fixed and variable allowances from CY 2022 financial data provided by the CCOs, combined for MississippiCAN and CHIP. These reported expenses were then adjusted to limit PMPM increases to the employment cost index (ECI) trend of 5.1% between CY 2021 and CY 2022 on a CCO level, if applicable, and to adjust administrative expenses consistent with the administrative expense audits conducted by Myers and Stauffer and related party administrative expense analysis completed by DOM. Applying adjustments consistent with the audit report and related party expenses decreased the CCO reported administrative costs by roughly 3.5% ($1.24 PMPM) and limiting the PMPM trend to 5.1% for the one CCO with higher trend decreased the reported administrative costs another 8.7% ($3.03 PMPM). Compared to CY 2021 administrative expenses underlying the SFY 2024 capitation rate, adjusted CY 2022 administrative expenses are down 1.1% on a PMPM basis from $36.42 to $36.02 alongside membership decreases for the same time period of 15% to 20%.

Adjusted CY 2022 administrative expenses were trended by an annual trend of 3.8% from CY 2022 to SFY 2025. The 3.8% annual trend is a blend of actual employment cost index (ECI) data from CY 2022 through CY 2023 of 4.4% and an assumed 3.4% annual trend from CY 2023 to SFY 2025. The future 3.4% trend assumption is consistent with the average ECI annual change from CY 2018 through CY 2022. The ECI data reflects expected changes in wages and other services that comprise a majority of administrative costs. In addition, we reviewed the CMS Medicare Economic Index (MEI) that includes actual changes through June 2023 and forecasted quarterly changes afterwards. The MEI from CY 2022 through SFY 2025 has an annualized change of 3.8%, similar to our analysis with the ECI data.

Administrative costs for SFY 2025 were also adjusted to reflect the transition of certain pharmacy claims from the CCOs to the DOM contracted PBA. Based on reporting provided by the CCOs and DOM, we estimate that approximately 85% of reported CCO PBM costs incurred during CY 2022 are related to duties that will no longer be performed by the CCOs in SFY 2025 and were therefore removed, resulting in a decrease in administrative costs of roughly $2.39 PMPM or approximately 7.5%. After the removal of these PBM fees the administrative expenses are projected to decrease by 10.7% on a PMPM basis compared to SFY 2024.

Finally, the administrative expenses are split between the MississippiCAN and CHIP programs, based on the distribution of costs in prior financial template reporting that split MississippiCAN and CHIP expenses. The final overall projected administrative cost PMPM (for fixed and variable expenses) is $33.30 for the MississippiCAN program in SFY 2025 as shown in columns (c) and (e) of Exhibit 3.

The margin of 1.8% of revenue is applied in column (f) of Exhibit 3 and premium tax of 3.00% of revenue is applied in column (i) of Exhibit 3 for costs included in the capitation rates and Exhibit 13 for state directed payments.

This report assumes the reader is familiar with the State of Mississippi's MississippiCAN program, its benefits, and rate setting principles. The report was prepared solely to provide assistance to DOM to set SFY 2025 capitation rates for the MississippiCAN program. It may not be appropriate for other purposes. Milliman does not intend to benefit, and assumes no duty or liability to, other parties who receive this work. This material should only be reviewed in its entirety.

Step 4: Adjust for Geographic Area

CCO capitation payments will vary based on their members' county of residence. We assigned each county to one of the following regions (as defined in Appendix A): North, Central, or South. Table 20 shows the geographic area factor adjustments that are applied based on a beneficiary's region.

Table 20
Mississippi Division of Medicaid
Area Factors

	Area Factors		
Region	**SSI**	**Adults and Deliveries**	**Children**
North	0.878	0.993	1.018
Central	1.040	1.026	1.075
South	1.097	0.983	0.913

We developed the geographic area factors on a budget-neutral basis by blending projected claims PMPM across rate cell groupings weighted upon the statewide rate cell distribution for each region and reviewing the relative difference in PMPM cost for each region. We created three different rate cell groups (as shown in Table 5) to aggregate experience for similar rate cells, so that we could adequately reflect area factor differences among rate cells and still maintain credibility.

Exhibit 4 includes the resulting capitation rates for each region using these area factors.

Step 5: Adjust for Quality Withhold

Continuing in SFY 2025, a 1.0% quality withhold will be placed on capitation rates for the MississippiCAN program. The terms of the withhold arrangement are outlined in the contract with the CCOs. To earn back the withhold the CCOs must achieve HEDIS scores for the following conditions that are greater than or equal to 2.0% above the baseline HEDIS scores, with a percentage of the withhold assigned to each category. The benchmarks for SFY 2025 will be set based on the average of all CCO reported scores from calendar years 2021 and 2022 (prorated based on member months).

Each of the following HEDIS measures will be used to earn back one twelfth (approximately 8.33%) of the quality withhold, for approximately 83.33% total across all HEDIS measures:

- Well-Child First 30 months (W15 metrics impact the quality withhold; W30 is reporting only for SFY 2025):
  - Six or more visits for children 15 months of age
  - Two or more visits for children 30 months of age
- Immunization for Adolescents (IMA):
  - Combination 2: Meningococcal, Tdap, and HPV
- Anti-Depressant Management-Acute (AMM-AD):
  - Effective Acute Phase Treatment
- Follow-Up After Hospitalization for Mental Illness:
  - 30 Days – Ages 6 to 17
- Prenatal and Postpartum Care (PPC-AD):
  - Timeliness of Prenatal Care
- Comprehensive Diabetes Care:

This report assumes the reader is familiar with the State of Mississippi's MississippiCAN program, its benefits, and rate setting principles. The report was prepared solely to provide assistance to DOM to set SFY 2025 capitation rates for the MississippiCAN program. It may not be appropriate for other purposes. Milliman does not intend to benefit, and assumes no duty or liability to, other parties who receive this work. This material should only be reviewed in its entirety.

  - HbA1c Testing
  - Blood Pressure Control
  - Eye Exams

- Adult and Children Asthma Control – Ages 5 to 64

- Adults Pharmacotherapy Management of COPD Exacerbation: Systemic Corticosteroid

DOM will be monitoring readmission rates reported as part of the QIPP in SFY 2025. For SFY 2025, this will be included as a scored metric for the quality withhold. During SFY 25, CCOs will be required to improve their actual-to-expected (A/E) ratio compared to the baseline years by 2.0% if the baseline A/E ratio is >1.0 or not allow the A/E ratio to be >1.0 for the reporting period if the baseline A/E ratio is <1.0. During SFY 2025, CY 2020 and CY 2021 will serve as the baseline years. This PPHR measure will be used to earn back 8.33% of the quality withhold.

Consistent with SFY 2024, DOM will also be monitoring the cesarean section (C-section) rates among all births paid for by a CCO during the measurement period (CY 2024) and comparing to the baseline period (CY 2021). To earn back the final 8.33% of the withhold a CCO must improve their individual C-section rate by two (2.0) percentage points during the measurement period compared to the baseline period.

If a CCO does not have sufficient data to consider its HEDIS scores credible, DOM will not hold the CCO liable for not meeting the measurement. In this case, the portion of the incentive withheld related to that measurement will be returned to the CCO. DOM will not prorate the results for a CCO based on the outcomes of the measures attained during SFY 2025. After discussions with DOM about the metric development and expectations, we believe that a return of 100% of the withhold is reasonably achievable by the CCOs.

Exhibit 4 includes the resulting capitation rates for each region net of the quality withhold.

Step 6: Adjust For CCO-Specific Risk Score (if Applicable)

Risk Adjustment for the Non-Newborn SSI / Disabled, MA Adult, MA Children, and Quasi-CHIP Rate Cells

The capitation rates for the Non-Newborn SSI / Disabled, MA Adult, MA Children, and Quasi-CHIP rate cells will be further adjusted for each CCO using the combined Chronic Illness and Disability Payment System and Medicaid Rx risk adjuster (CDPS + Rx). Costs for the Breast and Cervical Cancer, Foster Care, and Pregnant Women populations are less variable since they tend to utilize similar services across each population. In addition, some of the population sizes are too small from which to develop custom weights specific to the covered services and MississippiCAN reimbursement levels. Therefore, we do not risk adjust these populations. Since the risk adjustment is prospective, there is no historical diagnosis information from which to develop a risk score for newborns.

The CDPS + Rx risk adjuster will be used to adjust for the acuity differences between the enrolled populations of each CCO. Risk adjustment will be budget-neutral to DOM. This risk sharing mechanism is developed in accordance with generally accepted actuarial principles and practices.

To establish these risk scores, the CDPS + Rx risk adjuster will be run with risk weights consistent with services covered in MississippiCAN for the given time period. These risk weights are calculated using Mississippi FFS and encounter data for the Non-Newborn SSI / Disabled, MA Adult, MA Children, and Quasi-CHIP populations. In addition, a beneficiary must have at least six months of eligibility in the data year to be scored. If a beneficiary does not have enough data, they will receive a score based on demographic information, such as age and gender. We will monitor the percentage of CCO enrollees who are not scored and adjust the methodology if necessary.

DOM's MMIS vendor changed in October 2022, and we have been working to evaluate the quality of the membership and encounter claims data after this transition. Now that this process is complete, we plan to utilize this data to develop new population specific cost weights and risk scores reflecting the populations and services covered during SFY 2025. We plan to complete this work over the next few months and will follow up with updated results in late summer or early fall 2024.

This report assumes the reader is familiar with the State of Mississippi's MississippiCAN program, its benefits, and rate setting principles. The report was prepared solely to provide assistance to DOM to set SFY 2025 capitation rates for the MississippiCAN program. It may not be appropriate for other purposes. Milliman does not intend to benefit, and assumes no duty or liability to, other parties who receive this work. This material should only be reviewed in its entirety.

Table 21 Mississippi Division of Medicaid CCO Capitation Rate Risk Adjustment Schedule SFY 2025 Capitation Payments			
Rate Cell	Capitation Payments	Diagnosis Source Data	Enrollment Source
Non-Newborn SSI / Disabled, MA Adult, MA Children, and Quasi-CHIP	July 2024 to December 2024	TBD	TBD
Non-Newborn SSI / Disabled, MA Adult, MA Children, and Quasi-CHIP	January 2025 to June 2025	TBD	TBD

Risk Adjustment for the Foster Care Rate Cell

Starting in SFY 2021, the Foster Care rate cell is concurrently risk adjusted after the risk adjustment period ends. The Foster Care rate cell will be risk adjusted using a custom risk adjustment model that does not depend on the CDPS + Rx risk adjuster. After testing the predictive ability of several potential models, we determined the member's eligibility for either state or federal financial assistance was the most accurate indicator of the member's risk score. This status is captured by the money code field on DOM's enrollment records. Risk factors associated with a member's money code will be updated prior to risk adjustment for SFY 2025.

Unlike the other risk-adjusted populations, risk adjustment for the Foster Care rate cell will be applied concurrently after the risk adjustment period ends. Given the small size of the Foster Care rate cell, small fluctuations in membership could have a material impact on risk adjustment if applied prospectively. Therefore, we anticipate that we will continue to concurrently risk adjust the Foster Care rate cell in SFY 2025.

Application of Risk Scores

A CCO's capitation rate will be determined based upon the following formula:

CCO Capitation Rate = Base Capitation Rate x CCO Normalized Risk Factor

The base capitation rates are found in Exhibit 4.

The CCO normalized risk factor will equal the average risk factor across all beneficiaries that a CCO enrolls divided by the average risk factor for the rate cell's population. Regional risk scores will be normalized to ensure the risk adjustment process is revenue neutral across all CCOs.

Step 8: Directed Payments

DOM will process the capitation rate adjustments for multiple directed payments outside of the monthly capitation rate payment system in the form of payments to the CCOs for the actual amount paid to providers and the associated premium tax impact related to these payments. We will calculate and certify adjusted CCO-specific capitation rates at the conclusion of SFY 2025. This recertification is expected to be completed by June 2026.

MHAP Overview

Concurrent with the inclusion of inpatient hospital services in MississippiCAN capitation rates effective December 1, 2015, MHAP was established. This program helps to ensure sufficient access to inpatient and outpatient hospital services for the Medicaid population by including enhanced hospital reimbursement in the capitation rates.

MHAP is funded through a broad-based hospital assessment for facilities in Mississippi and an intergovernmental transfer (IGT) for a facility in Memphis (located within a county contiguous to Mississippi). This provider assessment is outlined in Miss. Code Ann §43-13-145.

Per CMS's approval on January 12, 2018, beginning in SFY 2018 MHAP began to transition to directed payments according to the specifications and requirements of 42 CFR 438.6 et seq. Table 22 displays the two components of MHAP (FSA and QIPP) and the total dollars in each component from SFY 2024 to SFY 2025.

This report assumes the reader is familiar with the State of Mississippi's MississippiCAN program, its benefits, and rate setting principles. The report was prepared solely to provide assistance to DOM to set SFY 2025 capitation rates for the MississippiCAN program. It may not be appropriate for other purposes. Milliman does not intend to benefit, and assumes no duty or liability to, other parties who receive this work. This material should only be reviewed in its entirety.

Table 22 Mississippi Division of Medicaid MississippiCAN Capitation Rates MHAP Distribution by SFY			
SFY	MHAP FSA	MHAP QIPP	Total MHAP
2024	$733,317,426	$788,996,459	$1,522,313,885
2025	$733,317,426	$832,522,898	$1,565,840,324

MHAP FSA

For SFY 2025, a payment of $733.3 million is included as a directed FSA on inpatient and outpatient claims that will be paid monthly outside the capitation rates as a separate payment term.

The preliminary FSA amounts are shown in column (c) of Exhibit 13, consistent with the program design that 60% of the $733.3 million will be paid for inpatient hospital services, and 40% will be paid for outpatient hospital services using projected SFY 2025 membership. These calculations were performed across all MississippiCAN rate cells with each of the inpatient and outpatient FSA percentage impacts applied uniformly. This results in a larger proportion of the FSA funding included in rate cells with higher inpatient and outpatient utilization.

The estimated FSA PMPM in Exhibit 13 is based on projected SFY 2025 membership and estimated utilization across all CCOs. Due to actual vs. projected CCO-specific MississippiCAN membership and claim utilization, this estimated capitation adjustment may result in an overpayment or underpayment of the FSA in SFY 2025 if no adjustments are made. The final CCO specific FSA amounts will be calculated on a PMPM basis at the end of SFY 2025, and the appropriate documentation will be provided to CMS.

The adjustments to capitation rates are consistent with the preprint that was filed with CMS for SFY 2025 on April 10, 2024. The control name for this preprint is MS_Fee.VBP_IPH.OPH_Renewal_20240701-20250630.

The MHAP FSA additive adjustment is shown in column (c) in Exhibit 13. An additional allowance for premium tax on the MHAP FSA is included in column (d) in Exhibit 13.

MHAP QIPP

Beginning in SFY 2020, a quality incentive payment program (QIPP) was included as a component of MHAP. Consistent with the preprint submitted to CMS, the QIPP will be paid as a uniform payment arrangement for SFY 2025. The goal of the QIPP is to utilize state and federal investments to improve the quality of care and health status of the Mississippi Medicaid population. The introduction of QIPP was a multi-year process with an increasing percentage of the payments linked to performance improvements achieved and maintained by the hospital industry.

For SFY 2025, the QIPP will consist of approximately $789.0 million, which will be paid outside of the capitation rates on a quarterly basis as a separate payment term. DOM will determine the payments made to facilities based on agreed upon performance measures. Capitation rates will be retroactively adjusted once actual membership and utilization is known for SFY 2025 to include a QIPP PMPM for each CCO, which will include a provision for premium tax.

New for SFY 2025, additional funding of $43.5 million is included in the expected QIPP payments related to a new VBP arrangement in which hospitals can earn bonus payments for meeting performance levels assigned to a variety of metrics. These payments will only be made to hospitals that meet the prescribed performance levels for each metric.

The adjustments to capitation rates are consistent with the preprint that was filed with CMS for SFY 2025 on April 10, 2024. The control name for this preprint is MS_Fee.VBP_IPH.OPH_Renewal_20240701-20250630.

The MHAP QIPP additive adjustment is shown in column (e) in Exhibit 13. An additional allowance for premium tax on the MHAP QIPP is included in column (f) in Exhibit 13.

TREAT Program

Beginning July 1, 2022, emergency ambulance reimbursement are proposed to be increased consistent with a §438.6(c) directed payment for eligible providers. Subject to CMS approval, payments for the TREAT program are

This report assumes the reader is familiar with the State of Mississippi's MississippiCAN program, its benefits, and rate setting principles. The report was prepared solely to provide assistance to DOM to set SFY 2025 capitation rates for the MississippiCAN program. It may not be appropriate for other purposes. Milliman does not intend to benefit, and assumes no duty or liability to, other parties who receive this work. This material should only be reviewed in its entirety.

estimated to be $25.3 million for SFY 2025 and will be paid outside the capitation rate as a uniform payment arrangement.

Capitation rates will be retroactively adjusted once actual membership and utilization is known for SFY 2025 to include a TREAT PMPM for each CCO, which will include a provision for premium tax. The adjustments to capitation rates are consistent with the preprint that will be filed with CMS for SFY 2025.

The TREAT additive adjustment is shown in column (g) in Exhibit 13. An additional allowance for premium tax on the TREAT payments is included in column (h) in Exhibit 13.

Mississippi MAPS Program

Beginning in SFY 2020, the Mississippi Medicaid Access to Physician Services (MAPS) program enhanced payments to physicians who are employed by a qualifying hospital or who assigned Mississippi Medicaid payments to a qualifying hospital. The term "qualifying hospital" means a Mississippi state-owned academic health science center with a Level 1 trauma center, Level 4 neonatal intensive care nursery, an organ transplant program, and more than a four hundred (400) physician multispecialty practice group.

DOM will require that CCOs provide the same supplemental percentage increase, equal to 58.63% of Medicare rates, to all qualifying providers. Payments in SFY 2025 are expected to be $32.9 million. Similar to MHAP, capitation rates will be retroactively adjusted for SFY 2025 to include a MAPS PMPM including a provision for premium tax for each CCO and rate cell based on actual membership and utilization. The appropriate documentation will be submitted to CMS at the time of this retroactive adjustment.

This program is being made under a §438.6(c) payment arrangement consistent with the preprint that will be filed with CMS for SFY 2025.

The MAPS additive adjustment is shown in column (i) in Exhibit 13. An additional allowance for premium tax on the MAPS is included in column (j) in Exhibit 13.

Table 23 below shows a summary of the MHAP, MAPS, and TREAT payments for SFY 2024 and SFY 2025.

Table 23
Mississippi Division of Medicaid
Summary of Directed Payments by SFY

	SFY 2024	SFY 2025
Total MHAP	**$1,522,313,885**	**$1,565,840,324**
MHAP FSA[1]	$733,317,426	$733,317,426
MHAP QIPP[1]	$788,996,459	$832,522,898
MAPS	$39,420,290	$32,920,290
TREAT	$20,616,966	$25,285,224
Total Directed Payments	**$1,582,351,141**	**$1,624,045,838**

[1] Preprints for the SFY 2025 MHAP FSA and MHAP QIPP are pending CMS approval.

Step 9: Calculate Risk Corridor Settlements

Subject to CMS approval, DOM will implement a symmetrical risk corridor to address the uncertainty around cell and gene therapies (CGTs) and other potential high-cost medications.

High-Cost Pharmacy Risk Corridor

Some Medicaid members have conditions requiring very expensive drug treatments. These members are infrequent and not evenly distributed among the CCOs. To help mitigate the CCO's risk, the state is continuing the high-cost pharmacy risk corridor started in SFY 2024, subject to CMS approval. The risk corridor is applicable to total drug spend and related costs due to administration and monitoring for specified products of $250,000 or more per year at a member level. Table 24 below, as well as Exhibit 14A, include a PMPM estimate of the costs that will be covered in the high-cost pharmacy risk corridor specific to each rate cell. Please see Exhibits 14C and 14D for the detailed calculations of the high-cost pharmacy targets below. The actual costs from the CCOs will be compared to these estimated costs for the settlement calculations.

This report assumes the reader is familiar with the State of Mississippi's MississippiCAN program, its benefits, and rate setting principles. The report was prepared solely to provide assistance to DOM to set SFY 2025 capitation rates for the MississippiCAN program. It may not be appropriate for other purposes. Milliman does not intend to benefit, and assumes no duty or liability to, other parties who receive this work. This material should only be reviewed in its entirety.

Table 24 Mississippi Division of Medicaid SFY 2025 High-Cost Pharmacy Risk Corridor	
Rate Cell	**SFY 2025 High-Cost Pharmacy Target PMPM**
Non-Newborn SSI / Disabled	$35.03
Breast and Cervical Cancer	$0.00
MA Adult	$0.64
Pregnant Women	$0.00
SSI / Disabled Newborn	$0.48
Non-SSI Newborns 0 to 2 Months	$29.66
Non-SSI Newborns 3 to 12 Months	$17.24
Foster Care	$5.08
MYPAC	$0.00
MA Children	$4.53
Quasi-CHIP	$0.00
Total	$8.39

Table 25 summarizes the share of gains and losses relative to the estimated high-cost pharmacy costs for each party.

Table 25 Mississippi Division of Medicaid Proposed High-Cost Pharmacy Risk Corridor Parameters		
CCO Gain / Loss	**CCO Share of Gain / Loss in Corridor**	**DOM Share of Gain / Loss in Corridor**
Less than -6.0%	0%	100%
-6.0% to -3.0%	50%	50%
-3.0% to +3.0%	100%	0%
+3.0% to +6.0%	50%	50%
Greater than +6.0%	0%	100%

The high-cost pharmacy risk corridor will be implemented using the following provisions:

- Estimated high-cost pharmacy costs are calculated separately for each rate cell based on the expected mix of high-cost products.
- Each rate cell's actual high-cost pharmacy costs will include payments made for the following:
  - All drugs billed as medical claims with a HCPCS code that starts with the letter "J."
  - Inpatient stays for the administration and monitoring for select gene therapies and other select products. The estimated pharmacy costs included in the high-cost risk corridor include the following; however, DOM will monitor and revise the list of approved products if additional products are covered by DOM for use during SFY 2025.
    - Lyfgenia
    - Casgevy
    - Zynteglo
- The timing of the initial and final high-cost pharmacy risk corridor settlements are outlined below.
  - The initial settlement will occur after the contract year is closed, using six months of runout.
  - The final settlement will occur once the MLR audit has been completed. MLR audits are usually completed 12 to 18 months after the close of the SFY.

This report assumes the reader is familiar with the State of Mississippi's MississippiCAN program, its benefits, and rate setting principles. The report was prepared solely to provide assistance to DOM to set SFY 2025 capitation rates for the MississippiCAN program. It may not be appropriate for other purposes. Milliman does not intend to benefit, and assumes no duty or liability to, other parties who receive this work. This material should only be reviewed in its entirety.

- The 91.3% minimum MLR provision (Federal MLR definition) in the CCO contract will apply after the high-cost pharmacy risk corridor settlement calculation.

Other Program Considerations

Minimum MLR Requirement

The program includes a minimum federal MLR requirement of 91.3% of revenue. The sum of medical expenses and HCQI expenses must meet or exceed 91.3% of revenue. Revenue for premium taxes is excluded from the MLR calculation. If the 91.3% threshold is not met, CCOs return revenue to DOM until the threshold is met.

Value-Based Payment Incentive Program

Effective July 1, 2024, DOM will implement a value-based payment incentive program (VBP) as part of the MississippiCAN contract. In alignment with DOM's Comprehensive Quality Strategy the VBP will target three primary focus areas: maternal health, metabolic health, and mental health.

- Maternal Health. Mississippi has the highest maternal mortality rate in the country with 82 maternal deaths per 100,000 births. Mississippi also has the highest percentage of births by black mothers (42% of all births) in the country, which is significant given that black women have higher mortality rates than any other racial or ethnic group.
- Metabolic Health. Nationally, obesity rates have risen, and obesity is a significant contributor to a host of conditions, such as type II diabetes, hypertension, coronary artery disease, stroke, and many others. Mississippi has the sixth highest obesity rate in the country with more than 39% of its residents being obese. Additionally, the percentage of the Mississippi Medicaid population that is considered to be obese is estimated to be higher than the state average with obesity rates being higher among individuals with lower income.
- Mental Health. Mental health has an impact on physical health. For example, depression increases the risk for many conditions, such as diabetes, heart disease, and stroke. Mississippi was ranked 47th in the nation for access to mental health services. Additionally, mental health conditions have been shown to contribute to a large proportion of pregnancy-related deaths (23%).

The program will consist of associated quality measures, payment arrangements and amounts, as determined and defined by DOM, which promote quality in the delivery of services. DOM will leverage the Health Care Payment Learning & Action Network (LAN) Framework that characterizes payment models. Within this framework, the progression of payment models is tied to cost and quality and progress from fee-for-service models in Category 1 to population-based payments at Category 4. Similarly, the VBP will be phased in, such that a portion of incentives are tied to pay for reporting on the implementation of redesigned systems and performance measures (Category 2B) and will transition to pay for performance (Category 2C) while a portion of incentives will begin as pay for performance.

While the program launch is July 1, 2024 to align with the CCO contract start date, the first performance period will be based on CY 2024 data and will be reported in July 2025. Each subsequent program year will be based on the calendar year and reported annually in July.

For SFY 2025, the following performance measures are to be assessed and incentivized:

1. Severe Maternal Morbidity Risk Assessment – Part A: Assessment Completion, and Part B: Timely Follow-up
2. Low-risk Cesarean Delivery (LRCD-CH)
3. Antidepressant Medication Management (AMM-AD)
4. Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medication (SSD-AD)

Severe Maternal Morbidity (SMM) includes the unexpected outcomes of labor and delivery that result in significant short- or long-term consequences to a woman's health. To manage poor outcomes, Mississippi will use diagnostic information to develop a maternal health risk assessment to be used by hospitals at time of discharge. Based upon the Mississippi Outcomes for Maternal Safety (MOMS) score assigned to the beneficiary at the time of discharge, required

This report assumes the reader is familiar with the State of Mississippi's MississippiCAN program, its benefits, and rate setting principles. The report was prepared solely to provide assistance to DOM to set SFY 2025 capitation rates for the MississippiCAN program. It may not be appropriate for other purposes. Milliman does not intend to benefit, and assumes no duty or liability to, other parties who receive this work. This material should only be reviewed in its entirety.

interventions will be employed to ensure follow-up care within specified timeframes. Incentives will be based initially upon reporting on assessment and follow-up implementation activities (e.g., technology infrastructure), then transition to pay for reporting performance, and in future performance years, transition to pay for performance.

The new VBP program builds upon the current CCO incentive withhold program as a quality-based incentive (i.e., bonus) payment in addition to the CCO's monthly capitation rates. Under the VBP program, each CCO will be eligible to receive additional funds over and above base capitation rates. Monetary incentives will not exceed one-half percent (.5%) above the capitation payment and, as such will not be in excess of 105% of the approved capitation payments in accordance with 42 C.F.R. § 438.6(b). The introduction of the VBP program does not impact how capitation rates were calculated for SFY 2025.

DOM will apply a weighted percentage of the eligible incentive allocation and each measure will be evaluated separately for payment.

Pay for performance incentives will be based on statewide performance targets. Targets will be defined by DOM using nationally available benchmarks where available and align to the CCO incentive withhold program, as applicable. Failure to meet a measure target will result in no incentive being paid for that measure. There will be no partial incentive payments awarded.

The payment model will recognize the contributions of CCOs, hospitals and other providers, through the distribution of incentive payments to the CCOs that are then shared as applicable and in proportions as set by DOM. In exchange for incentives created through the VBP, CCOs, hospitals, and other providers are expected to collaborate with one another, utilizing care management and other available tools to ensure that performance targets set by DOM are met. At DOM's discretion, additional incentives for CCOs may include priority in CCO auto-enrollment, with higher performing CCOs having the potential to be assigned auto-enrolled members at a higher percentage rate.

Upon collection of data in July of each year, DOM will review actual performance to target performance to calculate measure achievement. Based on performance achieved, incentive payment will be calculated. CCOs will receive a performance report indicating performance and payment achieved. CCOs will have an opportunity to review and request information or a reconsideration of payments applied. DOM will then finalize and release incentive payments. The timeline will align with the CCO incentive withhold program and allows six months after the calendar year to gather, review and analyze the applicable data. CCOs are then expected to share incentives with hospitals and other providers based on program requirements.

DRAFT

This report assumes the reader is familiar with the State of Mississippi's MississippiCAN program, its benefits, and rate setting principles. The report was prepared solely to provide assistance to DOM to set SFY 2025 capitation rates for the MississippiCAN program. It may not be appropriate for other purposes. Milliman does not intend to benefit, and assumes no duty or liability to, other parties who receive this work. This material should only be reviewed in its entirety.

EXHIBITS 1 THROUGH 16

(Provided in Excel Format Only)

DRAFT

This report assumes the reader is familiar with the State of Mississippi's MississippiCAN program, its benefits, and rate setting principles. The report was prepared solely to provide assistance to DOM to set SFY 2025 capitation rates for the MississippiCAN program. It may not be appropriate for other purposes. Milliman does not intend to benefit, and assumes no duty or liability to, other parties who receive this work. This material should only be reviewed in its entirety.

June 4, 2024

APPENDIX A

SFY 2025 Rate Cell Definitions

DRAFT

This report assumes the reader is familiar with the State of Mississippi's MississippiCAN program, its benefits, and rate setting principles. The report was prepared solely to provide assistance to DOM to set SFY 2025 capitation rates for the MississippiCAN program. It may not be appropriate for other purposes. Milliman does not intend to benefit, and assumes no duty or liability to, other parties who receive this work. This material should only be reviewed in its entirety.

June 4, 2024

APPENDIX A

SFY 2025 RATE CELL DEFINITIONS

This section of our report outlines the rate cell definitions to be used for SFY 2025 for the populations addressed in this report. These definitions are summarized in Table 1 below. Capitation rate cells for SFY 2025 were kept consistent with the SFY 2024 capitation rate cells. Previously the MA Adult and Pregnant Women rate cells included an additional breakout of delivery service costs in Exhibit 2, which has been removed now that level of detail is provided for delivery costs as part of the service category breakouts.

Table 1
Mississippi Division of Medicaid
Rate Cell Definitions

Rate Cell Grouping for Assumption Development	Rate Cell	Age Requirement	Category of Eligibility (COE)
Children	SSI / Disabled Newborns	Ages 0 to 12 months (13-month duration)	001, 019
Children	Non-SSI Newborns – age 0 to 2 months	Ages 0 to 2 months (3-month duration)	003, 026, 071, 088
Children	Non-SSI Newborns – age 3 to 12 months	Ages 3 to 12 months (10-month duration)	003, 026, 071, 088
Children	MA Children	Ages 1 to 19	072, 073
Children	Quasi-CHIP	Ages 1 to 19	074
Children	MYPAC[1]	Ages 1 to 20	N/A, Lckn_cd = SED
Children	Foster Care	Ages 1+	003, 026
Adult	Pregnant Women	Ages 8 to 64	088
Adult	MA Adult	Ages 19+	075
SSI	Non-Newborn SSI / Disabled	Ages 1+	001, 019, 025
SSI	Breast and Cervical Cancer	N/A	027

[1] *MYPAC rate cell is defined using the 'SED' lock-in code along with claims and eligibility information due to issues with the 'SED' lock-in code after July 1, 2021.*

All rate cell eligibility excludes the following individuals not enrolled in MississippiCAN:

- Retroactive membership
- Dual eligible members
- Institutionalized beneficiaries in a long-term care facility
- Individuals in the following waiver programs: WAL, WED, WMR, or WTB

Additionally, fee-for-service (FFS) eligibility and claims data will be used to summarize experience for members with hemophilia or Von Willebrand disease in CY 2022 who will be enrolled in MississippiCAN during SFY 2025 and to review acuity differences due to enrollment shifts between FFS and MississippiCAN during the COVID-19 Public Health Emergency (PHE).

GEOGRAPHIC REGIONS

DOM uses regional payments to better reflect enrollment for CCOs that enroll a disproportionate number of members from higher-cost or lower-cost regions of the state. DOM uses the three regions of North, Central, and South based on the county where a beneficiary lives. Table 2 displays the counties included in each region.

DRAFT

APPENDIX A

SFY 2025 RATE CELL DEFINITIONS

Table 2
Mississippi Division of Medicaid
Geographic Regions by County

North Region	Central Region	South Region
Alcorn	Calhoun	Adams
Attala	Chickasaw	Amite
Benton	Choctaw	Covington
Bolivar	Claiborne	Forrest
Carroll	Clarke	Franklin
Coahoma	Clay	George
DeSoto	Copiah	Greene
Grenada	Hinds	Hancock
Holmes	Issaquena	Harrison
Humphreys	Jasper	Jackson
Itawamba	Kemper	Jefferson
Lafayette	Lauderdale	Jefferson Davis
Lee	Leake	Jones
LeFlore	Lowndes	Lamar
Marshall	Madison	Lawrence
Montgomery	Monroe	Lincoln
Panola	Neshoba	Marion
Pontotoc	Newton	Pearl River
Prentiss	Noxubee	Perry
Quitman	Okitbbeha	Pike
Sunflower	Rankin	Stone
Tallahatchie	Scott	Walthall
Tate	Sharkey	Wayne
Tippah	Simpson	Wilkinson
Tishomingo	Smith	
Tunica	Warren	
Union	Webster	
Washington	Winston	
Yalobusha	Yazoo	

To determine a beneficiary's county, we used the following approach:

- County code included on a beneficiary's enrollment record in a given month.
- Absent (a), we mapped zip codes in the enrollment file to counties. In cases where a zip code is present in more than one county, we assumed that a zip code maps to a given county if:
  - The zip code shows up most frequently for a given county in the enrollment file (assuming a minimum of five occurrences).
  - Census information indicating the portion of a zip code's population that resides in each county. County is assigned to a zip code based on the county that includes the largest portion of a zip code's population.

If a beneficiary could not be assigned to a region, we excluded their eligibility and claim experience from the base data. This accounts for less than 0.4% of all current MississippiCAN eligible members in CY 2022.

APPENDIX B

Data Sources and Processing

DRAFT

APPENDIX B

DATA SOURCES AND PROCESSING

A number of data sources are used to develop the base data for the SFY 2025 MississippiCAN capitation rates.

- Medicaid eligibility data
- FFS claim data
- CCO encounter data
- CCO financial data

CY 2022 experience forms the primary base data for the SFY 2025 capitation rates.

This section of the report outlines each data source and steps to process the data.

MEDICAID ELIGIBILITY

DOM's MMIS vendor provided detailed Medicaid eligibility data for CY 2022. Before analyzing claims, we pared down the eligibility data to groups that are eligible to enroll in MississippiCAN, as defined in Appendix A of our report. In order to isolate data only for this group, we applied various filters as described in the rest of this appendix.

We relied upon the 'CAN' lock-in code for each eligibility span to include individuals enrolled in MississippiCAN in the base period. This assumes that MMIS-calculated enrollment criteria in the base period is consistent with how it will be applied for SFY 2025 capitation rate payments. In addition, this removes opt-outs from voluntary populations (SSI children and Mississippi Band of Choctaw Indians) from the base data used to develop capitation rates.

In addition, adjustments were made for the removal of retroactive eligibility periods and records not able to map to a geographic area.

Removal of Retroactive Eligibility Periods

Beneficiary enrollment in the FFS program can occur retroactively. When some individuals apply and qualify for Medicaid coverage, DOM reimburses claims, which occurred during the retroactive qualification period prior to their application. DOM backdates the eligibility of the individual to accommodate the retroactive coverage.

There is also a lag between the first date of eligibility and the date of enrollment in a CCO because Medicaid eligibility begins on the first day of the month in which the application was received. Once a Medicaid beneficiary signs up for a CCO, they will be enrolled on the first day of the subsequent month. The retroactive enrollment period is not covered by the CCO, so we removed retroactive eligibility included in the data provided to us using the following criteria:

- Eligibility months prior to the date that a beneficiary was added to the Medicaid enrollment file were removed. For example, if a beneficiary is active January 15, 2022, but they were added to the enrollment file February 1, 2022, we only included data on or after February 1, 2022 to exclude any retroactivity that may have occurred.

As of December 2015, newborns are enrolled in MississippiCAN at the time of their birth. Therefore, the retroactive eligibility exclusion is not applicable to these populations.

Geographic Area

If a beneficiary could not be assigned to a region, we excluded them from the base data. This accounts for less than 0.4% of all current MississippiCAN eligible member months in CY 2022. See Appendix A for additional information on the assignment of a geographic region.

FFS DATA

FFS claims are provided by DOM's MMIS vendor. These claims include any populations and / or services not included in MississippiCAN. We reviewed the FFS data for reasonability for several considerations, including the following, and verified it was consistent with monthly DOM cost reporting:

- Monthly claim counts per member
- Monthly payments per member
- Average cost per unit
- Monthly units and payments by COS
- Monthly units and payments by rate cell

APPENDIX B

DATA SOURCES AND PROCESSING

ENCOUNTER DATA

Encounter claims are included in the data provided by DOM's MMIS vendor. This data represents the actual amounts paid to the provider, so no repricing was done as part of the development of capitation rates. A claim processed by a CCO and submitted to DOM can be identified in the data based on the cde_claim_ffs_enc field. A value of 'E' in this field denotes an encounter claim. Please note, field names may vary from those provided in the encounter data submission from the CCOs.

For all service categories we used CY 2022 encounter data with runout through June 2023.

Only encounter claims for members flagged as a MississippiCAN enrollee in the eligibility data were included in the base data. Encounter claims which failed to be mapped to a MississippiCAN CCO enrollee were removed.

CCO encounters are rigorously vetted by Myers and Stauffer as part of their reconciliation of encounters against CCOs' cash disbursement journals (CDJs). As part of this reconciliation, Myers and Stauffer identifies encounter claims that are duplicates, voids, or replacements for other encounter claims. Myers and Stauffer shares these findings with CCOs at a claim level to ensure they are accurately determining the final, non-duplicated version of each paid claim. As a result of their analysis, Myers and Stauffer are able to reconcile closely to the CCOs' CDJs (historically within 0.5% on a paid basis). We use summaries provided by Myers and Stauffer to identify final, non-duplicative claims consistent with their CDJ reconciliation.

Lastly, the encounter data is run through Milliman's *Health Cost Guidelines*™ (*HCGs*) grouper to map the encounter data into detailed categories of service. These categories of service are then rolled up into eleven high level categories of service used for rate development. This mapping from detailed category of service to broad category of service is included as Exhibit 2.

After processing the data, we review the encounter data for several considerations, including:

- Monthly encounter counts per member (including and excluding $0 payments)
- Monthly payments per member
- Average cost per unit
- Monthly units and payments by COS
- Quarterly units and payments relative to financials by COS
- Frequency of diagnosis completion by COS

Removal of Pharmacy Benefit Administered Claims

Starting in July 2024, DOM expects to enter into an arrangement with their Pharmacy Benefits Administrator (PBA) in which certain pharmacy claims will be paid through the PBA. As such, we identified and removed the associated pharmacy claims from the CY 2022 base data for the purpose of developing SFY 2025 capitation rates. These claims were identified and removed using the follow logic:

- Claim Type equal to "P" or "Q"

FINANCIAL REPORTING DATA

For base data development, each CCO submitted a financial report reconciled to their organization's audited CY 2022 financial statements for Mississippi. Reports were submitted for CY 2022 including earned premium, claim experience with run out through June 2023 for CY 2022 data, best estimate IBNR claim amounts, subcapitated arrangements, non-service expenses, and membership. The reported membership was close in total to the MMIS enrollment, so we utilized the MMIS enrollment for rate development.

We worked with each CCO to validate that their reports were filled out consistently with the category of service and non-medical definitions used in the capitation rate development. Adjustments were made to the original submissions to help align these definitions.

CLAIMS ABOVE STATE-PLAN COVERED SERVICE LIMITS

When processing encounter data, we identify claims above Mississippi's state-plan covered service limits. These services are provided by some CCOs as an expanded benefit. However, as they are not state-plan-covered, these services are excluded from the base data when setting capitation rates. We identified three types of benefits offered by

APPENDIX B

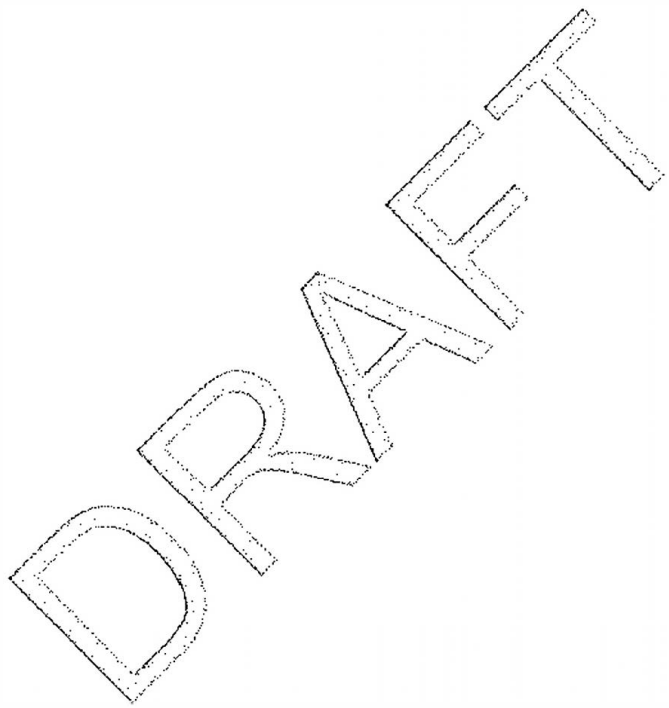
DATA SOURCES AND PROCESSING

CCOs that are above state-plan covered service limits, described below. Children receiving EPSDT services, identified as individuals under the age of 21, are exempt from the service limits described below.

- ***Physician Visits*** – Members are limited to 16 physician visits within a state fiscal year. This limit is applied separately for psychiatric and non-psychiatric visits.

  To identify physician visits, claims are required to have a claim type of "M" (Professional). Additionally, the claim must have one of a list of specific procedure codes. Exhibits 15A and 15B show the required procedure codes for non-psychiatric and psychiatric physician visits, respectively. Due to issues identifying claims at this level of detail within the CY 2022 data we are estimating the value of physician visits above the limit based on percentages from the CY 2021 data used for SFY 2024 capitation rate development.

- ***Home Health Visits*** – Up to 36 home health visits per state fiscal year are covered under Mississippi's state plan. Home health visits are identified as claims with a claim type of "H" (Home Health) and a revenue code of 421, 441, 551, 571, or 589.



APPENDIX C

CMS Managed Care Rate Setting Guide Response

DRAFT

APPENDIX D

Actuarial Certification of SFY 2025 MississippiCAN Capitation Rates

DRAFT

State of Mississippi Division of Medicaid
SFY 2025 MississippiCAN Preliminary Rate Calculation and Certification - DRAFT

This report assumes the reader is familiar with the State of Mississippi's MississippiCAN program, its benefits, and rate setting principles. The report was prepared solely to provide assistance to DOM to set SFY 2025 capitation rates for the MississippiCAN program. It may not be appropriate for other purposes. Milliman does not intend to benefit, and assumes no duty or liability to, other parties who receive this work. This material should only be reviewed in its entirety.

June 4, 2024

APPENDIX E

Data Reliance Letter

DRAFT

This report assumes the reader is familiar with the State of Mississippi's MississippiCAN program, its benefits, and rate setting principles. The report was prepared solely to provide assistance to DOM to set SFY 2025 capitation rates for the MississippiCAN program. It may not be appropriate for other purposes. Milliman does not intend to benefit, and assumes no duty or liability to, other parties who receive this work. This material should only be reviewed in its entirety.

June 4, 2024

For more information about Milliman, please visit us at:

milliman.com

DRAFT

Milliman

Milliman is among the world's largest providers of actuarial and related products and services. The firm has consulting practices in life insurance and financial services, property & casualty insurance, healthcare, and employee benefits. Founded in 1947, Milliman is an independent firm with offices in major cities around the globe.

milliman.com

CONTACTS

Jill Bruckert
jill.bruckert@milliman.com

Katarina Lorenz
katarina.lorenz@milliman.com

© 2024 Milliman, Inc. All Rights Reserved. The materials in this document represent the opinion of the authors and are not representative of the views of Milliman, Inc. Milliman does not certify the information, nor does it guarantee the accuracy and completeness of such information. Use of such information is voluntary and should not be relied upon unless an independent review of its accuracy and completeness has been performed. Materials may not be reproduced without the express consent of Milliman.

Caveats and Limitations
Mississippi Division of Medicaid

READ BEFORE PROCEEDING

Milliman has developed certain models to estimate the values included in these exhibits and appendices. The intent of the models was to estimate SFY 2025 capitation rates. We reviewed the models, including their inputs, calculations, and outputs for consistency, reasonableness, and appropriateness to the intended purpose and in compliance with generally accepted actuarial practice and relevant actuarial standards of practice (ASOP).

The models rely on data and information as input to the models. We used CCO encounter data and CCO financial reporting for January 2022 to December 2022 with runout through June 2023, historical and projected reimbursement information, fee schedules, and other information from DOM, MississippiCAN CCOs, Change Healthcare, Myers and Stauffer, and CMS to calculate the preliminary MississippiCAN base data shown in exhibits and appendicies.If the underlying data used is inadequate or incomplete, the results will be likewise inadequate or incomplete. Please see Appendix E for a full list of the data relied upon to develop the SFY 2025 capitation rates.

Differences between the capitation rates and actual experience will depend on the extent to which future experience conforms to the assumptions made in the capitation rate calculations. It is certain that actual experience will not conform exactly to the assumptions used. Actual amounts will differ from projected amounts to the extent that actual experience is better or worse than expected.

Our exhibits and appendices are intended for the internal use of DOM to review preliminary MississippiCAN capitation rates for SFY 2025. The exhibits and appendices and the models used to develop the values in these exhibits and appendices may not be appropriate for other purposes. We anticipate the exhibits and appendices will be shared with contracted CCOs, CMS and other interested parties. Milliman does not intend to service, and assumes no duty or liability to, other parties who receive this work. It should only be distributed and reviewed in its entirety. These capitation rates may not be appropriate for all CCOs. Any CCO considering participating in MississippiCAN should consider their unique circumstances before deciding to contract under these rates.

The results of these exhibits and appendices are technical in nature and are dependent upon specific assumptions and methods. No party should rely on these results without a thorough understanding of those assumptions and methods. Such an understanding may require consultation with qualified professionals.

The authors of these exhibits and appendices are actuaries employed by Milliman, members of the American Academy of Actuaries, and meet the Qualification Standards of the Academy to render the actuarial opinion

Exhibit 1A
Mississippi Division of Medicaid
All Regions SFY 2025 MississippiCAN Capitation Rate Development
CY 2022 Encounter Data

Non-Newborn SSI / Disabled Rate Cell

		Category of Service											
Calculation Step	**CY 2022 PMPM Cost Development**	**Inpatient Hospital - Maternity / Deliveries**	**Inpatient Hospital - Psychiatric / Substance Abuse**	**Inpatient Hospital - Other**	**Outpatient Hospital - Emergency Room**	**Outpatient Hospital - Pharmacy**	**Outpatient Hospital - Other**	**Physician - Maternity / Deliveries**	**Physician - Psychiatric / Substance Abuse**	**Physician - Other**	**Dental**	**Other**	**Total**
a	CY 2022 Member Months	720,708	720,708	720,708	720,708	720,708	720,708	720,708	720,708	720,708	720,708	720,708	**720,708**
b	Total Allowed Dollars	$1,746,132	$23,624,663	$91,947,622	$22,938,424	$36,344,710	$84,770,345	$381,828	$32,332,756	$123,713,195	$6,641,841	$42,483,559	**$466,925,075**
c = b / a	CY 2022 PMPM Costs	$2.42	$32.78	$127.58	$31.83	$50.43	$117.62	$0.53	$44.86	$171.66	$9.22	$58.95	**$647.87**
d	MYPAC Member Identification Change	0.991	0.990	1.000	0.999	1.000	1.000	0.992	0.959	0.998	0.997	0.999	**0.996**
e	Encounter to Financial Adjustment	0.979	0.979	0.979	1.007	1.007	1.007	1.007	1.007	1.007	0.971	1.007	**0.999**
f	Missing Data	1.002	0.999	1.001	1.000	1.002	1.000	1.002	0.999	1.000	0.998	0.994	**1.000**
g	IBNR Adjustment	1.028	1.026	1.030	1.002	1.002	1.002	1.001	1.001	1.001	1.000	1.006	**1.009**
h	Non-Covered Services	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	0.981	1.000	1.000	**0.995**
i	Remove Zolgensma Claims	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	**1.000**
j	TPL Adjustment	0.998	0.998	0.998	0.998	0.998	0.998	0.998	0.998	0.998	0.998	0.998	**0.998**
k	IMD Removal	1.000	0.976	0.995	0.999	1.000	1.000	1.000	0.998	1.000	1.000	0.999	**0.997**
l	IMD Repricing	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	**1.000**
m	SSI Children - COE Change	1.000	1.148	1.000	1.000	1.000	1.000	1.000	1.001	1.000	1.002	1.000	**1.008**
Product of c through m	**Adjusted CY 2022 PMPM Costs**	**$2.42**	**$36.43**	**$127.78**	**$31.99**	**$50.89**	**$118.39**	**$0.53**	**$43.16**	**$169.12**	**$8.91**	**$59.16**	**$648.77**

Breast and Cervical Cancer Rate Cell

		Category of Service											
Calculation Step	**CY 2022 PMPM Cost Development**	**Inpatient Hospital - Maternity / Deliveries**	**Inpatient Hospital - Psychiatric / Substance Abuse**	**Inpatient Hospital - Other**	**Outpatient Hospital - Emergency Room**	**Outpatient Hospital - Pharmacy**	**Outpatient Hospital - Other**	**Physician - Maternity / Deliveries**	**Physician - Psychiatric / Substance Abuse**	**Physician - Other**	**Dental**	**Other**	**Total**
a	CY 2022 Member Months	961	961	961	961	961	961	961	961	961	961	961	**961**
b	Total Allowed Dollars	$0	$0	$145,031	$20,144	$806,433	$534,634	$0	$6,341	$842,707	$8,370	$38,704	**$2,402,364**
c = b / a	CY 2022 PMPM Costs	$0.00	$0.00	$150.92	$20.96	$839.16	$556.33	$0.00	$6.60	$876.91	$8.71	$40.28	**$2,499.86**
d	MYPAC Member Identification Change	N/A	N/A	1.000	1.000	1.000	1.000	N/A	1.000	1.000	1.000	1.000	**1.000**
e	Encounter to Financial Adjustment	N/A	N/A	0.979	1.007	1.007	1.007	N/A	1.007	1.007	0.971	1.007	**1.005**
f	Missing Data	N/A	N/A	1.002	1.003	1.002	1.002	N/A	1.003	1.003	0.987	0.995	**1.002**
g	IBNR Adjustment	N/A	N/A	1.009	1.003	1.003	1.003	N/A	1.002	1.002	1.000	1.003	**1.003**
h	Non-Covered Services	N/A	N/A	1.000	1.000	1.000	1.000	N/A	1.000	0.993	1.000	1.000	**0.998**
i	Remove Zolgensma Claims	N/A	N/A	1.000	1.000	1.000	1.000	N/A	1.000	1.000	1.000	1.000	**1.000**
j	TPL Adjustment	N/A	N/A	0.998	0.998	0.998	0.998	N/A	0.998	0.998	0.998	0.998	**0.998**
k	IMD Removal	N/A	N/A	1.000	1.000	1.000	1.000	N/A	1.000	1.000	1.000	1.000	**1.000**
l	IMD Repricing	N/A	N/A	1.000	1.000	1.000	1.000	N/A	1.000	1.000	1.000	1.000	**1.000**
m	SSI Children - COE Change	N/A	N/A	1.000	1.000	1.000	1.000	N/A	1.000	1.000	1.000	1.000	**1.000**
Product of c through m	**Adjusted CY 2022 PMPM Costs**	**$0.00**	**$0.00**	**$149.06**	**$21.21**	**$846.91**	**$561.98**	**$0.00**	**$6.66**	**$879.12**	**$8.34**	**$40.39**	**$2,513.67**

Exhibit 1A
Mississippi Division of Medicaid
All Regions SFY 2025 MississippiCAN Capitation Rate Development
CY 2022 Encounter Data

MA Adult Rate Cell

		Category of Service											
Calculation Step	**CY 2022 PMPM Cost Development**	**Inpatient Hospital - Maternity / Deliveries**	**Inpatient Hospital - Psychiatric / Substance Abuse**	**Inpatient Hospital - Other**	**Outpatient Hospital - Emergency Room**	**Outpatient Hospital - Pharmacy**	**Outpatient Hospital - Other**	**Physician - Maternity / Deliveries**	**Physician - Psychiatric / Substance Abuse**	**Physician - Other**	**Dental**	**Other**	**Total**
a	CY 2022 Member Months	451,802	451,802	451,802	451,802	451,802	451,802	451,802	451,802	451,802	451,802	451,802	**451,802**
b	Total Allowed Dollars	$12,769,641	$2,434,397	$13,322,645	$11,328,871	$5,810,283	$27,306,485	$3,019,032	$3,857,983	$48,037,346	$2,212,633	$5,487,761	**$135,587,078**
c = b / a	CY 2022 PMPM Costs	$28.26	$5.39	$29.49	$25.07	$12.86	$60.44	$6.68	$8.54	$106.32	$4.90	$12.15	**$300.10**
d	MYPAC Member Identification Change	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	**1.000**
e	Encounter to Financial Adjustment	0.979	0.979	0.979	1.007	1.007	1.007	1.007	1.007	1.007	0.971	1.007	**1.000**
f	Missing Data	1.001	1.003	1.002	1.000	0.987	1.001	1.000	1.000	1.000	0.994	1.129	**1.005**
g	IBNR Adjustment	1.017	1.016	1.017	1.002	1.002	1.002	1.001	1.001	1.001	1.001	1.005	**1.005**
h	Non-Covered Services	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	0.987	1.000	1.000	**0.995**
i	Remove Zolgensma Claims	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	**1.000**
j	TPL Adjustment	0.998	0.998	0.998	0.998	0.998	0.998	0.998	0.998	0.998	0.998	0.998	**0.998**
k	IMD Removal	1.000	0.987	1.000	1.000	1.000	1.000	1.000	0.999	1.000	1.000	1.000	**1.000**
l	IMD Repricing	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	**1.000**
m	SSI Children - COE Change	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	**1.000**
Product of c through m	**Adjusted CY 2022 PMPM Costs**	**$28.10**	**$5.29**	**$29.37**	**$25.25**	**$12.79**	**$60.91**	**$6.73**	**$8.58**	**$105.56**	**$4.72**	**$13.85**	**$301.15**

Pregnant Women Rate Cell

		Category of Service											
Calculation Step	**CY 2022 PMPM Cost Development**	**Inpatient Hospital - Maternity / Deliveries**	**Inpatient Hospital - Psychiatric / Substance Abuse**	**Inpatient Hospital - Other**	**Outpatient Hospital - Emergency Room**	**Outpatient Hospital - Pharmacy**	**Outpatient Hospital - Other**	**Physician - Maternity / Deliveries**	**Physician - Psychiatric / Substance Abuse**	**Physician - Other**	**Dental**	**Other**	**Total**
a	CY 2022 Member Months	96,821	96,821	96,821	96,821	96,821	96,821	96,821	96,821	96,821	96,821	96,821	**96,821**
b	Total Allowed Dollars	$45,126,085	$143,665	$638,264	$2,982,081	$1,047,266	$6,133,717	$11,332,019	$280,741	$18,733,372	$330,787	$1,072,067	**$87,820,063**
c = b / a	CY 2022 PMPM Costs	$466.08	$1.48	$6.59	$30.80	$10.82	$63.35	$117.04	$2.90	$193.48	$3.42	$11.07	**$907.04**
d	MYPAC Member Identification Change	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	**1.000**
e	Encounter to Financial Adjustment	0.979	0.979	0.979	1.007	1.007	1.007	1.007	1.007	1.007	0.971	1.007	**0.992**
f	Missing Data	0.998	1.004	1.002	0.996	0.988	0.993	0.998	1.001	0.997	0.980	1.130	**0.999**
g	IBNR Adjustment	1.016	1.014	1.017	1.002	1.002	1.002	1.002	1.001	1.002	1.001	1.006	**1.009**
h	Non-Covered Services	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	0.998	1.000	1.000	**1.000**
i	Remove Zolgensma Claims	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	**1.000**
j	TPL Adjustment	0.998	0.998	0.998	0.998	0.998	0.998	0.998	0.998	0.998	0.998	0.998	**0.998**
k	IMD Removal	1.000	0.858	1.000	1.000	1.000	1.000	1.000	0.991	1.000	1.000	0.999	**1.000**
l	IMD Repricing	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	**1.000**
m	SSI Children - COE Change	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	**1.000**
Product of c through m	**Adjusted CY 2022 PMPM Costs**	**$461.96**	**$1.26**	**$6.57**	**$30.91**	**$10.77**	**$63.36**	**$117.58**	**$2.89**	**$193.88**	**$3.25**	**$12.64**	**$905.07**

Exhibit 1A
Mississippi Division of Medicaid
All Regions SFY 2025 MississippiCAN Capitation Rate Development
CY 2022 Encounter Data

SSI / Disabled Newborn Rate Cell

		Category of Service											
Calculation Step	**CY 2022 PMPM Cost Development**	**Inpatient Hospital - Maternity / Deliveries**	**Inpatient Hospital - Psychiatric / Substance Abuse**	**Inpatient Hospital - Other**	**Outpatient Hospital - Emergency Room**	**Outpatient Hospital - Pharmacy**	**Outpatient Hospital - Other**	**Physician - Maternity / Deliveries**	**Physician - Psychiatric / Substance Abuse**	**Physician - Other**	**Dental**	**Other**	**Total**
a	CY 2022 Member Months	5,039	5,039	5,039	5,039	5,039	5,039	5,039	5,039	5,039	5,039	5,039	**5,039**
b	Total Allowed Dollars	$14,004,077	$67,231	$3,888,917	$286,736	$236,674	$904,274	$0	$3,724	$6,982,000	$4,653	$1,010,700	**$27,388,986**
c = b / a	CY 2022 PMPM Costs	$2,779.14	$13.34	$771.76	$56.90	$46.97	$179.46	$0.00	$0.74	$1,385.59	$0.92	$200.58	**$5,435.40**
d	MYPAC Member Identification Change	1.000	1.000	1.000	1.000	1.000	1.000	N/A	1.000	1.000	1.000	1.000	**1.000**
e	Encounter to Financial Adjustment	0.979	0.979	0.979	1.007	1.007	1.007	N/A	1.007	1.007	0.971	1.007	**0.988**
f	Missing Data	1.003	1.000	1.002	1.002	1.000	1.002	N/A	1.001	1.002	1.003	1.000	**1.002**
g	IBNR Adjustment	1.019	1.017	1.016	1.003	1.003	1.003	N/A	1.002	1.001	1.001	1.004	**1.012**
h	Non-Covered Services	1.000	1.000	1.000	1.000	1.000	1.000	N/A	1.000	1.000	1.000	1.000	**1.000**
i	Remove Zolgensma Claims	1.000	1.000	1.000	1.000	1.000	1.000	N/A	1.000	1.000	1.000	1.000	**1.000**
j	TPL Adjustment	0.998	0.998	0.998	0.998	0.998	0.998	N/A	0.998	0.998	0.998	0.998	**0.998**
k	IMD Removal	1.000	1.000	1.000	1.000	1.000	1.000	N/A	1.000	1.000	1.000	1.000	**1.000**
l	IMD Repricing	1.000	1.000	1.000	1.000	1.000	1.000	N/A	1.000	1.000	1.000	1.000	**1.000**
m	SSI Children - COE Change	1.000	1.000	1.000	1.000	1.000	1.000	N/A	1.000	1.000	1.000	1.000	**1.000**
Product of c through m	**Adjusted CY 2022 PMPM Costs**	**$2,772.61**	**$13.26**	**$768.04**	**$57.47**	**$47.35**	**$181.25**	**$0.00**	**$0.74**	**$1,396.56**	**$0.90**	**$202.35**	**$5,440.53**

Non-SSI Newborns 0 to 2 Months Rate Cell

		Category of Service											
Calculation Step	**CY 2022 PMPM Cost Development**	**Inpatient Hospital - Maternity / Deliveries**	**Inpatient Hospital - Psychiatric / Substance Abuse**	**Inpatient Hospital - Other**	**Outpatient Hospital - Emergency Room**	**Outpatient Hospital - Pharmacy**	**Outpatient Hospital - Other**	**Physician - Maternity / Deliveries**	**Physician - Psychiatric / Substance Abuse**	**Physician - Other**	**Dental**	**Other**	**Total**
a	CY 2022 Member Months	67,578	67,578	67,578	67,578	67,578	67,578	67,578	67,578	67,578	67,578	67,578	**67,578**
b	Total Allowed Dollars	$87,571,946	$0	$7,532,674	$1,541,127	$151,806	$1,949,311	$0	$9,720	$29,497,384	$55,359	$957,872	**$129,267,199**
c = b / a	CY 2022 PMPM Costs[1]	$1,295.86	$0.00	$111.47	$22.81	$2.25	$28.85	$0.00	$0.14	$436.49	$0.82	$14.17	**$1,912.86**
d	MYPAC Member Identification Change	1.000	N/A	1.000	1.000	1.000	1.000	N/A	1.000	1.000	1.000	1.000	**1.000**
e	Encounter to Financial Adjustment	0.979	N/A	0.979	1.007	1.007	1.007	N/A	1.007	1.007	0.971	1.007	**0.986**
f	Missing Data	1.002	N/A	1.003	1.003	1.003	1.003	N/A	1.004	1.002	1.001	1.104	**1.003**
g	IBNR Adjustment	1.019	N/A	1.019	1.002	1.002	1.002	N/A	1.002	1.001	1.001	1.006	**1.015**
h	Non-Covered Services	1.000	N/A	1.000	1.000	1.000	1.000	N/A	1.000	1.000	1.000	1.000	**1.000**
i	Remove Zolgensma Claims	1.000	N/A	1.000	1.000	1.000	1.000	N/A	1.000	0.881	1.000	1.000	**0.973**
j	TPL Adjustment	0.998	N/A	0.998	0.998	0.998	0.998	N/A	0.998	0.998	0.998	0.998	**0.998**
k	IMD Removal	1.000	N/A	1.000	1.000	1.000	1.000	N/A	1.000	1.000	1.000	1.000	**1.000**
l	IMD Repricing	1.000	N/A	1.000	1.000	1.000	1.000	N/A	1.000	1.000	1.000	1.000	**1.000**
m	SSI Children - COE Change	1.000	N/A	1.000	1.000	1.000	1.000	N/A	1.000	1.000	1.000	1.000	**1.000**
Product of c through m	**Adjusted CY 2022 PMPM Costs**	**$1,293.17**	**$0.00**	**$111.18**	**$23.03**	**$2.27**	**$29.13**	**$0.00**	**$0.15**	**$388.05**	**$0.79**	**$15.82**	**$1,863.59**

Exhibit 1A
Mississippi Division of Medicaid
All Regions SFY 2025 MississippiCAN Capitation Rate Development
CY 2022 Encounter Data

Non-SSI Newborns 3 to 12 Months Rate Cell

		Category of Service											
Calculation Step	CY 2022 PMPM Cost Development	Inpatient Hospital - Maternity / Deliveries	Inpatient Hospital - Psychiatric / Substance Abuse	Inpatient Hospital - Other	Outpatient Hospital - Emergency Room	Outpatient Hospital - Pharmacy	Outpatient Hospital - Other	Physician - Maternity / Deliveries	Physician - Psychiatric / Substance Abuse	Physician - Other	Dental	Other	Total
a	CY 2022 Member Months	232,493	232,493	232,493	232,493	232,493	232,493	232,493	232,493	232,493	232,493	232,493	**232,493**
b	Total Allowed Dollars	$860,044	$0	$8,451,777	$5,841,876	$378,487	$7,349,076	$0	$6,433	$30,767,777	$290,546	$1,749,853	**$55,695,868**
c = b / a	CY 2022 PMPM Costs	$3.70	$0.00	$36.35	$25.13	$1.63	$31.61	$0.00	$0.03	$132.34	$1.25	$7.53	**$239.56**
d	MYPAC Member Identification Change	1.000	N/A	1.000	1.000	1.000	1.000	N/A	1.000	1.000	1.000	1.000	**1.000**
e	Encounter to Financial Adjustment	0.979	N/A	0.979	1.007	1.007	1.007	N/A	1.007	1.007	0.971	1.007	**1.002**
f	Missing Data	1.003	N/A	1.002	1.003	1.002	1.003	N/A	1.003	1.002	1.001	1.180	**1.008**
g	IBNR Adjustment	1.048	N/A	1.037	1.003	1.003	1.003	N/A	1.002	1.001	1.001	1.006	**1.008**
h	Non-Covered Services	1.000	N/A	1.000	1.000	1.000	1.000	N/A	1.000	1.000	1.000	1.000	**1.000**
i	Remove Zolgensma Claims	1.000	N/A	1.000	1.000	1.000	1.000	N/A	1.000	0.940	1.000	1.000	**0.967**
j	TPL Adjustment	0.998	N/A	0.998	0.998	0.998	0.998	N/A	0.998	0.998	0.998	0.998	**0.998**
k	IMD Removal	1.000	N/A	1.000	1.000	1.000	1.000	N/A	1.000	1.000	1.000	1.000	**1.000**
l	IMD Repricing	1.000	N/A	1.000	1.000	1.000	1.000	N/A	1.000	1.000	1.000	1.000	**1.000**
m	SSI Children - COE Change	1.000	N/A	1.000	1.000	1.000	1.000	N/A	1.000	1.000	1.000	1.000	**1.000**
Product of c through m	**Adjusted CY 2022 PMPM Costs**	**$3.80**	**$0.00**	**$36.92**	**$25.41**	**$1.65**	**$31.95**	**$0.00**	**$0.03**	**$125.39**	**$1.21**	**$8.97**	**$235.33**

Foster Care Rate Cell

		Category of Service											
Calculation Step	CY 2022 PMPM Cost Development	Inpatient Hospital - Maternity / Deliveries	Inpatient Hospital - Psychiatric / Substance Abuse	Inpatient Hospital - Other	Outpatient Hospital - Emergency Room	Outpatient Hospital - Pharmacy	Outpatient Hospital - Other	Physician - Maternity / Deliveries	Physician - Psychiatric / Substance Abuse	Physician - Other	Dental	Other	Total
a	CY 2022 Member Months	82,463	82,463	82,463	82,463	82,463	82,463	82,463	82,463	82,463	82,463	82,463	**82,463**
b	Total Allowed Dollars	$108,566	$20,826,834	$649,484	$663,372	$192,649	$3,005,829	$10,997	$5,734,540	$7,660,449	$2,305,374	$1,251,589	**$42,409,682**
c = b / a	CY 2022 PMPM Costs[1]	$1.32	$252.56	$7.88	$8.04	$2.34	$36.45	$0.13	$69.54	$92.90	$27.96	$15.18	**$514.29**
d	MYPAC Member Identification Change	1.000	0.980	1.000	0.974	0.998	0.987	1.000	0.676	0.947	0.975	0.990	**0.934**
e	Encounter to Financial Adjustment	0.979	0.979	0.979	1.007	1.007	1.007	1.007	1.007	1.007	0.971	1.007	**0.990**
f	Missing Data	1.000	1.000	1.000	1.001	1.001	1.001	1.001	1.001	1.000	1.001	0.981	**1.000**
g	IBNR Adjustment	1.014	1.027	1.028	1.004	1.003	1.004	1.001	1.001	1.001	1.000	1.010	**1.015**
h	Non-Covered Services	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	**1.000**
i	Remove Zolgensma Claims	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	**1.000**
j	TPL Adjustment	0.998	0.998	0.998	0.998	0.998	0.998	0.998	0.998	0.998	0.998	0.998	**0.998**
k	IMD Removal	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	**1.000**
l	IMD Repricing	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	**1.000**
m	SSI Children - COE Change	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	**1.000**
Product of c through m	**Adjusted CY 2022 PMPM Costs**	**$1.30**	**$248.29**	**$7.91**	**$7.91**	**$2.35**	**$36.33**	**$0.13**	**$47.30**	**$88.52**	**$26.46**	**$14.95**	**$481.46**

Exhibit 1A
Mississippi Division of Medicaid
All Regions SFY 2025 MississippiCAN Capitation Rate Development
CY 2022 Encounter Data

MYPAC Rate Cell

		Category of Service											
Calculation Step	**CY 2022 PMPM Cost Development**	**Inpatient Hospital - Maternity / Deliveries**	**Inpatient Hospital - Psychiatric / Substance Abuse**	**Inpatient Hospital - Other**	**Outpatient Hospital - Emergency Room**	**Outpatient Hospital - Pharmacy**	**Outpatient Hospital - Other**	**Physician - Maternity / Deliveries**	**Physician - Psychiatric / Substance Abuse**	**Physician - Other**	**Dental**	**Other**	**Total**
a	CY 2022 Member Months	10,612	10,612	10,612	10,612	10,612	10,612	10,612	10,612	10,612	10,612	10,612	**10,612**
b	Total Allowed Dollars	$10,786	$3,303,457	$21,595	$144,890	$21,651	$300,435	$4,102	$7,579,631	$7,200,922	$247,887	$148,947	**$18,984,303**
c = b / a	CY 2022 PMPM Costs	$1.02	$311.29	$2.03	$13.65	$2.04	$28.31	$0.39	$714.25	$678.56	$23.36	$14.04	**$1,788.95**
d	MYPAC Member Identification Change	2.789	1.390	3.550	1.596	1.347	1.568	2.077	1.864	1.179	1.603	1.726	**1.512**
e	Encounter to Financial Adjustment	0.979	0.979	0.979	1.007	1.007	1.007	1.007	1.007	1.007	0.971	1.007	**1.002**
f	Missing Data	1.000	1.000	1.000	1.004	1.009	1.004	1.000	1.000	1.000	1.003	1.045	**1.001**
g	IBNR Adjustment	1.011	1.065	1.051	1.015	1.015	1.014	1.001	1.000	1.000	1.001	1.094	**1.012**
h	Non-Covered Services	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	**1.000**
i	Remove Zolgensma Claims	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	**1.000**
j	TPL Adjustment	0.998	0.998	0.998	0.998	0.998	0.998	0.998	0.998	0.998	0.998	0.998	**0.998**
k	IMD Removal	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	**1.000**
l	IMD Repricing	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	**1.000**
m	SSI Children - COE Change	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	**1.000**
Product of c through m	**Adjusted CY 2022 PMPM Costs**	**$2.80**	**$450.26**	**$7.41**	**$22.33**	**$2.83**	**$45.43**	**$0.81**	**$1,338.60**	**$804.47**	**$36.41**	**$27.82**	**$2,739.17**

MA Children Rate Cell

		Category of Service											
Calculation Step	**CY 2022 PMPM Cost Development**	**Inpatient Hospital - Maternity / Deliveries**	**Inpatient Hospital - Psychiatric / Substance Abuse**	**Inpatient Hospital - Other**	**Outpatient Hospital - Emergency Room**	**Outpatient Hospital - Pharmacy**	**Outpatient Hospital - Other**	**Physician - Maternity / Deliveries**	**Physician - Psychiatric / Substance Abuse**	**Physician - Other**	**Dental**	**Other**	**Total**
a	CY 2022 Member Months	2,558,562	2,558,562	2,558,562	2,558,562	2,558,562	2,558,562	2,558,562	2,558,562	2,558,562	2,558,562	2,558,562	**2,558,562**
b	Total Allowed Dollars	$2,969,914	$26,477,977	$15,937,761	$24,504,299	$4,333,988	$57,883,102	$775,688	$30,365,208	$144,247,595	$63,889,014	$12,478,645	**$383,863,190**
c = b / a	CY 2022 PMPM Costs	$1.16	$10.35	$6.23	$9.58	$1.69	$22.62	$0.30	$11.87	$56.38	$24.97	$4.88	**$150.03**
d	MYPAC Member Identification Change	0.999	0.979	1.000	0.998	0.999	0.999	0.998	0.899	0.996	0.999	0.996	**0.988**
e	Encounter to Financial Adjustment	0.979	0.979	0.979	1.007	1.007	1.007	1.007	1.007	1.007	0.971	1.007	**0.998**
f	Missing Data	1.001	1.001	1.001	1.002	1.003	1.003	1.002	1.002	1.002	1.002	1.363	**1.014**
g	IBNR Adjustment	1.015	1.015	1.015	1.002	1.002	1.002	1.001	1.001	1.001	1.001	1.006	**1.003**
h	Non-Covered Services	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	**1.000**
i	Remove Zolgensma Claims	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	**1.000**
j	TPL Adjustment	0.998	0.998	0.998	0.998	0.998	0.998	0.998	0.998	0.998	0.998	0.998	**0.998**
k	IMD Removal	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	**1.000**
l	IMD Repricing	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	**1.000**
m	SSI Children - COE Change	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	**1.000**
Product of c through m	**Adjusted CY 2022 PMPM Costs**	**$1.15**	**$10.05**	**$6.18**	**$9.65**	**$1.71**	**$22.81**	**$0.30**	**$10.75**	**$56.61**	**$24.24**	**$6.69**	**$150.16**

Exhibit 1A
Mississippi Division of Medicaid
All Regions SFY 2025 MississippiCAN Capitation Rate Development
CY 2022 Encounter Data

Quasi-CHIP Rate Cell

		Category of Service											
Calculation Step	**CY 2022 PMPM Cost Development**	**Inpatient Hospital - Maternity / Deliveries**	**Inpatient Hospital - Psychiatric / Substance Abuse**	**Inpatient Hospital - Other**	**Outpatient Hospital - Emergency Room**	**Outpatient Hospital - Pharmacy**	**Outpatient Hospital - Other**	**Physician - Maternity / Deliveries**	**Physician - Psychiatric / Substance Abuse**	**Physician - Other**	**Dental**	**Other**	**Total**
a	CY 2022 Member Months	283,644	283,644	283,644	283,644	283,644	283,644	283,644	283,644	283,644	283,644	283,644	**283,644**
b	Total Allowed Dollars	$308,447	$3,685,595	$1,719,270	$1,976,198	$560,878	$5,288,882	$81,783	$3,628,429	$14,972,700	$8,897,406	$1,679,072	**$42,798,661**
c = b / a	CY 2022 PMPM Costs	$1.09	$12.99	$6.06	$6.97	$1.98	$18.65	$0.29	$12.79	$52.79	$31.37	$5.92	**$150.89**
d	MYPAC Member Identification Change	1.000	0.981	0.991	0.997	0.998	0.999	1.000	0.913	0.994	0.999	0.997	**0.988**
e	Encounter to Financial Adjustment	0.979	0.979	0.979	1.007	1.007	1.007	1.007	1.007	1.007	0.971	1.007	**0.996**
f	Missing Data	1.001	1.001	1.001	1.003	1.004	1.003	1.002	1.002	1.002	1.002	1.290	**1.013**
g	IBNR Adjustment	1.015	1.015	1.016	1.003	1.003	1.002	1.001	1.001	1.001	1.001	1.005	**1.003**
h	Non-Covered Services	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	**1.000**
i	Remove Zolgensma Claims	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	**1.000**
j	TPL Adjustment	0.998	0.998	0.998	0.998	0.998	0.998	0.998	0.998	0.998	0.998	0.998	**0.998**
k	IMD Removal	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	**1.000**
l	IMD Repricing	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	**1.000**
m	SSI Children - COE Change	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	**1.000**
Product of c through m	**Adjusted CY 2022 PMPM Costs**	**$1.08**	**$12.64**	**$5.96**	**$7.01**	**$2.00**	**$18.81**	**$0.29**	**$11.78**	**$52.89**	**$30.45**	**$7.69**	**$150.61**

Exhibit 2
Mississippi Division of Medicaid
All Regions SFY 2025 MississippiCAN Capitation Rate Development
Final Base Data and Projection Assumptions

Non-Newborn SSI / Disabled Rate Cell

		Category of Service											
Calculation Step	SFY 2025 PMPM Cost Development	Inpatient Hospital - Maternity / Deliveries	Inpatient Hospital - Psychiatric / Substance Abuse	Inpatient Hospital - Other	Outpatient Hospital - Emergency Room	Outpatient Hospital - Pharmacy	Outpatient Hospital - Other	Physician - Maternity / Deliveries	Physician - Psychiatric / Substance Abuse	Physician - Other	Dental	Other	Total
	Base Period Summaries												
a	CY 2022 PMPM Costs	$2.42	$36.43	$127.78	$31.99	$50.89	$118.39	$0.53	$43.16	$169.12	$8.91	$59.16	**$648.77**
	Trends												
b	Utilization Trend Factors CY 2022 to SFY 2025	1.025	1.130	1.130	1.000	1.051	1.130	1.025	1.157	1.143	1.103	1.077	**1.117**
c	Charge Trend Factors CY 2022 to SFY 2025	0.955	0.976	0.955	1.035	1.104	1.044	1.026	1.064	1.061	1.012	1.045	**1.032**
d	Seasonal Virus Adjustment	0.982	0.995	0.958	0.971	0.997	0.985	0.994	1.000	0.984	1.000	0.996	**0.983**
	Population Changes												
e	SFY 2025 Population Acuity Adjustment	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	**1.000**
f	Postpartum Coverage Extension	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	**1.000**
g	Hemophilia Population Carve-In	0.999	0.999	1.015	1.000	1.000	1.000	0.999	1.000	1.000	1.000	1.003	**1.003**
	Program Changes												
h	Gene Therapy Drug Coverage	1.000	1.000	1.012	1.000	1.000	1.000	1.000	1.000	1.130	1.000	1.000	**1.038**
	Reimbursement Changes												
i	Preventative and Diagnostic Dental Reimbursement Change	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.028	1.000	**1.000**
j	Restorative Dental Reimbursement Change	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.025	1.000	**1.000**
Product of a through j	**Projected SFY 2025 PMPM Costs**	**$2.32**	**$39.92**	**$135.78**	**$32.15**	**$58.84**	**$137.57**	**$0.55**	**$53.12**	**$228.02**	**$10.47**	**$66.50**	**$765.25**

Breast and Cervical Cancer Rate Cell

		Category of Service											
Calculation Step	SFY 2025 PMPM Cost Development	Inpatient Hospital - Maternity / Deliveries	Inpatient Hospital - Psychiatric / Substance Abuse	Inpatient Hospital - Other	Outpatient Hospital - Emergency Room	Outpatient Hospital - Pharmacy	Outpatient Hospital - Other	Physician - Maternity / Deliveries	Physician - Psychiatric / Substance Abuse	Physician - Other	Dental	Other	Total
	Base Period Summaries												
a	CY 2022 PMPM Costs	$0.00	$0.00	$149.06	$21.21	$846.91	$561.98	$0.00	$6.66	$879.12	$8.34	$40.39	**$2,513.67**
	Trends												
b	Utilization Trend Factors CY 2022 to SFY 2025	N/A	N/A	1.077	1.000	1.051	1.077	N/A	1.077	1.143	1.103	1.077	**1.091**
c	Charge Trend Factors CY 2022 to SFY 2025	N/A	N/A	0.955	1.035	1.104	1.046	N/A	1.050	1.058	1.000	1.039	**1.063**
d	Seasonal Virus Adjustment	N/A	N/A	0.957	0.994	1.000	0.997	N/A	1.000	0.997	1.000	1.000	**0.996**
	Population Changes												
e	SFY 2025 Population Acuity Adjustment	N/A	N/A	1.000	1.000	1.000	1.000	N/A	1.000	1.000	1.000	1.000	**1.000**
f	Postpartum Coverage Extension	N/A	N/A	1.000	1.000	1.000	1.000	N/A	1.000	1.000	1.000	1.000	**1.000**
g	Hemophilia Population Carve-In	N/A	N/A	1.000	1.000	1.000	1.000	N/A	1.000	1.000	1.000	1.000	**1.000**
	Program Changes												
h	Gene Therapy Drug Coverage	N/A	N/A	1.000	1.000	1.000	1.000	N/A	1.000	1.000	1.000	1.000	**1.000**
	Reimbursement Changes												
i	Preventative and Diagnostic Dental Reimbursement Change	N/A	N/A	1.000	1.000	1.000	1.000	N/A	1.000	1.000	1.024	1.000	**1.000**
j	Restorative Dental Reimbursement Change	N/A	N/A	1.000	1.000	1.000	1.000	N/A	1.000	1.000	1.000	1.000	**1.000**
Product of a through j	**Projected SFY 2025 PMPM Costs**	**$0.00**	**$0.00**	**$146.70**	**$21.81**	**$982.51**	**$631.30**	**$0.00**	**$7.54**	**$1,060.03**	**$9.42**	**$45.16**	**$2,904.47**

Exhibit 2
Mississippi Division of Medicaid
All Regions SFY 2025 MississippiCAN Capitation Rate Development
Final Base Data and Projection Assumptions

MA Adult Rate Cell

		Category of Service											
Calculation Step	SFY 2025 PMPM Cost Development	Inpatient Hospital - Maternity / Deliveries	Inpatient Hospital - Psychiatric / Substance Abuse	Inpatient Hospital - Other	Outpatient Hospital - Emergency Room	Outpatient Hospital - Pharmacy	Outpatient Hospital - Other	Physician - Maternity / Deliveries	Physician - Psychiatric / Substance Abuse	Physician - Other	Dental	Other	Total
	Base Period Summaries												
a	CY 2022 PMPM Costs	$28.10	$5.29	$29.37	$25.25	$12.79	$60.91	$6.73	$8.58	$105.56	$4.72	$13.85	**$301.15**
	Trends												
b	Utilization Trend Factors CY 2022 to SFY 2025	1.025	1.051	1.051	1.000	1.038	1.051	1.025	1.051	1.051	1.103	1.077	**1.045**
c	Charge Trend Factors CY 2022 to SFY 2025	1.039	1.039	1.039	1.052	1.077	1.056	1.035	1.040	1.040	1.000	1.039	**1.045**
d	Seasonal Virus Adjustment	0.979	0.983	0.952	0.953	0.989	0.965	0.994	1.000	0.956	1.000	0.994	**0.966**
	Population Changes												
e	SFY 2025 Population Acuity Adjustment	0.985	0.985	0.985	0.985	0.985	0.985	0.985	0.985	0.985	0.985	0.985	**0.985**
f	Postpartum Coverage Extension	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	**1.000**
g	Hemophilia Population Carve-In	1.002	0.999	0.999	1.000	1.001	1.000	1.001	1.000	1.000	1.000	1.000	**1.000**
	Program Changes												
h	Gene Therapy Drug Coverage	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	**1.000**
	Reimbursement Changes												
i	Preventative and Diagnostic Dental Reimbursement Change	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.028	1.000	**1.000**
j	Restorative Dental Reimbursement Change	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.002	1.000	**1.000**
Product of a through j	**Projected SFY 2025 PMPM Costs**	**$28.90**	**$5.59**	**$30.04**	**$24.95**	**$13.94**	**$64.24**	**$6.99**	**$9.24**	**$108.60**	**$5.28**	**$15.16**	**$312.93**

Pregnant Women Rate Cell

		Category of Service											
Calculation Step	SFY 2025 PMPM Cost Development	Inpatient Hospital - Maternity / Deliveries	Inpatient Hospital - Psychiatric / Substance Abuse	Inpatient Hospital - Other	Outpatient Hospital - Emergency Room	Outpatient Hospital - Pharmacy	Outpatient Hospital - Other	Physician - Maternity / Deliveries	Physician - Psychiatric / Substance Abuse	Physician - Other	Dental	Other	Total
	Base Period Summaries												
a	CY 2022 PMPM Costs	$461.96	$1.26	$6.57	$30.91	$10.77	$63.36	$117.58	$2.89	$193.88	$3.25	$12.64	**$905.07**
	Trends												
b	Utilization Trend Factors CY 2022 to SFY 2025	1.025	1.051	1.051	1.000	1.038	1.051	1.025	1.051	1.025	1.103	1.077	**1.028**
c	Charge Trend Factors CY 2022 to SFY 2025	1.039	1.039	1.039	1.052	1.077	1.053	1.035	1.038	1.039	1.002	1.039	**1.040**
d	Seasonal Virus Adjustment	0.989	0.971	0.973	0.974	0.982	0.978	0.998	1.000	0.987	1.000	0.999	**0.988**
	Population Changes												
e	SFY 2025 Population Acuity Adjustment	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	**1.000**
f	Postpartum Coverage Extension	0.481	0.742	0.742	0.742	0.742	0.742	0.481	0.742	0.742	0.742	0.742	**0.575**
g	Hemophilia Population Carve-In	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	**1.000**
	Program Changes												
h	Gene Therapy Drug Coverage	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	**1.000**
	Reimbursement Changes												
i	Preventative and Diagnostic Dental Reimbursement Change	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.032	1.000	**1.000**
j	Restorative Dental Reimbursement Change	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.012	1.000	**1.000**
Product of a through j	**Projected SFY 2025 PMPM Costs**	**$233.96**	**$0.99**	**$5.18**	**$23.50**	**$8.77**	**$50.89**	**$59.83**	**$2.34**	**$151.30**	**$2.78**	**$10.49**	**$550.03**

Exhibit 2
Mississippi Division of Medicaid
All Regions SFY 2025 MississippiCAN Capitation Rate Development
Final Base Data and Projection Assumptions

SSI / Disabled Newborn Rate Cell

Calculation Step	SFY 2025 PMPM Cost Development	Category of Service: Inpatient Hospital - Maternity / Deliveries	Inpatient Hospital - Psychiatric / Substance Abuse	Inpatient Hospital - Other	Outpatient Hospital - Emergency Room	Outpatient Hospital - Pharmacy	Outpatient Hospital - Other	Physician - Maternity / Deliveries	Physician - Psychiatric / Substance Abuse	Physician - Other	Dental	Other	Total
	Base Period Summaries												
a	CY 2022 PMPM Costs	$2,772.61	$13.26	$768.04	$57.47	$47.35	$181.25	$0.00	$0.74	$1,396.56	$0.90	$202.35	**$5,440.53**
	Trends												
b	Utilization Trend Factors CY 2022 to SFY 2025	1.025	1.000	1.000	1.000	1.064	1.077	N/A	1.077	1.051	1.103	1.077	**1.032**
c	Charge Trend Factors CY 2022 to SFY 2025	1.086	1.086	1.086	1.065	1.131	1.066	N/A	1.015	1.012	1.000	1.055	**1.065**
d	Seasonal Virus Adjustment	1.000	1.000	0.994	0.995	1.000	0.998	N/A	1.000	0.999	1.000	1.000	**0.999**
	Population Changes												
e	SFY 2025 Population Acuity Adjustment	1.000	1.000	1.000	1.000	1.000	1.000	N/A	1.000	1.000	1.000	1.000	**1.000**
f	Postpartum Coverage Extension	1.000	1.000	1.000	1.000	1.000	1.000	N/A	1.000	1.000	1.000	1.000	**1.000**
g	Hemophilia Population Carve-In	1.000	1.000	1.000	1.000	1.000	1.000	N/A	1.000	1.000	1.000	1.000	**1.000**
	Program Changes												
h	Gene Therapy Drug Coverage	1.000	1.000	1.000	1.000	1.000	1.000	N/A	1.000	1.000	1.000	1.000	**1.000**
	Reimbursement Changes												
i	Preventative and Diagnostic Dental Reimbursement Change	1.000	1.000	1.000	1.000	1.000	1.000	N/A	1.000	1.000	1.067	1.000	**1.000**
j	Restorative Dental Reimbursement Change	1.000	1.000	1.000	1.000	1.000	1.000	N/A	1.000	1.000	1.000	1.000	**1.000**
Product of a through j	**Projected SFY 2025 PMPM Costs**	**$3,085.93**	**$14.39**	**$829.05**	**$60.88**	**$56.97**	**$207.63**	**$0.00**	**$0.81**	**$1,483.56**	**$1.06**	**$229.67**	**$5,969.95**

Non-SSI Newborns 0 to 2 Months Rate Cel

Calculation Step	SFY 2025 PMPM Cost Development	Category of Service: Inpatient Hospital - Maternity / Deliveries	Inpatient Hospital - Psychiatric / Substance Abuse	Inpatient Hospital - Other	Outpatient Hospital - Emergency Room	Outpatient Hospital - Pharmacy	Outpatient Hospital - Other	Physician - Maternity / Deliveries	Physician - Psychiatric / Substance Abuse	Physician - Other	Dental	Other	Total
	Base Period Summaries												
a	CY 2022 PMPM Costs	$1,293.17	$0.00	$111.18	$23.03	$2.27	$29.13	$0.00	$0.15	$388.05	$0.79	$15.82	**$1,863.59**
	Trends												
b	Utilization Trend Factors CY 2022 to SFY 2025	1.025	N/A	1.000	1.000	1.064	1.077	N/A	1.077	1.038	1.103	1.077	**1.027**
c	Charge Trend Factors CY 2022 to SFY 2025	1.086	N/A	1.086	1.065	1.131	1.065	N/A	1.040	1.012	1.000	1.043	**1.069**
d	Seasonal Virus Adjustment	1.000	N/A	0.979	0.973	0.975	0.967	N/A	1.000	0.996	1.000	0.995	**0.997**
	Population Changes												
e	SFY 2025 Population Acuity Adjustment	1.000	N/A	1.000	1.000	1.000	1.000	N/A	1.000	1.000	1.000	1.000	**1.000**
f	Postpartum Coverage Extension	1.000	N/A	1.000	1.000	1.000	1.000	N/A	1.000	1.000	1.000	1.000	**1.000**
g	Hemophilia Population Carve-In	1.000	N/A	1.000	1.000	1.000	1.000	N/A	1.000	1.000	1.000	1.000	**1.000**
	Program Changes												
h	Gene Therapy Drug Coverage	1.000	N/A	1.000	1.000	1.000	1.000	N/A	1.000	1.081	1.000	1.000	**1.016**
	Reimbursement Changes												
i	Preventative and Diagnostic Dental Reimbursement Change	1.000	N/A	1.000	1.000	1.000	1.000	N/A	1.000	1.000	1.042	1.000	**1.000**
j	Restorative Dental Reimbursement Change	1.000	N/A	1.000	1.000	1.000	1.000	N/A	1.000	1.000	1.000	1.000	**1.000**
Product of a through j	**Projected SFY 2025 PMPM Costs**	**$1,438.69**	**$0.00**	**$118.19**	**$23.86**	**$2.66**	**$32.31**	**$0.00**	**$0.16**	**$438.96**	**$0.91**	**$17.67**	**$2,073.43**

Exhibit 2
Mississippi Division of Medicaid
All Regions SFY 2025 MississippiCAN Capitation Rate Development
Final Base Data and Projection Assumptions

Non-SSI Newborns 3 to 12 Months Rate Cell

		Category of Service											
Calculation Step	SFY 2025 PMPM Cost Development	Inpatient Hospital - Maternity / Deliveries	Inpatient Hospital - Psychiatric / Substance Abuse	Inpatient Hospital - Other	Outpatient Hospital - Emergency Room	Outpatient Hospital - Pharmacy	Outpatient Hospital - Other	Physician - Maternity / Deliveries	Physician - Psychiatric / Substance Abuse	Physician - Other	Dental	Other	Total
	Base Period Summaries												
a	CY 2022 PMPM Costs	$3.80	$0.00	$36.92	$25.41	$1.65	$31.95	$0.00	$0.03	$125.39	$1.21	$8.97	**$235.33**
	Trends												
b	Utilization Trend Factors CY 2022 to SFY 2025	1.025	N/A	1.000	1.000	1.064	1.077	N/A	1.077	1.051	1.103	1.077	**1.042**
c	Charge Trend Factors CY 2022 to SFY 2025	0.974	N/A	0.974	1.065	1.131	1.066	N/A	1.031	1.043	1.000	1.038	**1.037**
d	Seasonal Virus Adjustment	1.000	N/A	0.967	0.966	0.971	0.952	N/A	1.000	0.981	1.000	0.993	**0.974**
	Population Changes												
e	SFY 2025 Population Acuity Adjustment	1.000	N/A	1.000	1.000	1.000	1.000	N/A	1.000	1.000	1.000	1.000	**1.000**
f	Postpartum Coverage Extension	1.000	N/A	1.000	1.000	1.000	1.000	N/A	1.000	1.000	1.000	1.000	**1.000**
g	Hemophilia Population Carve-In	1.000	N/A	1.000	1.000	1.000	1.000	N/A	1.000	1.000	1.000	1.000	**1.000**
	Program Changes												
h	Gene Therapy Drug Coverage	1.000	N/A	1.000	1.000	1.000	1.000	N/A	1.000	1.146	1.000	1.000	**1.080**
	Reimbursement Changes												
i	Preventative and Diagnostic Dental Reimbursement Change	1.000	N/A	1.000	1.000	1.000	1.000	N/A	1.000	1.000	1.071	1.000	**1.000**
j	Restorative Dental Reimbursement Change	1.000	N/A	1.000	1.000	1.000	1.000	N/A	1.000	1.000	1.001	1.000	**1.000**
Product of a through j	**Projected SFY 2025 PMPM Costs**	**$3.79**	**$0.00**	**$34.78**	**$26.14**	**$1.92**	**$34.92**	**$0.00**	**$0.03**	**$154.57**	**$1.43**	**$9.96**	**$267.56**

Foster Care Rate Cell

		Category of Service											
Calculation Step	SFY 2025 PMPM Cost Development	Inpatient Hospital - Maternity / Deliveries	Inpatient Hospital - Psychiatric / Substance Abuse	Inpatient Hospital - Other	Outpatient Hospital - Emergency Room	Outpatient Hospital - Pharmacy	Outpatient Hospital - Other	Physician - Maternity / Deliveries	Physician - Psychiatric / Substance Abuse	Physician - Other	Dental	Other	Total
	Base Period Summaries												
a	CY 2022 PMPM Costs	$1.30	$248.29	$7.91	$7.91	$2.35	$36.33	$0.13	$47.30	$88.52	$26.46	$14.95	**$481.46**
	Trends												
b	Utilization Trend Factors CY 2022 to SFY 2025	1.025	1.077	1.077	1.000	1.064	1.077	1.025	1.077	1.077	1.103	1.077	**1.077**
c	Charge Trend Factors CY 2022 to SFY 2025	0.974	1.070	0.974	1.065	1.131	1.071	1.037	1.054	1.048	1.019	1.049	**1.059**
d	Seasonal Virus Adjustment	0.968	0.999	0.963	0.965	0.990	0.973	1.000	1.000	0.969	1.000	0.995	**0.990**
	Population Changes												
e	SFY 2025 Population Acuity Adjustment	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	**1.000**
f	Postpartum Coverage Extension	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	**1.000**
g	Hemophilia Population Carve-In	0.999	0.999	1.008	1.001	1.010	1.000	0.999	1.000	1.000	1.000	0.999	**1.000**
	Program Changes												
h	Gene Therapy Drug Coverage	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	**1.000**
	Reimbursement Changes												
i	Preventative and Diagnostic Dental Reimbursement Change	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.032	1.000	**1.002**
j	Restorative Dental Reimbursement Change	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.032	1.000	**1.002**
Product of a through j	**Projected SFY 2025 PMPM Costs**	**$1.26**	**$285.42**	**$8.06**	**$8.13**	**$2.83**	**$40.77**	**$0.14**	**$53.67**	**$96.77**	**$31.72**	**$16.80**	**$545.58**

Exhibit 2
Mississippi Division of Medicaid
All Regions SFY 2025 MississippiCAN Capitation Rate Development
Final Base Data and Projection Assumptions

MYPAC Rate Cell

		Category of Service											
Calculation Step	SFY 2025 PMPM Cost Development	Inpatient Hospital - Maternity / Deliveries	Inpatient Hospital - Psychiatric / Substance Abuse	Inpatient Hospital - Other	Outpatient Hospital - Emergency Room	Outpatient Hospital - Pharmacy	Outpatient Hospital - Other	Physician - Maternity / Deliveries	Physician - Psychiatric / Substance Abuse	Physician - Other	Dental	Other	Total
	Base Period Summaries												
a	CY 2022 PMPM Costs	$2.80	$450.26	$7.41	$22.33	$2.83	$45.43	$0.81	$1,338.60	$804.47	$36.41	$27.82	**$2,739.17**
	Trends												
b	Utilization Trend Factors CY 2022 to SFY 2025	1.025	1.077	1.077	1.000	1.064	1.077	1.025	1.004	1.007	1.103	1.077	**1.020**
c	Charge Trend Factors CY 2022 to SFY 2025	0.974	1.024	0.974	1.065	1.131	1.067	1.037	1.089	1.084	1.022	1.027	**1.074**
d	Seasonal Virus Adjustment	1.000	0.999	0.982	0.986	0.997	0.977	1.000	1.000	0.997	1.000	0.999	**0.998**
	Population Changes												
e	SFY 2025 Population Acuity Adjustment	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	**1.000**
f	Postpartum Coverage Extension	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	**1.000**
g	Hemophilia Population Carve-In	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	**1.000**
	Program Changes												
h	Gene Therapy Drug Coverage	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	**1.000**
	Reimbursement Changes												
i	Preventative and Diagnostic Dental Reimbursement Change	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.027	1.000	**1.000**
j	Restorative Dental Reimbursement Change	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.035	1.000	**1.000**
Product of a through j	**Projected SFY 2025 PMPM Costs**	**$2.79**	**$495.93**	**$7.63**	**$23.44**	**$3.40**	**$51.02**	**$0.86**	**$1,463.13**	**$875.01**	**$43.62**	**$30.73**	**$2,997.56**

MA Children Rate Cell

		Category of Service											
Calculation Step	SFY 2025 PMPM Cost Development	Inpatient Hospital - Maternity / Deliveries	Inpatient Hospital - Psychiatric / Substance Abuse	Inpatient Hospital - Other	Outpatient Hospital - Emergency Room	Outpatient Hospital - Pharmacy	Outpatient Hospital - Other	Physician - Maternity / Deliveries	Physician - Psychiatric / Substance Abuse	Physician - Other	Dental	Other	Total
	Base Period Summaries												
a	CY 2022 PMPM Costs	$1.15	$10.05	$6.18	$9.65	$1.71	$22.81	$0.30	$10.75	$56.61	$24.24	$6.69	**$150.16**
	Trends												
b	Utilization Trend Factors CY 2022 to SFY 2025	1.025	1.077	1.077	1.000	1.064	1.077	1.025	1.077	1.077	1.103	1.077	**1.075**
c	Charge Trend Factors CY 2022 to SFY 2025	0.974	1.043	0.974	1.065	1.131	1.068	1.037	1.040	1.044	1.019	1.029	**1.041**
d	Seasonal Virus Adjustment	0.990	0.999	0.968	0.956	0.986	0.954	0.997	1.000	0.947	1.000	0.995	**0.969**
	Population Changes												
e	SFY 2025 Population Acuity Adjustment	1.025	1.025	1.025	1.025	1.025	1.025	1.025	1.025	1.025	1.025	1.025	**1.025**
f	Postpartum Coverage Extension	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	**1.000**
g	Hemophilia Population Carve-In	1.000	1.000	1.002	1.000	1.005	1.000	1.000	1.000	1.000	1.000	1.000	**1.000**
	Program Changes												
h	Gene Therapy Drug Coverage	1.000	1.000	1.010	1.000	1.000	1.000	1.000	1.000	1.064	1.000	1.000	**1.024**
	Reimbursement Changes												
i	Preventative and Diagnostic Dental Reimbursement Change	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.029	1.000	**1.005**
j	Restorative Dental Reimbursement Change	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.036	1.000	**1.006**
Product of a through j	**Projected SFY 2025 PMPM Costs**	**$1.17**	**$11.55**	**$6.51**	**$10.08**	**$2.09**	**$25.66**	**$0.33**	**$12.35**	**$65.77**	**$29.77**	**$7.57**	**$172.86**

Exhibit 2
Mississippi Division of Medicaid
All Regions SFY 2025 MississippiCAN Capitation Rate Development
Final Base Data and Projection Assumptions

Quasi-CHIP Rate Cell

		Category of Service											
Calculation Step	**SFY 2025 PMPM Cost Development**	**Inpatient Hospital - Maternity / Deliveries**	**Inpatient Hospital - Psychiatric / Substance Abuse**	**Inpatient Hospital - Other**	**Outpatient Hospital - Emergency Room**	**Outpatient Hospital - Pharmacy**	**Outpatient Hospital - Other**	**Physician - Maternity / Deliveries**	**Physician - Psychiatric / Substance Abuse**	**Physician - Other**	**Dental**	**Other**	**Total**
	Base Period Summaries												
a	CY 2022 PMPM Costs	$1.08	$12.64	$5.96	$7.01	$2.00	$18.81	$0.29	$11.78	$52.89	$30.45	$7.69	**$150.61**
	Trends												
b	Utilization Trend Factors CY 2022 to SFY 2025	1.025	1.077	1.077	1.000	1.064	1.077	1.025	1.077	1.077	1.103	1.077	**1.078**
c	Charge Trend Factors CY 2022 to SFY 2025	0.974	1.035	0.974	1.065	1.131	1.070	1.050	1.041	1.044	1.025	1.027	**1.040**
d	Seasonal Virus Adjustment	0.994	0.998	0.988	0.956	0.992	0.959	1.000	1.000	0.935	1.000	0.994	**0.969**
	Population Changes												
e	SFY 2025 Population Acuity Adjustment	1.025	1.025	1.025	1.025	1.025	1.025	1.025	1.025	1.025	1.025	1.025	**1.025**
f	Postpartum Coverage Extension	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	**1.000**
g	Hemophilia Population Carve-In	1.000	1.000	1.000	1.002	1.011	1.001	1.000	1.000	1.000	1.000	1.000	**1.000**
	Program Changes												
h	Gene Therapy Drug Coverage	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	**1.000**
	Reimbursement Changes												
i	Preventative and Diagnostic Dental Reimbursement Change	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.029	1.000	**1.006**
j	Restorative Dental Reimbursement Change	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.028	1.000	**1.006**
Product of a through j	**Projected SFY 2025 PMPM Costs**	**$1.10**	**$14.40**	**$6.33**	**$7.33**	**$2.47**	**$21.32**	**$0.32**	**$13.53**	**$56.95**	**$37.33**	**$8.66**	$169.75

Exhibit 3
Mississippi Division of Medicaid
SFY 2025 MississippiCAN Capitation Rate Development
Statewide Non-Service Expense Allocation Development

Rate Cell	*a* Projected SFY 2025 Membership	*b* SFY 2025 PMPM Cost	*c* Fixed Non-Service Expense Load	*d* Non-Service Percentage	*e = d × j* Non-Service PMPM	*f* Margin Percentage	*g = f × j* Margin PMPM	*h* Premium Tax Percentage	*i = h × j* Premium Tax PMPM	*j = (b + c) / (1 - d - f - h)* Total
Non-Newborn SSI / Disabled	716,865	$765.25	$9.99	6.15%	$53.55	1.80%	$15.67	3.00%	$26.12	$870.59
Breast and Cervical Cancer	912	$2,904.47	$9.99	6.15%	$201.33	1.80%	$58.91	3.00%	$98.19	$3,272.89
MA Adult	690,767	$312.93	$9.99	6.15%	$22.31	1.80%	$6.53	3.00%	$10.88	$362.64
Pregnant Women	201,312	$550.03	$9.99	6.15%	$38.69	1.80%	$11.32	3.00%	$18.87	$628.90
SSI / Disabled Newborn	5,977	$5,969.95	$9.99	6.15%	$413.10	1.80%	$120.88	3.00%	$201.46	$6,715.37
Non-SSI Newborns 0 to 2 Months	68,675	$2,073.43	$9.99	6.15%	$143.92	1.80%	$42.11	3.00%	$70.19	$2,339.64
Non-SSI Newborns 3 to 12 Months	228,658	$267.56	$9.99	6.15%	$19.17	1.80%	$5.61	3.00%	$9.35	$311.68
Foster Care	94,542	$545.58	$9.99	6.15%	$38.38	1.80%	$11.23	3.00%	$18.72	$623.89
MYPAC	10,757	$2,997.56	$9.99	6.15%	$207.76	1.80%	$60.79	3.00%	$101.32	$3,377.43
MA Children	3,121,602	$172.86	$9.99	6.15%	$12.63	1.80%	$3.70	3.00%	$6.16	$205.33
Quasi-CHIP	366,592	$169.75	$9.99	6.15%	$12.42	1.80%	$3.63	3.00%	$6.06	$201.84
Total	**5,506,661**	**$327.43**	**$9.99**	**6.15%**	**$23.31**	**1.80%**	**$6.82**	**3.00%**	**$11.37**	**$378.91**

Exhibit 4
Mississippi Division of Medicaid
SFY 2025 MississippiCAN Capitation Rate Development
Final SFY 2025 Capitation Rates

Rate Cell	*a* SFY 2025 Statewide Capitation Rates	*b* Area Adjustments	*c = a × b* SFY 2025 Regional Capitation Rates	*d = c × -1.00%* Quality Withhold	*e = c + d* Total Rate at 1.0 Risk Score after Withhold	*f* Projected SFY 2025 Member Months
Non-Newborn SSI / Disabled	$870.59			($8.71)	$861.88	716,865
North Region		0.878	$764.62	($7.65)	$756.97	250,536
Central Region		1.040	905.24	($9.05)	$896.19	259,238
South Region		1.097	954.92	($9.55)	$945.37	207,091
Breast and Cervical Cancer	$3,272.89			($32.73)	$3,240.16	912
North Region		0.878	$2,874.53	($28.75)	$2,845.78	186
Central Region		1.040	3,403.17	($34.03)	$3,369.14	301
South Region		1.097	3,589.93	($35.90)	$3,554.03	425
MA Adult	$362.64			($3.63)	$359.01	690,767
North Region		0.993	$360.00	($3.60)	$356.40	186,517
Central Region		1.026	372.10	($3.72)	$368.37	215,088
South Region		0.983	356.35	($3.56)	$352.79	289,162
Pregnant Women	$628.90			($6.29)	$622.61	201,312
North Region		0.993	$624.32	($6.24)	$618.08	66,481
Central Region		1.026	645.30	($6.45)	$638.85	74,991
South Region		0.983	618.00	($6.18)	$611.82	59,840
SSI / Disabled Newborn	$6,715.37			($67.15)	$6,648.22	5,977
North Region		1.018	$6,839.33	($68.39)	$6,770.94	1,874
Central Region		1.075	7,219.49	($72.19)	$7,147.29	2,541
South Region		0.913	6,129.93	($61.30)	$6,068.63	1,562
Non-SSI Newborns 0 to 2 Months	$2,339.64			($23.40)	$2,316.24	68,675
North Region		1.018	$2,382.83	($23.83)	$2,359.00	21,619
Central Region		1.075	2,515.27	($25.15)	$2,490.12	25,152
South Region		0.913	2,135.67	($21.36)	$2,114.32	21,904
Non-SSI Newborns 3 to 12 Months	$311.68			($3.12)	$308.56	228,658
North Region		1.018	$317.43	($3.17)	$314.26	72,261
Central Region		1.075	335.08	($3.35)	$331.72	82,830
South Region		0.913	284.51	($2.85)	$281.66	73,567
Foster Care	$623.89			($6.24)	$617.66	94,542
North Region		1.018	$635.41	($6.35)	$629.06	27,826
Central Region		1.075	670.73	($6.71)	$664.02	28,079
South Region		0.913	569.50	($5.70)	$563.81	38,638
MYPAC	$3,377.43			($33.77)	$3,343.66	10,757
North Region		1.018	$3,439.78	($34.40)	$3,405.38	3,150
Central Region		1.075	3,630.97	($36.31)	$3,594.66	3,523
South Region		0.913	3,082.99	($30.83)	$3,052.16	4,084
MA Children	$205.33			($2.05)	$203.28	3,121,602
North Region		1.018	$209.12	($2.09)	$207.03	890,157
Central Region		1.075	220.75	($2.21)	$218.54	1,053,233
South Region		0.913	187.43	($1.87)	$185.56	1,178,213
Quasi-CHIP	$201.84			($2.02)	$199.82	366,592
North Region		1.018	$205.57	($2.06)	$203.51	115,780
Central Region		1.075	217.00	($2.17)	$214.83	128,455
South Region		0.913	184.25	($1.84)	$182.40	122,356
Total Capitation Dollars						
Statewide Capitation Rates			$2,086,535,868			
Regional Capitation Rates			$2,086,535,868			

Exhibit 5
Mississippi Division of Medicaid
SFY 2024 to SFY 2025 Rate Change[1]

	Non-Newborn SSI / Disabled	Breast and Cervical Cancer	MA Adult	Pregnant Women	SSI / Disabled Newborn	Non-SSI Newborns 0 to 2 Months	Non-SSI Newborns 3 to 12 Months	Foster Care	MYPAC	MA Children	Quasi-CHIP	Total - Aggregated with Actual CY 2022 MMs	Total - Aggregated with Projected SFY 2025 MMs
Membership													
Actual CY 2022 MMs	720,708	961	451,802	96,821	5,039	67,578	232,493	82,463	10,612	2,558,562	283,644	4,510,683	N/A
Projected SFY 2025 MMs	716,865	912	690,767	201,312	5,977	68,675	228,658	94,542	10,757	3,121,602	366,592	N/A	5,506,661
SFY 2024 Capitation Rate - Including Pharmacy Services	**$1,322.15**	**$3,469.05**	**$571.88**	**$824.76**	**$8,357.35**	**$2,274.90**	**$303.45**	**$727.92**	**$3,798.05**	**$237.95**	**$249.54**	**$518.94**	**$496.04**
Remove Non-Physician Administered Pharmacy Services	0.628	0.804	0.720	0.950	0.915	0.978	0.874	0.843	0.943	0.812	0.779	0.748	0.758
SFY 2024 Capitation Rate - Excluding Pharmacy Services	**$830.91**	**$2,788.36**	**$411.47**	**$783.11**	**$7,649.10**	**$2,224.68**	**$265.16**	**$613.52**	**$3,582.92**	**$193.26**	**$194.45**	**$388.42**	**$375.97**
Shift CGT Estimates from Pharmacy to Physician	1.109	1.000	1.000	1.000	1.000	1.016	1.041	1.000	1.000	1.021	1.000	1.046	1.040
SFY 2024 Capitation Rate - Excluding Pharmacy Services with CGT Shift	**$921.75**	**$2,788.36**	**$411.47**	**$783.11**	**$7,649.10**	**$2,261.37**	**$276.00**	**$613.52**	**$3,582.92**	**$197.37**	**$194.45**	**$406.37**	**$391.03**
Base Period Data Update	0.969	1.114	0.986	0.990	0.862	1.004	1.086	0.922	0.853	1.036	1.032	0.993	0.995
Restate CY 2022 to SFY 2024 Trends	1.016	1.005	0.985	0.944	0.997	1.000	0.975	1.028	1.039	1.003	1.008	1.003	1.000
Restate SFY 2024 Hemophilia Population Carve-In[2]	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
Restate SFY 2024 Cell / Gene Therapy Coverage[2]	0.927	1.000	1.000	1.000	1.000	1.001	1.035	1.000	1.000	0.999	1.000	0.975	0.979
Remove SFY 2024 Population Acuity Adjustment[3] [4]	1.000	1.000	0.930	1.000	1.000	1.000	1.000	1.000	1.000	0.948	0.944	0.976	0.973
Other Restated SFY 2024 Assumptions	0.996	1.000	1.000	1.000	1.000	1.000	1.000	0.999	1.000	0.998	0.998	0.998	0.998
Updates Relative to SFY 2024 Assumptions	**0.909**	**1.119**	**0.903**	**0.934**	**0.859**	**1.005**	**1.096**	**0.947**	**0.886**	**0.982**	**0.979**	**0.946**	**0.946**
SFY 2024 to SFY 2025 Utilization Trends	1.039	1.032	1.017	1.012	1.012	1.011	1.018	1.027	1.007	1.025	1.027	1.027	1.025
SFY 2024 to SFY 2025 Unit Cost Trends	1.010	1.019	1.002	1.001	1.004	1.001	1.005	1.020	1.027	1.006	1.007	1.007	1.007
SFY 2025 Population Acuity Adjustment[3]	1.000	1.000	0.987	1.000	1.000	1.000	1.000	1.000	1.000	1.021	1.022	1.006	1.005
SFY 2025 Seasonal Virus Adjustment[3]	0.992	0.994	0.990	1.037	1.022	1.021	1.007	1.031	1.039	1.011	1.011	1.005	1.007
SFY 2025 Hemophilia Population Carve-In[2]	1.003	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.001	1.001
SFY 2025 Postpartum Coverage Extension[2]	1.000	1.000	1.000	0.840	1.000	1.000	1.000	1.000	1.000	1.000	1.000	0.993	0.988
SFY 2024 to SFY 2025 Restorative Dental Reimbursement Change[2]	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.001	1.000	1.002	1.002	1.001	1.001
Update SFY 2025 Admin	1.002	1.009	0.988	0.981	0.989	1.002	1.008	0.999	0.994	1.001	1.000	0.999	0.998
Remove SFY 2025 PBA Pharmacy Admin[2]	0.994	0.995	0.992	0.993	0.995	0.995	0.992	0.993	0.995	0.990	0.990	0.993	0.993
Preliminary SFY 2025 Rate Change	**0.944**	**1.174**	**0.881**	**0.803**	**0.878**	**1.035**	**1.129**	**1.017**	**0.943**	**1.040**	**1.038**	**0.976**	**0.969**
SFY 2025 Rate Change - Excluding Program Changes[2]	**1.022**	**1.180**	**0.888**	**0.963**	**0.883**	**1.040**	**1.100**	**1.023**	**0.948**	**1.049**	**1.046**	**1.013**	**1.007**
SFY 2025 Rate Change - Excluding COVID-19 Adjustments[3]	**0.952**	**1.181**	**0.970**	**0.774**	**0.859**	**1.014**	**1.122**	**0.986**	**0.907**	**1.063**	**1.065**	**0.990**	**0.984**

[1] Rate changes exclude MHAP, MAPS, TREAT, the quality withhold, and the VBP.
[2] Program change that increases or decreases total program costs outside of the control of the CCOs.
[3] COVID-19 adjustments include the population acuity adjustments.
[4] The final SFY Population Acuity Adjustment is still outstanding and will be updated in the next iteration of SFY 2024 rates.

Exhibit 6
Mississippi Division of Medicaid
SFY 2025 MississippiCAN Capitation Rate Development
Service Category to Milliman *HCGs* Grouper Category Mapping

MR Line	Broad Category of Service - SFY 2024 Definition	Broad Category of Service - SFY 2025 Definition	Description
I21a	Inpatient Hospital	Inpatient Hospital - Maternity / Deliveries	Mat Norm Delivery
I21b	Inpatient Hospital	Inpatient Hospital - Maternity / Deliveries	Mat Norm Delivery - Mom\Baby Cmbnd
I22a	Inpatient Hospital	Inpatient Hospital - Maternity / Deliveries	Mat Csect Delivery
I22b	Inpatient Hospital	Inpatient Hospital - Maternity / Deliveries	Mat Csect Delivery - Mom\Baby Cmbnd
I23a	Inpatient Hospital	Inpatient Hospital - Maternity / Deliveries	Well Newborn - Normal Delivery
I23b	Inpatient Hospital	Inpatient Hospital - Maternity / Deliveries	Well Newborn - Csect Delivery
I23c	Inpatient Hospital	Inpatient Hospital - Maternity / Deliveries	Well Newborn - Unknown Delivery
I24	Inpatient Hospital	Inpatient Hospital - Maternity / Deliveries	Other Newborn
I25	Inpatient Hospital	Inpatient Hospital - Maternity / Deliveries	Maternity Non-Delivery
I13a	Inpatient Hospital	Inpatient Hospital - Psychiatric / Substance Abuse	Psychiatric - Hospital
I13b	Inpatient Hospital	Inpatient Hospital - Psychiatric / Substance Abuse	Psychiatric - Residential
I14a	Inpatient Hospital	Inpatient Hospital - Psychiatric / Substance Abuse	Substance Use Disorders - Hospital
I14b	Inpatient Hospital	Inpatient Hospital - Psychiatric / Substance Abuse	Substance Use Disorders - Residential
I11a	Inpatient Hospital	Inpatient Hospital - Other	Medical
I11b	Inpatient Hospital	Inpatient Hospital - Other	Rehabilitation
I12	Inpatient Hospital	Inpatient Hospital - Other	Surgical
I31	Inpatient Hospital	Inpatient Hospital - Other	SNF
O10b	Outpatient Hospital	Outpatient Hospital - Emergency Room	Observation - With ED
O11	Outpatient Hospital	Outpatient Hospital - Emergency Room	Emergency Department
O16a	Outpatient Hospital	Outpatient Hospital - Pharmacy	Pharmacy - General
O16b	Outpatient Hospital	Outpatient Hospital - Pharmacy	Pharmacy - Chemotherapy
O10a	Outpatient Hospital	Outpatient Hospital - Other	Observation - Without ED
O12a	Outpatient Hospital	Outpatient Hospital - Other	Surgery - Hospital Outpatient
O12b	Outpatient Hospital	Outpatient Hospital - Other	Surgery - Ambulatory Surgery Center
O13a	Outpatient Hospital	Outpatient Hospital - Other	Radiology General - Therapeutic
O13b	Outpatient Hospital	Outpatient Hospital - Other	Radiology General - Diagnostic
O14a	Outpatient Hospital	Outpatient Hospital - Other	Radiology - CT/MRI/PET - CT Scan
O14b	Outpatient Hospital	Outpatient Hospital - Other	Radiology - CT/MRI/PET - MRI
O14c	Outpatient Hospital	Outpatient Hospital - Other	Radiology - CT/MRI/PET - PET
O15	Outpatient Hospital	Outpatient Hospital - Other	Pathology/Lab
O17	Outpatient Hospital	Outpatient Hospital - Other	Cardiovascular
O18	Outpatient Hospital	Outpatient Hospital - Other	PT/OT/ST
O31a	Outpatient Hospital	Outpatient Hospital - Other	Psychiatric - Partial Hospitalization
O31b	Outpatient Hospital	Outpatient Hospital - Other	Psychiatric - Intensive Outpatient
O32a	Outpatient Hospital	Outpatient Hospital - Other	Substance Use Disorders - Partial Hospitalization
O32b	Outpatient Hospital	Outpatient Hospital - Other	Substance Use Disorders - Intensive Outpatient
O41a	Outpatient Hospital	Outpatient Hospital - Other	Other - General
O41b	Outpatient Hospital	Outpatient Hospital - Other	Other - Blood
O41d	Outpatient Hospital	Outpatient Hospital - Other	Other - Clinic
O41e	Outpatient Hospital	Outpatient Hospital - Other	Other - Diagnostic
O41f	Outpatient Hospital	Outpatient Hospital - Other	Other - Dialysis
O41g	Outpatient Hospital	Outpatient Hospital - Other	Other - DME/Supplies
O41h	Outpatient Hospital	Outpatient Hospital - Other	Other - Trtmt/SpcltySvcs
O41j	Outpatient Hospital	Outpatient Hospital - Other	Other - Pulmonary
O41l	Outpatient Hospital	Outpatient Hospital - Other	Other - Urgent Care
O51a	Outpatient Hospital	Outpatient Hospital - Other	Preventive - General
O51b	Outpatient Hospital	Outpatient Hospital - Other	Preventive - Colonoscopy
O51c	Outpatient Hospital	Outpatient Hospital - Other	Preventive - Mammography
O51d	Outpatient Hospital	Outpatient Hospital - Other	Preventive - Lab
P21a	Physician	Physician - Maternity / Deliveries	Maternity - Normal Deliveries
P21b	Physician	Physician - Maternity / Deliveries	Maternity - Cesarean Deliveries
P21c	Physician	Physician - Maternity / Deliveries	Maternity - Non-Deliveries
P21d	Physician	Physician - Maternity / Deliveries	Maternity - Ancillary
P21e	Physician	Physician - Maternity / Deliveries	Maternity - Anesthesia
P31e	Physician	Physician - Psychiatric / Substance Abuse	Inpatient Visits - Psychiatric
P31f	Physician	Physician - Psychiatric / Substance Abuse	Inpatient Visits - Substance Use Disorders
P66	Physician	Physician - Psychiatric / Substance Abuse	Outpatient Psychiatric
P67	Physician	Physician - Psychiatric / Substance Abuse	Outpatient Substance Use Disorders
P11	Physician	Physician - Other	Inpatient Surgery
P13	Physician	Physician - Other	Inpatient Anesthesia
P14	Physician	Physician - Other	Outpatient Surgery
P15	Physician	Physician - Other	Office Surgery
P16	Physician	Physician - Other	Outpatient Anesthesia
P31d	Physician	Physician - Other	Inpatient Visits - Medical
P32c	Physician	Physician - Other	Office/Home Visits - PCP
P32d	Physician	Physician - Other	Office/Home Visits - Specialist
P33	Physician	Physician - Other	Urgent Care Visits
P34a	Physician	Physician - Other	Office Administered Drugs - General
P34b	Physician	Physician - Other	Office Administered Drugs - Chemotherapy
P35	Physician	Physician - Other	Allergy Testing
P36	Physician	Physician - Other	Allergy Immunotherapy
P37a	Physician	Physician - Other	Miscellaneous Medical - General
P37b	Physician	Physician - Other	Miscellaneous Medical - Gastroenterology
P37c	Physician	Physician - Other	Miscellaneous Medical - Ophthalmology
P37d	Physician	Physician - Other	Miscellaneous Medical - Otorhinolaryngology
P37e	Physician	Physician - Other	Miscellaneous Medical - Vestibular Function Tests
P37f	Physician	Physician - Other	Miscellaneous Medical - Non-Invas. Vasc. Diag. Studies
P37g	Physician	Physician - Other	Miscellaneous Medical - Pulmonology
P37h	Physician	Physician - Other	Miscellaneous Medical - Neurology
P37i	Physician	Physician - Other	Miscellaneous Medical - Central Nervous System Tests
P37j	Physician	Physician - Other	Miscellaneous Medical - Dermatology
P37k	Physician	Physician - Other	Miscellaneous Medical - Dialysis
P40a	Physician	Physician - Other	Preventive Other - General
P40b	Physician	Physician - Other	Preventive Other - Colonoscopy
P40c	Physician	Physician - Other	Preventive Other - Mammography
P40d	Physician	Physician - Other	Preventive Other - Lab
P41	Physician	Physician - Other	Preventive Immunizations
P42	Physician	Physician - Other	Preventive Well Baby Exams
P43	Physician	Physician - Other	Preventive Physical Exams
P44	Physician	Physician - Other	Vision Exams
P45	Physician	Physician - Other	Hearing and Speech Exams
P51a	Physician	Physician - Other	ED Visits and Observation Care - Observation Care
P51b	Physician	Physician - Other	ED Visits and Observation Care - ED Visits
P53	Physician	Physician - Other	Physical Therapy
P54	Physician	Physician - Other	Cardiovascular
P55b	Physician	Physician - Other	Radiology IP - CT Scan
P55c	Physician	Physician - Other	Radiology IP - MRI
P55d	Physician	Physician - Other	Radiology IP - PET
P55e	Physician	Physician - Other	Radiology IP - General - Therapeutic
P55f	Physician	Physician - Other	Radiology IP - General - Diagnostic
P56a	Physician	Physician - Other	Radiology OP - General - Therapeutic
P56b	Physician	Physician - Other	Radiology OP - General - Diagnostic
P57a	Physician	Physician - Other	Radiology OP- CT/MRI/PET - CT Scan
P57b	Physician	Physician - Other	Radiology OP- CT/MRI/PET - MRI
P57c	Physician	Physician - Other	Radiology OP- CT/MRI/PET - PET
P58c	Physician	Physician - Other	Radiology Office - General - Therapeutic
P58d	Physician	Physician - Other	Radiology Office - General - Diagnostic
P58e	Physician	Physician - Other	Radiology Office - General - Radiology Center - Therapeutic
P58f	Physician	Physician - Other	Radiology Office - General - Radiology Center - Diagnostic
P59a	Physician	Physician - Other	Radiology Office - CT/MRI/PET - CT Scan
P59b	Physician	Physician - Other	Radiology Office - CT/MRI/PET - MRI
P59c	Physician	Physician - Other	Radiology Office - CT/MRI/PET - PET
P59d	Physician	Physician - Other	Radiology Office - CT/MRI/PET - CT Scan - Radiology Center
P59e	Physician	Physician - Other	Radiology Office - CT/MRI/PET - MRI - Radiology Center
P59f	Physician	Physician - Other	Radiology Office - CT/MRI/PET - PET - Radiology Center
P61a	Physician	Physician - Other	Pathology/Lab - Inpatient & Outpatient - Inpatient
P61b	Physician	Physician - Other	Pathology/Lab - Inpatient & Outpatient - Outpatient
P63a	Physician	Physician - Other	Pathology/Lab - Office - General
P63b	Physician	Physician - Other	Pathology/Lab - Office - Venipuncture
P63c	Physician	Physician - Other	Pathology/Lab - Office - Independent Lab
P65	Physician	Physician - Other	Chiropractor
P99e	Physician	Physician - Other	Benefits Other - Reproductive Medicine
P99f	Physician	Physician - Other	Benefits Other - Temporary Codes
P99g	Physician	Physician - Other	Benefits Other - Documentation
P99z	Physician	Physician - Other	Benefits Other - Unclassified
P82a	Other	Other	Home Health Care - HH
P82b	Other	Other	Home Health Care - Hospice
P82c	Other	Other	Home Health Care - Home Health (Medicare Covered)
P82d	Other	Other	Home Health Care - Hospice - Home Based
P82e	Other	Other	Home Health Care - Hospice - Facility Based
P82f	Other	Other	Home Health Care - Home Health (Not Medicare Covered)
P82g	Other	Other	Home Health Care - Personal/Custodial Care
P82h	Other	Other	Home Health Care - Adult Day Health Care
P82i	Other	Other	Home Health Care - Home Respite Care
P82j	Other	Other	Home Health Care - Personal Emergency Response System (PERS)
P82k	Other	Other	Home Health Care - Home Modification
P82l	Other	Other	Home Health Care - Home Delivered Meals
P82m	Other	Other	Home Health Care - Assisted Living Facility
P82n	Other	Other	Home Health Care - Ancillary Services Provided in the Home
P83	Other	Other	Ambulance
P84	Other	Other	DME and Supplies
P85	Other	Other	Prosthetics
P89	Other	Other	Benefits Glasses/Contacts
P99a	Other	Other	Benefits Other - General
P99b	Other	Other	Benefits Other - Hearing Aids
P99d	Other	Other	Benefits Other - Acupuncture
P99h	Other	Other	Benefits Other - Non-Emergency Transportation
P99c	Dental	Dental	Benefits Other - Dental
R73a	Drug	Drug - Traditional	Prescription Drugs - Preferred Generic
R73b	Drug	Drug - Traditional	Prescription Drugs - Non-Preferred Generic
R74a	Drug	Drug - Traditional	Prescription Drugs - Preferred Brand
R74b	Drug	Drug - Traditional	Prescription Drugs - Non-Preferred Brand
R75	Drug	Drug - Specialty	Prescription Drugs - Specialty
R76	Drug	Drug - Traditional	Prescription Drugs - Preventive
P81a	Drug	Drug - Traditional	Prescription Drugs - Non-Specialty Generic
P81b	Drug	Drug - Traditional	Prescription Drugs - Non-Specialty Multi Source Brand
P81c	Drug	Drug - Traditional	Prescription Drugs - Non-Specialty Single Source Brand
P81e	Drug	Drug - Traditional	Prescription Drugs - OTC
P81g	Drug	Drug - Specialty	Prescription Drugs - Specialty

**Broad Category of Service "Drug" is excluded from base data.*

Exhibit 7A
Mississippi Division of Medicaid
MississippiCAN Historical Completed Non-Pharmacy PMPM Costs and Trends
All Populations

PMPM Costs by Month[1]

Month	Member Months	Inpatient Hospital Services	Outpatient Hospital Services	Physician Services	Dental Services	Other Services	Non-Pharmacy Total
January 2019	437,026	$86.20	$78.01	$116.03	$21.53	$15.83	$317.60
February 2019	435,583	$80.51	$75.26	$111.70	$18.77	$14.78	$301.01
March 2019	434,251	$85.38	$70.36	$104.88	$19.18	$15.42	$295.21
April 2019	434,281	$87.46	$73.80	$109.78	$20.23	$16.06	$307.33
May 2019	435,675	$89.86	$72.87	$104.61	$17.26	$15.59	$300.18
June 2019	436,565	$82.39	$71.61	$93.13	$17.96	$14.70	$279.79
July 2019	435,173	$88.31	$73.26	$103.38	$22.10	$16.56	$303.61
August 2019	432,187	$85.48	$70.17	$112.10	$21.22	$17.42	$306.40
September 2019	431,636	$87.31	$69.42	$108.57	$19.77	$16.54	$301.61
October 2019	432,302	$95.86	$75.40	$118.28	$22.69	$16.77	$329.00
November 2019	433,427	$81.80	$67.89	$105.64	$18.11	$16.02	$289.46
December 2019	435,721	$89.91	$70.62	$104.84	$16.16	$15.88	$297.41
CY 2019[2,4]	**434,486**	**$86.71**	**$72.39**	**$107.74**	**$19.58**	**$15.96**	**$302.39**
January 2020	434,689	$85.69	$75.84	$118.73	$20.39	$17.26	$317.91
February 2020	431,725	$76.77	$70.60	$110.64	$18.73	$15.75	$292.48
March 2020	429,908	$79.10	$57.79	$93.69	$12.03	$15.73	$258.34
April 2020	430,080	$70.41	$37.21	$69.57	$1.36	$12.38	$190.93
May 2020	434,572	$78.76	$50.69	$80.08	$10.02	$13.56	$233.11
June 2020	443,044	$84.08	$59.77	$95.09	$16.13	$14.80	$269.86
July 2020	450,515	$84.44	$60.18	$95.50	$17.18	$14.22	$271.52
August 2020	456,517	$81.43	$57.88	$95.70	$16.99	$14.94	$266.93
September 2020	460,496	$77.13	$59.82	$97.66	$17.11	$14.84	$266.56
October 2020	464,815	$78.34	$61.51	$101.49	$17.60	$15.53	$274.47
November 2020	470,075	$72.23	$57.90	$91.54	$15.30	$14.58	$251.55
December 2020	474,757	$81.09	$57.44	$91.85	$15.14	$14.94	$260.48
CY 2020[2,4]	**448,433**	**$79.12**	**$58.88**	**$95.13**	**$14.83**	**$14.88**	**$262.84**
January 2021	478,618	$83.60	$56.48	$93.82	$15.87	$15.49	$265.27
February 2021	481,326	$77.39	$50.06	$83.51	$13.77	$13.29	$238.02
March 2021	483,763	$88.55	$65.11	$103.32	$18.83	$16.46	$292.27
April 2021	483,831	$82.08	$65.60	$103.19	$16.92	$15.73	$283.52
May 2021	486,505	$89.59	$66.24	$97.55	$14.50	$15.68	$283.57
June 2021	488,764	$90.27	$71.77	$100.83	$16.31	$16.45	$295.64
July 2021	473,300	$92.34	$69.97	$101.16	$16.70	$16.42	$296.60
August 2021	452,472	$94.91	$66.90	$119.11	$16.37	$16.61	$313.90
September 2021	439,660	$85.91	$65.64	$111.00	$17.65	$15.90	$296.09
October 2021	428,718	$81.71	$66.42	$106.14	$17.18	$16.44	$287.89
November 2021	419,121	$78.40	$64.31	$105.37	$17.82	$15.04	$280.94
December 2021	412,166	$76.92	$64.95	$100.14	$15.54	$14.76	$272.31
CY 2021[3,4]	**460,687**	**$85.14**	**$64.46**	**$102.10**	**$16.45**	**$15.69**	**$283.84**
January 2022	402,787	$86.71	$65.28	$117.14	$15.46	$14.39	$298.98
February 2022	395,077	$76.13	$60.70	$103.24	$16.03	$13.91	$270.02
March 2022	387,921	$79.78	$69.96	$111.88	$18.11	$15.55	$295.27
April 2022	375,645	$80.83	$66.21	$106.18	$16.53	$14.63	$284.39
May 2022	370,307	$87.03	$68.92	$107.55	$15.97	$15.28	$294.76
June 2022	365,108	$86.92	$71.41	$105.17	$17.63	$15.26	$296.38
July 2022	365,066	$86.15	$82.51	$101.81	$16.69	$14.79	$301.95
August 2022	360,856	$83.95	$77.39	$131.59	$20.00	$16.15	$329.08
September 2022	362,119	$79.80	$69.59	$119.70	$18.97	$14.80	$302.87
October 2022	365,733	$81.90	$69.98	$122.35	$18.95	$14.67	$307.85
November 2022	368,931	$80.22	$72.25	$123.64	$17.73	$14.24	$308.08
December 2022	384,117	$79.43	$63.32	$101.14	$15.60	$13.83	$273.32
CY 2022[3]	**375,306**	**$82.41**	**$69.79**	**$112.62**	**$17.31**	**$14.79**	**$296.91**
January 2023	387,438	$81.59	$66.43	$117.77	$21.23	$14.69	$301.72
February 2023	391,178	$76.17	$64.63	$109.32	$19.45	$13.25	$282.82
March 2023	393,792	$80.52	$71.65	$119.92	$21.29	$14.95	$308.34
April 2023	397,906	$86.33	$68.17	$113.81	$18.49	$14.46	$301.26
May 2023	400,584	$92.69	$72.24	$117.65	$19.50	$15.11	$317.18
June 2023	403,351	$83.48	$73.71	$104.63	$19.77	$15.53	$297.12
July 2023	395,034	$93.99	$71.54	$102.20	$16.74	$15.91	$300.37
August 2023	395,228	$95.62	$83.08	$131.05	$18.33	$16.53	$344.61
September 2023	396,242	$85.03	$70.70	$113.26	$18.52	$14.61	$302.11
Q1-Q3 2023[3]	**395,639**	**$86.16**	**$71.35**	**$114.40**	**$19.26**	**$15.00**	**$306.17**

Annual PMPM Trends

CY 2017 to CY 2018	4.4%	1.9%	3.8%	-7.1%	3.2%	2.7%
CY 2018 to CY 2019	6.0%	3.3%	7.1%	-1.3%	7.0%	5.3%
CY 2019 to CY 2020	-8.7%	-18.7%	-11.7%	-24.3%	-6.8%	-13.1%
CY 2020 to CY 2021	7.6%	9.5%	7.3%	10.9%	5.5%	8.0%
CY 2021 to CY 2022	-3.2%	8.3%	10.3%	5.2%	-5.7%	4.6%
CY 2022 to Q3 2023	5.2%	2.6%	1.8%	13.0%	1.6%	3.6%
CY 2021 to Q3 2023 (Annualized)	0.6%	5.6%	6.3%	8.8%	-2.4%	4.1%

[1] MississippiCAN PMPM figures have been adjusted for: the carveout of Zolgensma claims, adjustments related to the 5% assessment application and removal, OPPS reimbursment changes not related to the 5% assessment, PAD reimbursement changes, annual PDL changes to drug costs, AAC inclusion in drug pricing logic, PRTF inclusion in managed care, OP Dental reimbursment changes, GME removal from capitation rates, NET subcapitation changes, provider settlements, emergency ambulance reimbursement increases, financial to encounter adjustments, pharmacy rate freeze, dental reimbursement, and IBNR, and blend MississippiCAN rate cells using consistent enrollment from September 2023 to be directly comparable by month.

[2] CY 2019 and CY 2020 assumed to be fully complete with no explicit IBNR adjustment.

[3] CY 2021, CY 2022, and Q1-Q3 2023 IBNR as reported by CCOs in financial templates.

[4] CY 2019, CY 2020, and CY 2021 data is consistent with the data that supported trends in CY 2024 rates. We rely on this data due to known issues with the data vendor transition.

Exhibit 7B
Mississippi Division of Medicaid
MississippiCAN Historical Completed Non-Pharmacy PMPM Costs and Trends
SSI+ Population

PMPM Costs by Month[1]

Month	Member Months	Inpatient Hospital Services	Outpatient Hospital Services	Physician Services	Dental Services	Other Services	Non-Pharmacy Total
January 2019	63,961	$198.50	$227.22	$234.41	$10.36	$63.23	$733.72
February 2019	63,934	$174.57	$213.32	$215.61	$8.92	$61.06	$673.48
March 2019	63,712	$178.20	$206.23	$219.44	$9.05	$63.21	$676.13
April 2019	63,901	$183.63	$215.72	$227.84	$9.80	$64.71	$701.69
May 2019	63,768	$192.95	$218.29	$225.39	$8.69	$65.25	$710.57
June 2019	63,938	$161.33	$209.80	$207.51	$7.81	$61.96	$648.42
July 2019	64,036	$182.70	$210.66	$220.97	$10.18	$65.36	$689.87
August 2019	63,876	$174.78	$207.85	$231.27	$10.27	$68.17	$692.34
September 2019	63,899	$197.09	$201.86	$220.26	$9.60	$66.37	$695.18
October 2019	63,899	$212.62	$216.94	$239.25	$10.97	$67.57	$747.35
November 2019	63,924	$183.13	$184.32	$202.08	$8.39	$66.06	$643.98
December 2019	64,030	$188.51	$194.34	$204.91	$7.61	$64.27	$659.65
CY 2019[2,4]	**63,907**	**$185.67**	**$208.88**	**$220.74**	**$9.30**	**$64.77**	**$689.36**
January 2020	63,847	$188.73	$226.90	$234.82	$10.35	$69.68	$730.49
February 2020	63,841	$166.78	$206.18	$215.37	$9.39	$63.40	$661.11
March 2020	63,589	$177.93	$178.56	$195.64	$5.45	$67.58	$625.17
April 2020	63,509	$136.50	$139.25	$147.50	$1.42	$56.27	$480.95
May 2020	63,644	$168.37	$170.55	$170.16	$4.78	$58.84	$572.69
June 2020	63,879	$188.05	$192.44	$205.15	$7.49	$63.46	$656.59
July 2020	63,809	$176.38	$190.78	$197.71	$7.89	$58.05	$630.81
August 2020	63,777	$168.70	$180.01	$197.94	$8.44	$60.01	$615.10
September 2020	63,769	$164.88	$190.01	$204.15	$8.48	$61.31	$628.84
October 2020	63,695	$173.83	$192.72	$208.37	$8.84	$65.03	$648.78
November 2020	63,697	$153.15	$179.97	$185.51	$7.20	$61.32	$587.16
December 2020	63,532	$168.66	$182.73	$186.36	$7.42	$64.29	$609.46
CY 2020[2,4]	**63,716**	**$169.33**	**$185.84**	**$195.72**	**$7.26**	**$62.44**	**$620.60**
January 2021	63,329	$164.01	$175.46	$192.86	$7.92	$67.65	$607.89
February 2021	63,319	$164.55	$160.21	$172.41	$6.83	$57.25	$561.26
March 2021	62,918	$191.50	$201.67	$223.97	$9.05	$69.72	$695.91
April 2021	62,480	$167.44	$200.73	$210.93	$8.53	$67.08	$654.70
May 2021	62,352	$190.40	$202.74	$203.26	$8.56	$66.37	$671.32
June 2021	62,201	$175.97	$219.42	$214.25	$8.69	$69.37	$687.70
July 2021	62,317	$211.09	$208.70	$203.27	$7.72	$68.86	$699.65
August 2021	62,105	$200.82	$188.88	$211.90	$8.56	$70.08	$680.24
September 2021	61,811	$185.05	$196.00	$212.98	$9.21	$67.48	$670.73
October 2021	61,544	$163.31	$196.46	$209.96	$8.68	$69.10	$647.51
November 2021	61,417	$164.26	$192.37	$200.31	$8.73	$63.19	$628.86
December 2021	61,244	$156.75	$186.10	$187.86	$7.32	$61.65	$599.68
CY 2021[3,4]	**62,253**	**$177.93**	**$194.06**	**$203.66**	**$8.32**	**$66.48**	**$650.45**
January 2022	60,951	$181.07	$191.38	$217.00	$7.22	$58.54	$655.21
February 2022	60,778	$161.99	$185.88	$204.53	$8.05	$56.15	$616.60
March 2022	60,481	$164.89	$217.34	$227.67	$8.79	$62.16	$680.85
April 2022	59,975	$155.54	$200.07	$211.58	$7.83	$58.63	$633.64
May 2022	59,934	$169.09	$205.91	$221.99	$8.21	$60.99	$666.19
June 2022	59,826	$155.99	$212.14	$219.90	$8.50	$61.25	$657.79
July 2022	60,035	$166.00	$247.69	$205.28	$7.46	$58.99	$685.43
August 2022	59,883	$160.89	$226.17	$249.44	$9.77	$64.14	$710.41
September 2022	59,914	$160.38	$191.75	$227.49	$9.38	$58.79	$647.78
October 2022	60,030	$169.43	$189.54	$232.59	$10.08	$58.01	$659.66
November 2022	59,900	$168.35	$196.77	$224.08	$8.88	$59.16	$657.25
December 2022	60,502	$151.48	$177.84	$194.62	$7.77	$58.83	$590.54
CY 2022[3]	**60,184**	**$163.76**	**$203.54**	**$219.68**	**$8.49**	**$59.64**	**$655.11**
January 2023	59,914	$172.75	$192.67	$235.62	$10.04	$60.25	$671.34
February 2023	60,531	$159.41	$192.59	$215.86	$9.02	$56.09	$632.97
March 2023	60,180	$159.25	$207.21	$242.47	$11.04	$60.95	$680.92
April 2023	60,119	$185.82	$199.99	$224.86	$9.03	$60.16	$679.86
May 2023	59,998	$185.40	$219.98	$248.99	$10.02	$62.46	$726.85
June 2023	59,842	$181.52	$227.41	$227.56	$9.57	$65.20	$711.27
July 2023	59,628	$202.94	$221.08	$221.51	$8.38	$65.02	$718.92
August 2023	59,543	$215.10	$258.76	$251.78	$10.60	$68.08	$804.33
September 2023	59,366	$175.48	$203.38	$221.03	$9.63	$59.66	$669.18
Q1-Q3 2023[3]	**59,902**	**$181.96**	**$213.67**	**$232.19**	**$9.70**	**$61.99**	**$699.52**

Annual PMPM Trends

CY 2017 to CY 2018	1.5%	2.7%	5.9%	-9.0%	2.5%	3.1%
CY 2018 to CY 2019	5.5%	4.2%	6.1%	-7.0%	7.1%	5.2%
CY 2019 to CY 2020	-8.8%	-11.0%	-11.3%	-21.9%	-3.6%	-10.0%
CY 2020 to CY 2021	5.1%	4.4%	4.1%	14.5%	6.5%	4.8%
CY 2021 to CY 2022	-8.0%	4.9%	7.9%	2.1%	-10.3%	0.7%
CY 2022 to Q3 2023	12.8%	5.7%	6.5%	16.4%	4.5%	7.8%
CY 2021 to Q3 2023 (Annualized)	1.2%	5.3%	7.2%	8.6%	-3.7%	4.0%

[1] MississippiCAN PMPM figures have been adjusted for: the carveout of Zolgensma claims, adjustments related to the 5% assessment application and removal, OPPS reimbursment changes not related to the 5% assessment, PAD reimbursement changes, annual PDL changes to drug costs, AAC inclusion in drug pricing logic, PRTF inclusion in managed care, OP Dental reimbursment changes, GME removal from capitation rates, NET subcapitation changes, provider settlements, emergency ambulance reimbursement increases, financial to encounter adjustments, pharmacy rate freeze, dental reimbursement, and IBNR, and blend MississippiCAN rate cells using consistent enrollment from September 2023 to be directly comparable by month.

[2] CY 2019 and CY 2020 assumed to be fully complete with no explicit IBNR adjustment.

[3] CY 2021, CY 2022, and Q1-Q3 2023 IBNR as reported by CCOs in financial templates.

[4] CY 2019, CY 2020, and CY 2021 data is consistent with the data that supported trends in CY 2024 rates. We rely on this data due to known issues with the data vendor transition.

Exhibit 7C
Mississippi Division of Medicaid
MississippiCAN Historical Completed Non-Pharmacy PMPM Costs and Trends
Adults Population

PMPM Costs by Month[1]

Month	Member Months	Inpatient Hospital Services	Outpatient Hospital Services	Physician Services	Dental Services	Other Services	Non-Pharmacy Total
January 2019	52,746	$35.17	$122.22	$149.20	$8.14	$13.37	$328.09
February 2019	52,322	$34.28	$109.15	$133.06	$6.79	$12.18	$295.46
March 2019	52,133	$38.74	$109.84	$132.65	$6.75	$11.57	$299.55
April 2019	52,042	$43.27	$115.77	$140.22	$8.14	$12.36	$319.76
May 2019	52,603	$46.92	$113.79	$142.09	$6.78	$13.02	$322.59
June 2019	52,901	$39.31	$110.19	$130.01	$5.88	$12.25	$297.64
July 2019	53,101	$41.62	$122.20	$141.33	$6.13	$13.12	$324.40
August 2019	52,700	$39.88	$113.93	$144.41	$6.92	$14.32	$319.45
September 2019	52,760	$40.00	$107.65	$136.34	$5.95	$13.43	$303.36
October 2019	52,643	$43.40	$118.10	$149.73	$6.93	$14.35	$332.50
November 2019	52,387	$37.46	$101.23	$127.41	$5.08	$13.27	$284.45
December 2019	52,385	$34.95	$106.91	$131.01	$5.02	$12.93	$290.82
CY 2019[2,4]	**52,560**	**$39.58**	**$112.58**	**$138.12**	**$6.54**	**$13.01**	**$309.84**
January 2020	51,740	$46.76	$116.12	$152.50	$6.43	$14.45	$336.27
February 2020	51,070	$39.79	$104.78	$137.17	$6.10	$12.99	$300.84
March 2020	50,820	$32.06	$90.14	$125.38	$5.57	$12.10	$265.24
April 2020	50,697	$23.82	$59.34	$102.21	$2.81	$9.82	$198.00
May 2020	51,903	$38.25	$83.47	$119.69	$4.68	$11.79	$257.88
June 2020	53,590	$39.61	$99.65	$138.33	$7.03	$12.01	$296.63
July 2020	55,460	$45.42	$103.07	$137.30	$6.49	$12.33	$304.60
August 2020	56,368	$52.45	$99.13	$130.62	$5.98	$12.28	$300.46
September 2020	57,006	$35.66	$93.48	$132.01	$6.16	$12.12	$279.43
October 2020	57,418	$33.25	$96.70	$133.68	$5.89	$12.74	$282.26
November 2020	58,070	$33.78	$94.80	$120.37	$4.99	$11.68	$265.63
December 2020	58,626	$35.31	$92.34	$127.51	$5.03	$11.46	$271.65
CY 2020[2,4]	**54,397**	**$38.01**	**$94.42**	**$129.73**	**$5.60**	**$12.15**	**$279.91**
January 2021	59,089	$39.67	$91.02	$122.36	$5.18	$11.99	$270.22
February 2021	59,414	$28.12	$79.21	$105.37	$4.61	$9.51	$226.81
March 2021	59,864	$35.59	$101.26	$131.41	$5.63	$11.72	$285.61
April 2021	60,010	$32.42	$99.84	$128.36	$6.27	$10.70	$277.60
May 2021	60,641	$38.11	$97.27	$120.70	$4.81	$11.01	$271.89
June 2021	61,139	$41.19	$102.94	$131.25	$5.16	$11.41	$291.95
July 2021	59,248	$47.69	$97.44	$124.94	$4.13	$11.31	$285.50
August 2021	56,422	$66.68	$98.21	$140.09	$4.55	$12.57	$322.10
September 2021	55,101	$48.92	$97.39	$134.71	$4.70	$11.73	$297.45
October 2021	53,607	$39.29	$98.05	$124.20	$4.30	$11.63	$277.47
November 2021	52,343	$44.65	$89.37	$124.23	$4.40	$11.32	$273.97
December 2021	51,472	$40.19	$97.26	$123.50	$4.00	$11.72	$276.67
CY 2021[3,4]	**57,363**	**$41.88**	**$95.77**	**$125.93**	**$4.81**	**$11.38**	**$279.77**
January 2022	49,902	$42.12	$97.00	$138.45	$4.17	$11.99	$293.73
February 2022	48,632	$32.21	$82.54	$118.91	$4.53	$10.50	$248.69
March 2022	47,747	$36.49	$99.70	$133.85	$4.67	$12.32	$287.02
April 2022	45,576	$33.08	$99.07	$126.28	$4.59	$11.79	$274.81
May 2022	44,970	$41.62	$105.35	$129.30	$4.68	$12.16	$293.11
June 2022	44,155	$35.05	$103.56	$135.84	$4.36	$13.25	$292.06
July 2022	44,459	$29.79	$119.97	$125.93	$3.57	$11.01	$290.27
August 2022	43,820	$35.57	$115.62	$149.35	$4.60	$12.28	$317.42
September 2022	44,035	$32.11	$101.58	$130.81	$4.90	$11.32	$280.72
October 2022	44,498	$33.12	$93.75	$126.85	$4.30	$11.48	$269.50
November 2022	43,681	$33.64	$99.68	$129.96	$4.53	$11.73	$279.54
December 2022	47,156	$33.92	$88.72	$115.59	$3.38	$10.27	$251.88
CY 2022[3]	**45,719**	**$34.89**	**$100.55**	**$130.09**	**$4.36**	**$11.67**	**$281.56**
January 2023	47,530	$43.41	$95.14	$133.03	$5.42	$10.76	$287.76
February 2023	47,779	$29.46	$91.10	$119.13	$4.72	$8.64	$253.05
March 2023	48,146	$31.28	$103.26	$134.54	$5.70	$10.45	$285.23
April 2023	49,216	$36.86	$93.81	$128.81	$4.43	$10.43	$274.34
May 2023	49,600	$41.74	$100.95	$133.34	$4.59	$11.26	$291.88
June 2023	49,907	$38.07	$97.61	$126.87	$4.37	$12.06	$278.99
July 2023	48,698	$36.97	$96.33	$120.47	$3.10	$11.42	$268.28
August 2023	49,287	$36.83	$110.42	$139.78	$4.74	$11.87	$303.65
September 2023	50,895	$41.10	$96.07	$116.32	$4.42	$10.28	$268.19
Q1-Q3 2023[3]	**49,006**	**$37.30**	**$98.30**	**$128.03**	**$4.61**	**$10.80**	**$279.04**

Annual PMPM Trends

CY 2017 to CY 2018	-6.4%	5.6%	1.2%	-14.4%	4.6%	1.3%
CY 2018 to CY 2019	-5.9%	-1.2%	2.3%	-14.4%	4.9%	-0.4%
CY 2019 to CY 2020	-4.0%	-16.1%	-6.1%	-14.4%	-6.7%	-9.7%
CY 2020 to CY 2021	10.2%	1.4%	-2.9%	-14.0%	-6.3%	0.0%
CY 2021 to CY 2022	-16.7%	5.0%	3.3%	-9.5%	2.5%	0.6%
CY 2022 to Q3 2023	7.9%	-2.5%	-1.8%	6.7%	-8.5%	-1.0%
CY 2021 to Q3 2023 (Annualized)	-6.0%	1.4%	0.9%	-2.2%	-2.8%	-0.1%

[1] MississippiCAN PMPM figures have been adjusted for: the carveout of Zolgensma claims, adjustments related to the 5% assessment application and removal, OPPS reimbursment changes not related to the 5% assessment, PAD reimbursement changes, annual PDL changes to drug costs, AAC inclusion in drug pricing logic, PRTF inclusion in managed care, OP Dental reimbursment changes, GME removal from capitation rates, NET subcapitation changes, provider settlements, emergency ambulance reimbursement increases, financial to encounter adjustments, pharmacy rate freeze, dental reimbursement, and IBNR, and blend MississippiCAN rate cells using consistent enrollment from September 2023 to be directly comparable by month.

[2] CY 2019 and CY 2020 assumed to be fully complete with no explicit IBNR adjustment.

[3] CY 2021, CY 2022, and Q1-Q3 2023 IBNR as reported by CCOs in financial templates.

[4] CY 2019, CY 2020, and CY 2021 data is consistent with the data that supported trends in CY 2024 rates. We rely on this data due to known issues with the data vendor transition.

Exhibit 7D
Mississippi Division of Medicaid
MississippiCAN Historical Completed Non-Pharmacy PMPM Costs and Trends
Children Population

PMPM Costs by Month[1]

Month	Member Months	Inpatient Hospital Services	Outpatient Hospital Services	Physician Services	Dental Services	Other Services	Non-Pharmacy Total
January 2019	320,319	$57.99	$39.15	$81.59	$26.23	$6.36	$211.32
February 2019	319,327	$55.38	$40.52	$82.46	$22.94	$5.57	$206.88
March 2019	318,406	$60.44	$35.10	$72.34	$23.49	$6.11	$197.48
April 2019	318,338	$61.66	$36.84	$76.05	$24.55	$6.52	$205.62
May 2019	319,304	$61.71	$35.35	$68.93	$20.90	$5.66	$192.54
June 2019	319,726	$59.86	$36.00	$59.04	$22.22	$5.26	$182.37
July 2019	318,036	$63.47	$35.98	$68.45	$27.41	$6.99	$202.31
August 2019	315,611	$61.31	$33.76	$77.71	$26.04	$7.37	$206.19
September 2019	314,977	$59.00	$35.08	$76.50	$24.34	$6.68	$201.61
October 2019	315,760	$66.65	$38.38	$83.45	$27.93	$6.57	$222.97
November 2019	317,116	$54.85	$37.73	$77.67	$22.45	$6.03	$198.74
December 2019	319,306	$64.96	$38.44	$75.34	$19.92	$6.29	$204.95
CY 2019[2,4]	**318,019**	**$60.61**	**$36.86**	**$74.96**	**$24.03**	**$6.28**	**$202.75**
January 2020	319,102	$57.17	$37.26	$84.59	$24.96	$6.81	$210.81
February 2020	316,814	$50.71	$36.33	$80.16	$22.92	$6.25	$196.37
March 2020	315,499	$52.94	$26.92	$62.95	$14.54	$5.55	$162.90
April 2020	315,874	$51.13	$12.05	$43.64	$1.09	$3.65	$111.55
May 2020	319,025	$53.28	$19.92	$50.25	$12.06	$4.41	$139.91
June 2020	325,575	$56.50	$25.08	$60.55	$19.54	$5.12	$166.79
July 2020	331,246	$58.33	$25.39	$62.74	$21.01	$5.41	$172.88
August 2020	336,372	$53.95	$25.14	$64.08	$20.72	$6.00	$169.89
September 2020	339,721	$52.42	$26.78	$65.49	$20.85	$5.63	$171.17
October 2020	343,702	$52.91	$27.97	$69.42	$21.51	$5.68	$177.49
November 2020	348,308	$48.79	$25.95	$62.98	$18.81	$5.31	$161.84
December 2020	352,599	$57.76	$25.19	$61.87	$18.55	$5.26	$168.62
CY 2020[2,4]	**330,320**	**$53.83**	**$26.16**	**$64.06**	**$18.05**	**$5.42**	**$167.52**
January 2021	356,200	$59.75	$25.59	$64.16	$19.42	$5.23	$174.15
February 2021	358,593	$52.85	$21.98	$57.28	$16.84	$4.78	$153.74
March 2021	360,981	$61.81	$30.30	$69.44	$23.20	$6.18	$190.93
April 2021	361,341	$57.93	$31.42	$72.35	$20.56	$5.91	$188.16
May 2021	363,512	$63.04	$32.35	$67.63	$17.46	$5.92	$186.41
June 2021	365,424	$66.20	$35.53	$67.98	$19.88	$6.29	$195.88
July 2021	351,735	$60.19	$36.25	$71.82	$20.81	$6.40	$195.48
August 2021	333,945	$61.91	$35.97	$92.21	$20.09	$6.16	$216.33
September 2021	322,748	$56.35	$32.91	$81.58	$21.70	$5.88	$198.42
October 2021	313,567	$57.07	$33.77	$77.52	$21.24	$6.33	$195.93
November 2021	305,361	$51.40	$33.23	$78.44	$22.09	$5.65	$190.81
December 2021	299,450	$51.68	$34.01	$73.94	$19.30	$5.50	$184.43
CY 2021[3,4]	**341,071**	**$58.35**	**$31.94**	**$72.86**	**$20.22**	**$5.85**	**$189.22**
January 2022	291,934	$60.43	$33.42	$88.72	$19.18	$5.60	$207.35
February 2022	285,667	$51.51	$30.80	$75.49	$19.73	$5.69	$183.23
March 2022	279,693	$55.59	$34.04	$79.95	$22.44	$6.39	$198.42
April 2022	270,094	$59.78	$32.54	$76.72	$20.46	$5.94	$195.45
May 2022	265,403	$63.75	$33.94	$76.02	$19.60	$6.30	$199.61
June 2022	261,127	$67.31	$36.43	$71.88	$21.89	$6.00	$203.51
July 2022	260,572	$64.80	$41.49	$72.04	$20.94	$6.22	$205.50
August 2022	257,153	$62.00	$39.67	$99.90	$24.87	$6.82	$233.26
September 2022	258,170	$57.42	$38.52	$91.37	$23.47	$6.24	$217.02
October 2022	261,205	$58.60	$40.89	$94.93	$23.39	$6.17	$223.99
November 2022	265,350	$56.14	$41.48	$97.88	$21.92	$5.30	$222.72
December 2022	276,459	$58.48	$34.99	$75.35	$19.40	$5.05	$193.26
CY 2022[3]	**269,402**	**$59.65**	**$36.52**	**$83.36**	**$21.44**	**$5.98**	**$206.94**
January 2023	279,994	$54.98	$35.08	$86.84	$26.37	$5.85	$209.13
February 2023	282,868	$52.74	$33.33	$81.52	$24.24	$5.13	$196.95
March 2023	285,466	$58.42	$37.85	$87.88	$26.20	$6.16	$216.51
April 2023	288,571	$59.55	$36.20	$84.02	$22.96	$5.62	$208.35
May 2023	290,986	$67.82	$36.44	$83.74	$24.11	$5.92	$218.04
June 2023	293,602	$56.03	$37.50	$71.25	$24.62	$5.78	$195.18
July 2023	286,708	$64.76	$36.02	$70.36	$20.90	$6.43	$198.47
August 2023	286,398	$64.00	$41.70	$100.43	$22.35	$6.59	$235.06
September 2023	285,981	$57.24	$38.57	$86.46	$22.87	$5.97	$211.11
Q1-Q3 2023[3]	**286,730**	**$59.51**	**$36.97**	**$83.61**	**$23.85**	**$5.94**	**$209.87**

Annual PMPM Trends

CY 2017 to CY 2018	8.9%	-1.0%	3.9%	-6.5%	3.4%	2.9%
CY 2018 to CY 2019	9.3%	4.9%	10.1%	0.0%	8.3%	7.5%
CY 2019 to CY 2020	-11.2%	-29.0%	-14.5%	-24.9%	-13.7%	-17.4%
CY 2020 to CY 2021	8.4%	22.1%	13.7%	12.0%	7.9%	13.0%
CY 2021 to CY 2022	2.2%	14.3%	14.4%	6.1%	2.1%	9.4%
CY 2022 to Q3 2023	-0.3%	1.4%	0.4%	12.9%	-0.7%	1.6%
CY 2021 to Q3 2023 (Annualized)	1.1%	8.1%	7.6%	9.2%	0.8%	5.7%

[1] MississippiCAN PMPM figures have been adjusted for: the carveout of Zolgensma claims, adjustments related to the 5% assessment application and removal, OPPS reimbursment changes not related to the 5% assessment, PAD reimbursement changes, annual PDL changes to drug costs, AAC inclusion in drug pricing logic, PRTF inclusion in managed care, OP Dental reimbursment changes, GME removal from capitation rates, NET subcapitation changes, provider settlements, emergency ambulance reimbursement increases, financial to encounter adjustments, pharmacy rate freeze, dental reimbursement, and IBNR, and blend MississippiCAN rate cells using consistent enrollment from September 2023 to be directly comparable by month.

[2] CY 2019 and CY 2020 assumed to be fully complete with no explicit IBNR adjustment.

[3] CY 2021, CY 2022, and Q1-Q3 2023 IBNR as reported by CCOs in financial templates.

[4] CY 2019, CY 2020, and CY 2021 data is consistent with the data that supported trends in CY 2024 rates. We rely on this data due to known issues with the data vendor transition.

Exhibit 7E
Mississippi Division of Medicaid
MississippiCAN Historical Completed Non-Pharmacy PMPM Costs and Trends
Deliveries
Per-Delivery Costs by Month[1]

Month	Deliveries	Inpatient Hospital Services	Outpatient Hospital Services	Physician Services	Dental Services	Other Services	Non-Pharmacy Total
January 2019	1,695	$3,986.61	$6.36	$1,127.91	$0.05	$19.20	$5,140.14
February 2019	1,415	$3,944.71	$12.76	$1,101.04	$0.04	$17.57	$5,076.12
March 2019	1,508	$3,983.59	$8.37	$1,088.77	$0.00	$19.28	$5,100.02
April 2019	1,468	$3,904.85	$9.85	$1,086.34	$0.08	$26.65	$5,027.76
May 2019	1,493	$4,103.76	$14.23	$1,123.88	$0.00	$21.75	$5,263.62
June 2019	1,449	$3,936.77	$15.86	$1,076.32	$0.00	$21.09	$5,050.04
July 2019	1,797	$3,864.92	$12.67	$1,074.26	$0.00	$15.48	$4,967.34
August 2019	1,721	$3,920.93	$10.89	$1,113.94	$0.03	$20.65	$5,066.44
September 2019	1,717	$3,975.27	$12.86	$1,123.17	$0.17	$17.94	$5,129.40
October 2019	1,732	$4,080.55	$13.20	$1,178.12	$0.00	$22.64	$5,294.51
November 2019	1,522	$3,936.21	$13.54	$1,162.09	$0.00	$25.46	$5,137.30
December 2019	1,741	$4,067.36	$8.60	$1,161.10	$0.00	$21.76	$5,258.81
CY 2019[2,4]	**1,605**	**$3,975.46**	**$11.60**	**$1,118.08**	**$0.03**	**$20.79**	**$5,125.96**
January 2020	1,684	$4,005.61	$15.08	$1,148.37	$0.07	$16.84	$5,185.97
February 2020	1,417	$3,978.15	$11.18	$1,144.31	$0.00	$26.62	$5,160.27
March 2020	1,479	$3,996.25	$11.88	$1,122.11	$0.00	$20.04	$5,150.28
April 2020	1,405	$3,950.93	$10.50	$1,125.32	$0.21	$19.14	$5,106.09
May 2020	1,449	$4,018.44	$16.20	$1,162.58	$0.00	$19.58	$5,216.80
June 2020	1,557	$3,964.22	$13.32	$1,141.01	$0.00	$19.67	$5,138.21
July 2020	1,668	$3,983.33	$13.39	$1,168.78	$0.00	$14.82	$5,180.31
August 2020	1,708	$4,139.11	$11.13	$1,193.06	$0.00	$17.68	$5,360.99
September 2020	1,698	$3,954.77	$6.72	$1,125.55	$0.07	$15.07	$5,102.18
October 2020	1,553	$3,884.76	$11.65	$1,184.50	$0.00	$18.76	$5,099.68
November 2020	1,535	$3,846.04	$12.77	$1,120.32	$0.00	$22.37	$5,001.49
December 2020	1,491	$3,792.28	$9.23	$1,147.52	$0.00	$17.87	$4,966.90
CY 2020[2,4]	**1,554**	**$3,959.49**	**$11.92**	**$1,148.62**	**$0.03**	**$19.04**	**$5,139.10**
January 2021	1,407	$4,269.88	$12.37	$1,149.08	$0.00	$17.68	$5,449.00
February 2021	1,314	$4,338.51	$7.37	$1,105.84	$0.04	$15.96	$5,467.73
March 2021	1,459	$4,219.80	$9.95	$1,093.70	$0.00	$19.23	$5,342.69
April 2021	1,218	$4,353.13	$10.97	$1,139.38	$0.00	$15.08	$5,518.56
May 2021	1,331	$4,216.00	$10.05	$1,101.03	$0.00	$19.13	$5,346.21
June 2021	1,424	$4,281.00	$12.71	$1,107.79	$0.00	$23.12	$5,424.63
July 2021	1,356	$4,403.17	$9.99	$1,115.62	$0.00	$13.70	$5,542.48
August 2021	1,480	$4,574.54	$11.38	$1,112.47	$0.00	$20.46	$5,718.86
September 2021	1,398	$4,436.80	$7.97	$1,147.27	$0.00	$13.67	$5,605.71
October 2021	1,354	$4,347.47	$6.05	$1,100.21	$0.08	$11.60	$5,465.42
November 2021	1,193	$4,330.23	$11.26	$1,102.57	$0.04	$17.15	$5,461.26
December 2021	1,258	$4,335.88	$11.09	$1,093.18	$0.00	$17.63	$5,457.78
CY 2021[3,4]	**1,349**	**$4,342.20**	**$10.10**	**$1,114.01**	**$0.01**	**$17.04**	**$5,483.36**
January 2022	1,224	$4,170.24	$11.88	$1,110.57	$0.00	$15.46	$5,308.14
February 2022	1,076	$4,165.75	$8.76	$1,122.41	$0.00	$16.47	$5,313.39
March 2022	1,165	$4,056.51	$7.35	$1,134.45	$0.00	$15.91	$5,214.22
April 2022	985	$4,004.37	$10.69	$1,142.38	$0.07	$17.30	$5,174.81
May 2022	1,037	$4,085.38	$16.03	$1,112.22	$0.00	$14.54	$5,228.18
June 2022	1,097	$4,134.15	$10.93	$1,142.85	$0.00	$17.84	$5,305.77
July 2022	1,154	$4,219.66	$15.71	$1,141.16	$0.00	$19.22	$5,395.75
August 2022	1,316	$4,159.10	$7.60	$1,157.20	$0.00	$17.25	$5,341.15
September 2022	1,127	$4,033.51	$4.55	$1,132.74	$0.00	$15.39	$5,186.20
October 2022	1,022	$3,939.42	$10.14	$1,064.58	$0.00	$21.26	$5,035.39
November 2022	1,069	$4,014.81	$9.07	$1,078.98	$0.00	$16.60	$5,119.46
December 2022	1,142	$4,019.67	$11.53	$1,088.28	$0.00	$19.61	$5,139.09
CY 2022[3]	**1,118**	**$4,083.55**	**$10.35**	**$1,118.99**	**$0.01**	**$17.24**	**$5,230.13**
January 2023	1,188	$4,128.77	$10.31	$1,067.62	$0.00	$21.55	$5,228.25
February 2023	936	$4,123.92	$7.56	$1,124.17	$0.00	$14.35	$5,270.00
March 2023	1,003	$4,142.21	$10.78	$1,139.85	$0.00	$12.04	$5,304.88
April 2023	870	$4,256.60	$10.99	$1,161.69	$0.00	$19.83	$5,449.10
May 2023	963	$4,186.91	$7.84	$1,098.70	$0.09	$11.76	$5,305.29
June 2023	984	$4,328.17	$14.02	$1,114.63	$0.00	$15.42	$5,472.23
July 2023	1,003	$4,776.62	$19.34	$1,088.17	$0.00	$23.66	$5,907.78
August 2023	1,083	$4,928.49	$12.33	$1,143.34	$0.00	$20.30	$6,104.47
September 2023	1,003	$4,797.80	$20.63	$1,107.27	$0.00	$16.42	$5,942.12
Q1-Q3 2023[3]	**1,004**	**$4,407.72**	**$12.64**	**$1,116.16**	**$0.01**	**$17.26**	**$5,553.79**

Annual PMPM Trends

CY 2017 to CY 2018	1.7%	6.1%	-2.4%	145.9%	46.1%	1.0%
CY 2018 to CY 2019	0.4%	48.7%	-2.4%	12.8%	-35.8%	-0.3%
CY 2019 to CY 2020	-0.4%	2.8%	2.7%	-3.4%	-8.4%	0.3%
CY 2020 to CY 2021	9.7%	-15.3%	-3.0%	-52.4%	-10.5%	6.7%
CY 2021 to CY 2022	-6.0%	2.5%	0.4%	-57.1%	1.2%	-4.6%
CY 2022 to Q3 2023	9.1%	25.7%	-0.3%	70.6%	0.1%	7.1%
CY 2021 to Q3 2023 (Annualized)	0.8%	12.7%	0.1%	-18.3%	0.7%	0.7%

[1] MississippiCAN PMPM figures have been adjusted for: the carveout of Zolgensma claims, adjustments related to the 5% assessment application and removal, OPPS reimbursment changes not related to the 5% assessment, PAD reimbursement changes, annual PDL changes to drug costs, AAC inclusion in drug pricing logic, PRTF inclusion in managed care, OP Dental reimbursment changes, GME removal from capitation rates, NET subcapitation changes, provider settlements, emergency ambulance reimbursement increases, financial to encounter adjustments, pharmacy rate freeze, dental reimbursement, and IBNR, and blend MississippiCAN rate cells using consistent enrollment from September 2023 to be directly comparable by month.

[2] CY 2019 and CY 2020 assumed to be fully complete with no explicit IBNR adjustment.

[3] CY 2021, CY 2022, and Q1-Q3 2023 IBNR as reported by CCOs in financial templates.

[4] CY 2019, CY 2020, and CY 2021 data is consistent with the data that supported trends in CY 2024 rates. We rely on this data due to known issues with the data vendor transition.

Exhibit 9A
Mississippi Division of Medicaid
Summary of CY 2022 MississippiCAN Encounter Claims
Summary of Total Costs by Rate Cell

Member Months	720,708	961	451,802	96,821	5,039	67,578	232,493	82,463	10,612	2,558,562	283,644	4,510,683
						Total Allowed Cost						
Service Category	**Non-Newborn SSI / Disabled**	**Breast and Cervical Cancer**	**MA Adult**	**Pregnant Women**	**SSI / Disabled Newborn**	**Non-SSI Newborns 0 to 2 Months**	**Non-SSI Newborns 3 to 12 Months**	**Foster Care**	**MYPAC**	**MA Children**	**Quasi-CHIP**	**All MSCAN Rate Cells**
Inpatient Facility Services												
Medical	$38,735,708	$62,223	$4,649,927	$233,254	$1,442,451	$1,954,611	$3,358,857	$240,532	$8,785	$5,816,102	$679,211	$57,181,662
Surgical	$53,211,914	$82,808	$8,672,717	$405,010	$2,446,466	$5,578,063	$5,092,920	$408,952	$12,809	$10,121,659	$1,040,059	$87,073,377
Maternity / Deliveries	$1,746,132	$0	$12,769,641	$45,126,085	$14,004,077	$87,571,946	$860,044	$108,566	$10,786	$2,969,914	$308,447	$165,475,638
Psychiatric / Substance Abuse	$23,624,663	$0	$2,434,397	$143,665	$67,231	$0	$0	$20,826,834	$3,303,457	$26,477,977	$3,685,595	$80,563,818
Skilled Nursing Facility	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Missing Data	$252,596	$353	$67,078	$115,971	$47,509	$216,604	$21,777	$1,162	$410	$52,478	$4,711	$780,647
Inpatient Facility Total	**$117,571,012**	**$145,385**	**$28,593,761**	**$46,023,984**	**$18,007,733**	**$95,321,223**	**$9,333,597**	**$21,586,046**	**$3,336,247**	**$45,438,130**	**$5,718,024**	**$391,075,143**
Outpatient Facility Services												
Emergency Room	$22,938,424	$20,144	$11,328,871	$2,982,081	$286,736	$1,541,127	$5,841,876	$663,372	$144,890	$24,504,299	$1,976,198	$72,228,018
Urgent Care	$44	$0	$543	$0	$0	$88	$562	$189	$0	$1,296	$65	$2,786
Radiology / Pathology	$23,615,045	$223,916	$9,625,199	$2,785,716	$174,616	$799,212	$3,326,865	$643,528	$119,328	$17,266,523	$1,685,595	$60,265,544
Psychiatric / Alcohol & Drug Abuse	$4,350,667	$209	$224,089	$30,507	$0	$0	$0	$942,077	$65,185	$7,562,627	$535,774	$13,711,135
Pharmacy	$36,344,710	$806,433	$5,810,283	$1,047,266	$236,674	$151,806	$378,487	$192,649	$21,651	$4,333,988	$560,878	$49,884,825
Other	$56,804,590	$310,509	$17,456,655	$3,317,494	$729,658	$1,150,012	$4,021,648	$1,420,036	$115,922	$33,052,656	$3,067,448	$121,446,626
Missing Data	$379,856	$3,541	$125,915	$25,989	$2,970	$10,500	$42,526	$4,673	$3,114	$224,571	$23,032	$846,686
Outpatient Facility Total	**$144,433,335**	**$1,364,751**	**$44,571,555**	**$10,189,054**	**$1,430,653**	**$3,652,744**	**$13,611,964**	**$3,866,523**	**$470,090**	**$86,945,960**	**$7,848,990**	**$318,385,620**
Physician Services												
IP Visits	$9,169,942	$14,414	$1,305,271	$403,870	$4,992,242	$12,206,068	$2,439,382	$70,947	$5,378	$1,427,872	$142,447	$32,177,833
IP Surgery	$3,468,244	$6,880	$906,437	$113,966	$377,063	$494,779	$396,615	$53,745	$1,436	$1,101,643	$141,914	$7,062,723
Office / Home Visits	$34,058,451	$92,840	$16,511,448	$1,158,995	$383,580	$2,903,566	$9,495,209	$2,566,180	$294,012	$61,905,026	$6,563,730	$135,933,038
Preventive Exams & Immunizations	$4,477,324	$13,065	$5,763,657	$9,763,077	$179,566	$7,781,313	$9,233,768	$723,590	$65,573	$18,203,815	$1,372,423	$57,577,171
Urgent Care Visits	$448,428	$1,093	$643,782	$59,655	$1,122	$2,549	$164,050	$112,965	$10,207	$2,916,835	$338,192	$4,698,879
ER Visits and Observation Care	$7,452,354	$6,664	$3,748,456	$1,052,021	$94,057	$536,868	$1,869,894	$226,182	$49,173	$8,210,261	$655,818	$23,901,747
OP Surgery	$11,029,489	$72,924	$5,242,191	$254,930	$95,178	$186,899	$931,115	$433,939	$22,027	$9,874,874	$948,265	$29,091,832
Physical Therapy	$9,015,261	$6,480	$1,148,343	$41,231	$209,533	$8,089	$414,453	$930,221	$26,219	$9,126,457	$782,777	$21,709,065
Psychiatric / Substance Abuse	$32,332,756	$6,341	$3,857,983	$280,741	$3,724	$9,720	$6,433	$5,734,540	$7,579,631	$30,365,208	$3,628,429	$83,805,506
Radiology / Pathology	$12,007,665	$105,152	$8,416,017	$5,438,635	$159,987	$630,413	$2,948,181	$638,436	$77,326	$19,090,547	$2,000,422	$51,512,778
Vision, Hearing, and Speech Exams	$2,324,686	$5,189	$1,204,056	$195,040	$23,294	$17,107	$61,933	$263,677	$27,617	$5,712,834	$819,530	$10,654,963
Maternity - Anesthesia	$103,847	$0	$820,843	$3,358,345	$0	$0	$0	$3,861	$1,548	$240,217	$21,807	$4,550,468
Maternity - Non-Anesthesia - Non-Deliveries	$8,269	$0	$47,357	$25,042	$0	$0	$0	$622	$0	$7,528	$926	$89,744
Maternity - Non-Anesthesia - Ancillary	$11,082	$0	$78,927	$303,051	$0	$0	$0	$514	$0	$18,765	$2,066	$414,405
Maternity - Non-Anesthesia - Cesarean Delive	$127,502	$0	$973,080	$3,285,998	$0	$0	$0	$1,548	$0	$130,480	$18,114	$4,536,722
Maternity - Non-Anesthesia - Normal Deliveri	$131,128	$0	$1,098,825	$4,359,584	$0	$0	$0	$4,452	$2,554	$378,698	$38,870	$6,014,110
Other	$30,261,350	$518,005	$3,147,688	$251,950	$466,379	$4,729,734	$2,813,178	$1,640,566	$6,621,955	$6,677,431	$1,207,183	$58,335,418
Missing Data	$263,863	$2,417	$119,070	$70,507	$12,424	$70,330	$67,036	$7,275	$2,691	$329,842	$36,828	$982,283
Physician Total	**$156,691,642**	**$851,465**	**$55,033,431**	**$30,416,639**	**$6,998,148**	**$29,577,434**	**$30,841,247**	**$13,413,261**	**$14,787,346**	**$175,718,332**	**$18,719,740**	**$533,048,684**
Pharmacy Services												
Pharmacy	$247,823,514	$603,003	$58,388,609	$3,495,061	$2,051,512	$677,523	$5,028,548	$7,005,678	$1,627,508	$85,836,392	$12,716,117	$425,253,464
Missing Data	$691,215	$1,008	$163,842	$11,948	$4,273	$2,508	$14,000	$14,553	$6,798	$271,249	$39,362	$1,220,756
Pharmacy Total	**$248,514,728**	**$604,011**	**$58,552,451**	**$3,507,009**	**$2,055,785**	**$680,030**	**$5,042,548**	**$7,020,232**	**$1,634,306**	**$86,107,641**	**$12,755,479**	**$426,474,220**
Dental Services												
Dental	$6,641,841	$8,370	$2,212,633	$330,787	$4,653	$55,359	$290,546	$2,305,374	$247,887	$63,889,014	$8,897,406	$84,883,870
Missing Data	$17,864	$23	$5,869	$848	$11	$43	$202	$3,135	$1,242	$177,155	$26,350	$232,741
Dental Total	**$6,659,705**	**$8,393**	**$2,218,502**	**$331,634**	**$4,665**	**$55,402**	**$290,748**	**$2,308,509**	**$249,129**	**$64,066,168**	**$8,923,756**	**$85,116,612**
Other Services												
Ambulance	$9,386,077	$5,192	$2,091,755	$531,311	$143,223	$814,867	$680,592	$169,949	$78,084	$3,103,052	$319,278	$17,323,381
Non-Emergency Transportation	$4,492,408	$18,722	$511,708	$116,798	$54,136	$24,542	$70,129	$29,444	$14,595	$555,352	$25,705	$5,913,538
DME	$19,577,731	$10,000	$2,155,127	$309,006	$511,405	$105,707	$750,570	$522,027	$27,490	$4,727,475	$741,607	$29,438,144
Glasses / Contacts	$966,105	$2,089	$570,231	$107,026	$146	$58	$2,299	$129,092	$18,741	$3,033,684	$486,566	$5,316,036
Other	$8,061,239	$2,701	$158,939	$7,925	$301,790	$12,698	$246,264	$401,077	$10,037	$1,059,083	$105,917	$10,367,671
Missing Data	-$140,796	-$183	$726,654	$144,417	$168	$100,420	$316,359	-$23,984	$11,553	$4,546,816	$489,138	$6,170,561
Other Total	**$42,342,764**	**$38,521**	**$6,214,415**	**$1,216,484**	**$1,010,868**	**$1,058,292**	**$2,066,212**	**$1,227,605**	**$160,500**	**$17,025,461**	**$2,168,210**	**$74,529,331**
Grand Total w/ PBA pharmacy services	**$716,213,187**	**$3,012,525**	**$195,184,115**	**$91,684,803**	**$29,507,853**	**$130,345,125**	**$61,186,316**	**$49,422,175**	**$20,637,618**	**$475,301,692**	**$56,134,199**	**$1,828,629,609**
Grand Total w/o PBA pharmacy services	**$467,698,458**	**$2,408,514**	**$136,631,664**	**$88,177,794**	**$27,452,068**	**$129,665,095**	**$56,143,768**	**$42,401,944**	**$19,003,312**	**$389,194,051**	**$43,378,720**	**$1,402,155,389**

**Pharmacy services will be excluded from capitation rates for SFY 2025 and are included for display only.*

Exhibit 9B
Mississippi Division of Medicaid
Summary of CY 2022 MississippiCAN Encounter Claims
Summary of Allowed PMPM by Rate Cell

Member Months	720,708	961	451,802	96,821	5,039	67,578	232,493	82,463	10,612	2,558,562	283,644	4,510,683
						PMPM Allowed Cost						
Service Category	**Non-Newborn SSI / Disabled**	**Breast and Cervical Cancer**	**MA Adult**	**Pregnant Women**	**SSI / Disabled Newborn**	**Non-SSI Newborns 0 to 2 Months**	**Non-SSI Newborns 3 to 12 Months**	**Foster Care**	**MYPAC**	**MA Children**	**Quasi-CHIP**	**All MSCAN Rate Cells**
Inpatient Facility Services												
Medical	$53.75	$64.75	$10.29	$2.41	$286.26	$28.92	$14.45	$2.92	$0.83	$2.27	$2.39	$12.68
Surgical	$73.83	$86.17	$19.20	$4.18	$485.51	$82.54	$21.91	$4.96	$1.21	$3.96	$3.67	$19.30
Maternity / Deliveries	$2.42	$0.00	$28.26	$466.08	$2,779.14	$1,295.86	$3.70	$1.32	$1.02	$1.16	$1.09	$36.69
Psychiatric / Substance Abuse	$32.78	$0.00	$5.39	$1.48	$13.34	$0.00	$0.00	$252.56	$311.29	$10.35	$12.99	$17.86
Skilled Nursing Facility	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Missing Data	$0.35	$0.37	$0.15	$1.20	$9.43	$3.21	$0.09	$0.01	$0.04	$0.02	$0.02	$0.17
Inpatient Facility Total	**$163.13**	**$151.28**	**$63.29**	**$475.35**	**$3,573.67**	**$1,410.54**	**$40.15**	**$261.77**	**$314.38**	**$17.76**	**$20.16**	**$86.70**
Outpatient Facility Services												
Emergency Room	$31.83	$20.96	$25.07	$30.80	$56.90	$22.81	$25.13	$8.04	$13.65	$9.58	$6.97	$16.01
Urgent Care	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Radiology / Pathology	$32.77	$233.00	$21.30	$28.77	$34.65	$11.83	$14.31	$7.80	$11.24	$6.75	$5.94	$13.36
Psychiatric / Alcohol & Drug Abuse	$6.04	$0.22	$0.50	$0.32	$0.00	$0.00	$0.00	$11.42	$6.14	$2.96	$1.89	$3.04
Pharmacy	$50.43	$839.16	$12.86	$10.82	$46.97	$2.25	$1.63	$2.34	$2.04	$1.69	$1.98	$11.06
Other	$78.82	$323.11	$38.64	$34.26	$144.80	$17.02	$17.30	$17.22	$10.92	$12.92	$10.81	$26.92
Missing Data	$0.53	$3.68	$0.28	$0.27	$0.59	$0.16	$0.18	$0.06	$0.29	$0.09	$0.08	$0.19
Outpatient Facility Total	**$200.40**	**$1,420.14**	**$98.65**	**$105.24**	**$283.92**	**$54.05**	**$58.55**	**$46.89**	**$44.30**	**$33.98**	**$27.67**	**$70.58**
Physician Services												
IP Visits	$12.72	$15.00	$2.89	$4.17	$990.72	$180.62	$10.49	$0.86	$0.51	$0.56	$0.50	$7.13
IP Surgery	$4.81	$7.16	$2.01	$1.18	$74.83	$7.32	$1.71	$0.65	$0.14	$0.43	$0.50	$1.57
Office / Home Visits	$47.26	$96.61	$36.55	$11.97	$76.12	$42.97	$40.84	$31.12	$27.71	$24.20	$23.14	$30.14
Preventive Exams & Immunizations	$6.21	$13.60	$12.76	$100.84	$35.64	$115.15	$39.72	$8.77	$6.18	$7.11	$4.84	$12.76
Urgent Care Visits	$0.62	$1.14	$1.42	$0.62	$0.22	$0.04	$0.71	$1.37	$0.96	$1.14	$1.19	$1.04
ER Visits and Observation Care	$10.34	$6.93	$8.30	$10.87	$18.67	$7.94	$8.04	$2.74	$4.63	$3.21	$2.31	$5.30
OP Surgery	$15.30	$75.88	$11.60	$2.63	$18.89	$2.77	$4.00	$5.26	$2.08	$3.86	$3.34	$6.45
Physical Therapy	$12.51	$6.74	$2.54	$0.43	$41.58	$0.12	$1.78	$11.28	$2.47	$3.57	$2.76	$4.81
Psychiatric / Substance Abuse	$44.86	$6.60	$8.54	$2.90	$0.74	$0.14	$0.03	$69.54	$714.25	$11.87	$12.79	$18.58
Radiology / Pathology	$16.66	$109.42	$18.63	$56.17	$31.75	$9.33	$12.68	$7.74	$7.29	$7.46	$7.05	$11.42
Vision, Hearing, and Speech Exams	$3.23	$5.40	$2.67	$2.01	$4.62	$0.25	$0.27	$3.20	$2.60	$2.23	$2.89	$2.36
Maternity - Anesthesia	$0.14	$0.00	$1.82	$34.69	$0.00	$0.00	$0.00	$0.05	$0.15	$0.09	$0.08	$1.01
Maternity - Non-Anesthesia - Non-Deliveries	$0.01	$0.00	$0.10	$0.26	$0.00	$0.00	$0.00	$0.01	$0.00	$0.00	$0.00	$0.02
Maternity - Non-Anesthesia - Ancillary	$0.02	$0.00	$0.17	$3.13	$0.00	$0.00	$0.00	$0.01	$0.00	$0.01	$0.01	$0.09
Maternity - Non-Anesthesia - Cesarean Delive	$0.18	$0.00	$2.15	$33.94	$0.00	$0.00	$0.00	$0.02	$0.00	$0.05	$0.06	$1.01
Maternity - Non-Anesthesia - Normal Deliveri	$0.18	$0.00	$2.43	$45.03	$0.00	$0.00	$0.00	$0.05	$0.24	$0.15	$0.14	$1.33
Other	$41.99	$539.03	$6.97	$2.60	$92.55	$69.99	$12.10	$19.89	$624.01	$2.61	$4.26	$12.93
Missing Data	$0.37	$2.51	$0.26	$0.73	$2.47	$1.04	$0.29	$0.09	$0.25	$0.13	$0.13	$0.22
Physician Total	**$217.41**	**$886.02**	**$121.81**	**$314.15**	**$1,388.80**	**$437.68**	**$132.65**	**$162.66**	**$1,393.46**	**$68.68**	**$66.00**	**$118.17**
Pharmacy Services												
Pharmacy	$343.86	$627.47	$129.23	$36.10	$407.13	$10.03	$21.63	$84.96	$153.36	$33.55	$44.83	$94.28
Missing Data	$0.96	$1.05	$0.36	$0.12	$0.85	$0.04	$0.06	$0.18	$0.64	$0.11	$0.14	$0.27
Pharmacy Total	**$344.82**	**$628.52**	**$129.60**	**$36.22**	**$407.97**	**$10.06**	**$21.69**	**$85.13**	**$154.01**	**$33.65**	**$44.97**	**$94.55**
Dental Services												
Dental	$9.22	$8.71	$4.90	$3.42	$0.92	$0.82	$1.25	$27.96	$23.36	$24.97	$31.37	$18.82
Missing Data	$0.02	$0.02	$0.01	$0.01	$0.00	$0.00	$0.00	$0.04	$0.12	$0.07	$0.09	$0.05
Dental Total	**$9.24**	**$8.73**	**$4.91**	**$3.43**	**$0.93**	**$0.82**	**$1.25**	**$27.99**	**$23.48**	**$25.04**	**$31.46**	**$18.87**
Other Services												
Ambulance	$13.02	$5.40	$4.63	$5.49	$28.42	$12.06	$2.93	$2.06	$7.36	$1.21	$1.13	$3.84
Non-Emergency Transportation	$6.23	$19.48	$1.13	$1.21	$10.74	$0.36	$0.30	$0.36	$1.38	$0.22	$0.09	$1.31
DME	$27.16	$10.41	$4.77	$3.19	$101.49	$1.56	$3.23	$6.33	$2.59	$1.85	$2.61	$6.53
Glasses / Contacts	$1.34	$2.17	$1.26	$1.11	$0.03	$0.00	$0.01	$1.57	$1.77	$1.19	$1.72	$1.18
Other	$11.19	$2.81	$0.35	$0.08	$59.89	$0.19	$1.06	$4.86	$0.95	$0.41	$0.37	$2.30
Missing Data	-$0.20	-$0.19	$1.61	$1.49	$0.03	$1.49	$1.36	-$0.29	$1.09	$1.78	$1.72	$1.37
Other Total	**$58.75**	**$40.08**	**$13.75**	**$12.56**	**$200.61**	**$15.66**	**$8.89**	**$14.89**	**$15.12**	**$6.65**	**$7.64**	**$16.52**
Grand Total w/ PBA pharmacy services	**$993.76**	**$3,134.78**	**$432.01**	**$946.95**	**$5,855.89**	**$1,928.81**	**$263.17**	**$599.33**	**$1,944.74**	**$185.77**	**$197.90**	**$405.40**
Grand Total w/o PBA pharmacy services	**$648.94**	**$2,506.26**	**$302.41**	**$910.73**	**$5,447.92**	**$1,918.75**	**$241.49**	**$514.19**	**$1,790.74**	**$152.11**	**$152.93**	**$310.85**

**Pharmacy services will be excluded from capitation rates for SFY 2025 and are included for display only.*

Exhibit 9C
Mississippi Division of Medicaid
Summary of CY 2022 MississippiCAN Encounter Claims
Summary of Total Costs by Rate Cell

Member Months	720,708	961	451,802	96,821	5,039	67,578	232,493	82,463	10,612	2,558,562	283,644	4,510,683
							% of Total Allowed Cost					
Service Category	**Non-Newborn SSI / Disabled**	**Breast and Cervical Cancer**	**MA Adult**	**Pregnant Women**	**SSI / Disabled Newborn**	**Non-SSI Newborns 0 to 2 Months**	**Non-SSI Newborns 3 to 12 Months**	**Foster Care**	**MYPAC**	**MA Children**	**Quasi-CHIP**	**All MSCAN Rate Cells**
Inpatient Facility Services												
Medical	5.4%	2.1%	2.4%	0.3%	4.9%	1.5%	5.5%	0.5%	0.0%	1.2%	1.2%	3.1%
Surgical	7.4%	2.7%	4.4%	0.4%	8.3%	4.3%	8.3%	0.8%	0.1%	2.1%	1.9%	4.8%
Maternity / Deliveries	0.2%	0.0%	6.5%	49.2%	47.5%	67.2%	1.4%	0.2%	0.1%	0.6%	0.5%	9.0%
Psychiatric / Substance Abuse	3.3%	0.0%	1.2%	0.2%	0.2%	0.0%	0.0%	42.1%	16.0%	5.6%	6.6%	4.4%
Skilled Nursing Facility	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Missing Data	0.0%	0.0%	0.0%	0.1%	0.2%	0.2%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Inpatient Facility Total	**16.4%**	**4.8%**	**14.6%**	**50.2%**	**61.0%**	**73.1%**	**15.3%**	**43.7%**	**16.2%**	**9.6%**	**10.2%**	**21.4%**
Outpatient Facility Services												
Emergency Room	3.2%	0.7%	5.8%	3.3%	1.0%	1.2%	9.5%	1.3%	0.7%	5.2%	3.5%	3.9%
Urgent Care	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Radiology / Pathology	3.3%	7.4%	4.9%	3.0%	0.6%	0.6%	5.4%	1.3%	0.6%	3.6%	3.0%	3.3%
Psychiatric / Alcohol & Drug Abuse	0.6%	0.0%	0.1%	0.0%	0.0%	0.0%	0.0%	1.9%	0.3%	1.6%	1.0%	0.7%
Pharmacy	5.1%	26.8%	3.0%	1.1%	0.8%	0.1%	0.6%	0.4%	0.1%	0.9%	1.0%	2.7%
Other	7.9%	10.3%	8.9%	3.6%	2.5%	0.9%	6.6%	2.9%	0.6%	7.0%	5.5%	6.6%
Missing Data	0.1%	0.1%	0.1%	0.0%	0.0%	0.0%	0.1%	0.0%	0.0%	0.0%	0.0%	0.0%
Outpatient Facility Total	**20.2%**	**45.3%**	**22.8%**	**11.1%**	**4.8%**	**2.8%**	**22.2%**	**7.8%**	**2.3%**	**18.3%**	**14.0%**	**17.4%**
Physician Services												
IP Visits	1.3%	0.5%	0.7%	0.4%	16.9%	9.4%	4.0%	0.1%	0.0%	0.3%	0.3%	1.8%
IP Surgery	0.5%	0.2%	0.5%	0.1%	1.3%	0.4%	0.6%	0.1%	0.0%	0.2%	0.3%	0.4%
Office / Home Visits	4.8%	3.1%	8.5%	1.3%	1.3%	2.2%	15.5%	5.2%	1.4%	13.0%	11.7%	7.4%
Preventive Exams & Immunizations	0.6%	0.4%	3.0%	10.6%	0.6%	6.0%	15.1%	1.5%	0.3%	3.8%	2.4%	3.1%
Urgent Care Visits	0.1%	0.0%	0.3%	0.1%	0.0%	0.0%	0.3%	0.2%	0.0%	0.6%	0.6%	0.3%
ER Visits and Observation Care	1.0%	0.2%	1.9%	1.1%	0.3%	0.4%	3.1%	0.5%	0.2%	1.7%	1.2%	1.3%
OP Surgery	1.5%	2.4%	2.7%	0.3%	0.3%	0.1%	1.5%	0.9%	0.1%	2.1%	1.7%	1.6%
Physical Therapy	1.3%	0.2%	0.6%	0.0%	0.7%	0.0%	0.7%	1.9%	0.1%	1.9%	1.4%	1.2%
Psychiatric / Substance Abuse	4.5%	0.2%	2.0%	0.3%	0.0%	0.0%	0.0%	11.6%	36.7%	6.4%	6.5%	4.6%
Radiology / Pathology	1.7%	3.5%	4.3%	5.9%	0.5%	0.5%	4.8%	1.3%	0.4%	4.0%	3.6%	2.8%
Vision, Hearing, and Speech Exams	0.3%	0.2%	0.6%	0.2%	0.1%	0.0%	0.1%	0.5%	0.1%	1.2%	1.5%	0.6%
Maternity - Anesthesia	0.0%	0.0%	0.4%	3.7%	0.0%	0.0%	0.0%	0.0%	0.0%	0.1%	0.0%	0.2%
Maternity - Non-Anesthesia - Non-Deliveries	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Maternity - Non-Anesthesia - Ancillary	0.0%	0.0%	0.0%	0.3%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Maternity - Non-Anesthesia - Cesarean Delive	0.0%	0.0%	0.5%	3.6%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.2%
Maternity - Non-Anesthesia - Normal Deliveri	0.0%	0.0%	0.6%	4.8%	0.0%	0.0%	0.0%	0.0%	0.0%	0.1%	0.1%	0.3%
Other	4.2%	17.2%	1.6%	0.3%	1.6%	3.6%	4.6%	3.3%	32.1%	1.4%	2.2%	3.2%
Missing Data	0.0%	0.1%	0.1%	0.1%	0.0%	0.1%	0.1%	0.0%	0.0%	0.1%	0.1%	0.1%
Physician Total	**21.9%**	**28.3%**	**28.2%**	**33.2%**	**23.7%**	**22.7%**	**50.4%**	**27.1%**	**71.7%**	**37.0%**	**33.3%**	**29.2%**
Pharmacy Services												
Pharmacy	34.6%	20.0%	29.9%	3.8%	7.0%	0.5%	8.2%	14.2%	7.9%	18.1%	22.7%	23.3%
Missing Data	0.1%	0.0%	0.1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.1%	0.1%	0.1%
Pharmacy Total	**34.7%**	**20.0%**	**30.0%**	**3.8%**	**7.0%**	**0.5%**	**8.2%**	**14.2%**	**7.9%**	**18.1%**	**22.7%**	**23.3%**
Dental Services												
Dental	0.9%	0.3%	1.1%	0.4%	0.0%	0.0%	0.5%	4.7%	1.2%	13.4%	15.9%	4.6%
Missing Data	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Dental Total	**0.9%**	**0.3%**	**1.1%**	**0.4%**	**0.0%**	**0.0%**	**0.5%**	**4.7%**	**1.2%**	**13.5%**	**15.9%**	**4.7%**
Other Services												
Ambulance	1.3%	0.2%	1.1%	0.6%	0.5%	0.6%	1.1%	0.3%	0.4%	0.7%	0.6%	0.9%
Non-Emergency Transportation	0.6%	0.6%	0.3%	0.1%	0.2%	0.0%	0.1%	0.1%	0.1%	0.1%	0.0%	0.3%
DME	2.7%	0.3%	1.1%	0.3%	1.7%	0.1%	1.2%	1.1%	0.1%	1.0%	1.3%	1.6%
Glasses / Contacts	0.1%	0.1%	0.3%	0.1%	0.0%	0.0%	0.0%	0.3%	0.1%	0.6%	0.9%	0.3%
Other	1.1%	0.1%	0.1%	0.0%	1.0%	0.0%	0.4%	0.8%	0.0%	0.2%	0.2%	0.6%
Missing Data	0.0%	0.0%	0.4%	0.2%	0.0%	0.1%	0.5%	0.0%	0.1%	1.0%	0.9%	0.3%
Other Total	5.9%	1.3%	3.2%	1.3%	3.4%	0.8%	3.4%	2.5%	0.8%	3.6%	3.9%	4.1%
Grand Total w/ PBA pharmacy services	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**
Grand Total w/o PBA pharmacy services	**65.3%**	**80.0%**	**70.0%**	**96.2%**	**93.0%**	**99.5%**	**91.8%**	**85.8%**	**92.1%**	**81.9%**	**77.3%**	**76.7%**

**Pharmacy services will be excluded from capitation rates for SFY 2025 and are included for display only.*

Exhibit 10
Mississippi Division of Medicaid
Summary of Program, Population, and Reimbursement Changes

Change	Change Type	Effective Date	Impacted Rate Cells	Where Reflected in Rate Development
Hemophilia Population Carve-In	Population	January 1, 2024	All	Exhibit 2
Seasonal Virus Adjustment	Program	N/A	All	Exhibit 2
Acuity Adjustment - Shift to FFS	Program	June 1, 2021 to September 30, 2022	MA Adult, MA Children, Quasi-CHIP	Exhibit 2
Acuity Adjustment - PHE Unwind	Program	July 1, 2023 to May 31, 2024		
SSI Children - COE Change	Program	October 1, 2018 to May 31, 2022	SSI	Exhibit 1
Gene Therapy Drug Coverage	Program	July 1, 2023	All	Exhibit 2
Preventative and Diagnostic Dental Reimbursement Change	Reimbursement	July 1, 2021, July 1, 2022 and July 1, 2023	All	Exhibit 2
Restorative Dental Reimbursement Change	Reimbursement	July 1, 2022, July 1, 2023 and July 1, 2024	All	Exhibit 2
Fee Schedule Updates	Reimbursement	Various	All	Exhibit 2
Postpartum Coverage Extension	Reimbursement	July 1, 2023	Pregnant Women	Exhibit 2
MYPAC Member Identification Change		July 1, 2022	Non-Newborn SSI / Disabled, Foster Care, MYPAC, MA Children, Quasi-CHIP	Exhibit 1

Exhibit 11A
Mississippi Division of Medicaid
Projected SFY 2024 and SFY 2025 Member Months

Cap Cell	SFY 2024 Member Months	SFY 2025 Member Months
Non-Newborn SSI / Disabled	721,209	716,865
Breast and Cervical Cancer	1,032	912
MA Adult	481,617	690,767
Pregnant Women	148,103	201,312
SSI / Disabled Newborn	5,041	5,977
Non-SSI Newborns 0 to 2 Months	68,503	68,675
Non-SSI Newborns 3 to 12 Months	233,040	228,658
Foster Care	91,055	94,542
MYPAC	10,331	10,757
MA Children	2,722,284	3,121,602
Quasi-CHIP	307,277	366,592
Total - All Cap Cells	**4,789,492**	**5,506,661**

Exhibit 11B
Mississippi Division of Medicaid
Components of SFY 2024 Capitation Rates

Cap Cell	Medical Costs PMPM	Pharmacy Costs PMPM	Non-Service Expenses PMPM[1]	Quality Withhold	Total Capitation Rate Prior to Withhold	Total Capitation Rate after Withhold
Non-Newborn SSI / Disabled	$738.49	$0.00	$107.96	($8.46)	$846.44	$837.98
Breast and Cervical Cancer	$2,503.02	$0.00	$335.77	($28.39)	$2,838.79	$2,810.40
MA Adult	$360.58	$0.00	$59.17	($4.20)	$419.75	$415.55
Pregnant Women	$694.74	$0.00	$102.31	($7.97)	$797.05	$789.08
SSI / Disabled Newborn	$6,883.79	$0.00	$901.35	($77.85)	$7,785.14	$7,707.29
Non-SSI Newborns 0 to 2 Months	$1,994.17	$0.00	$270.07	($22.64)	$2,264.24	$2,241.60
Non-SSI Newborns 3 to 12 Months	$227.84	$0.00	$42.03	($2.70)	$269.87	$267.17
Foster Care	$541.98	$0.00	$82.59	($6.25)	$624.57	$618.32
MYPAC	$3,218.59	$0.00	$428.15	($36.47)	$3,646.74	$3,610.28
MA Children	$163.22	$0.00	$33.69	($1.97)	$196.91	$194.94
Quasi-CHIP	$164.46	$0.00	$33.85	($1.98)	$198.31	$196.33
Total - All Cap Cells[1]						
Using SFY 2024 Member Months	$336.91	$0.00	$56.11	($3.93)	$393.02	$389.09
Using SFY 2025 Member Months	$328.05	$0.00	$54.97	($3.83)	$383.02	$379.19
Total Expenditures						
Using SFY 2024 Member Months	$1,613,609,549	$0	$268,754,731	($18,823,643)	$1,882,364,280	$1,863,540,637
Using SFY 2025 Member Months	$1,806,466,536	$0	$302,702,173	($21,091,687)	$2,109,168,709	$2,088,077,022

[1] "Non-Benefit Expenses PMPM" include margin, administrative costs, and premium tax prior to directed payments.

Exhibit 11C
Mississippi Division of Medicaid
Components of SFY 2025 Capitation Rates

Cap Cell	Medical Costs PMPM	Non-Service Expenses PMPM[1]	Quality Withhold	Total Capitation Rate Prior to Withhold	Total Capitation Rate after Withhold
Non-Newborn SSI / Disabled	$765.25	$105.33	($8.71)	$870.59	$861.88
Breast and Cervical Cancer	$2,904.47	$368.42	($32.73)	$3,272.89	$3,240.16
MA Adult	$312.93	$49.70	($3.63)	$362.64	$359.01
Pregnant Women	$550.03	$78.86	($6.29)	$628.90	$622.61
SSI / Disabled Newborn	$5,969.95	$745.42	($67.15)	$6,715.37	$6,648.22
Non-SSI Newborns 0 to 2 Months	$2,073.43	$266.21	($23.40)	$2,339.64	$2,316.24
Non-SSI Newborns 3 to 12 Months	$267.56	$44.12	($3.12)	$311.68	$308.56
Foster Care	$545.58	$78.32	($6.24)	$623.89	$617.66
MYPAC	$2,997.56	$379.87	($33.77)	$3,377.43	$3,343.66
MA Children	$172.86	$32.48	($2.05)	$205.33	$203.28
Quasi-CHIP	$169.75	$32.09	($2.02)	$201.84	$199.82
Total - All Cap Cells[1]					
Using SFY 2024 Member Months	$339.27	$52.94	($3.92)	$392.21	$388.29
Using SFY 2025 Member Months	$327.43	$51.49	($3.79)	$378.91	$375.12
Total Expenditures					
Using SFY 2024 Member Months	$1,624,929,080	$253,567,695	($18,784,968)	$1,878,496,775	$1,859,711,807
Using SFY 2025 Member Months	$1,803,020,674	$283,515,194	($20,865,359)	$2,086,535,868	$2,065,670,509

[1] "Non-Benefit Expenses PMPM" include margin, administrative costs, and premium tax prior to directed payments.

Exhibit 12
Mississippi Division of Medicaic
CY 2022 to SFY 2025 Unit Cost Trends by Category of Service

		Percentage of CY 2022 Paid										CY 2022 to SFY 2025 Unit Cost Trend (Annualized)										
Rate Cell	Category of Service	PPEC	PDN	BHS	ASC	ASD	HH	PRTF	MYPAC	Ortho	All Other	PPEC	PDN	BHS	ASC	ASD	HH	PRTF	MYPAC	Ortho	All Other	Composite
Non-Newborn SSI / Disabled	Inpatient Hospital Services - Maternity / Deliveries	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-1.83%	**-1.83%**
Non-Newborn SSI / Disabled	Inpatient Hospital Services - Psychiatric / Substance Abuse	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	13.9%	0.0%	0.0%	86.1%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	4.15%	0.00%	0.00%	-1.83%	**-0.97%**
Non-Newborn SSI / Disabled	Inpatient Hospital Services - All Other	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-1.83%	**-1.83%**
Non-Newborn SSI / Disabled	Outpatient Hospital Services - Emergency Room	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%	0.00%	0.00%	0.00%	3.06%	0.00%	0.00%	0.00%	0.00%	0.00%	1.38%	**1.38%**
Non-Newborn SSI / Disabled	Outpatient Hospital Services - Pharmacy	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	4.04%	**4.04%**
Non-Newborn SSI / Disabled	Outpatient Hospital Services - All Other	0.0%	0.6%	5.0%	1.5%	0.0%	2.6%	0.0%	0.0%	0.0%	90.3%	0.00%	5.75%	3.00%	5.15%	0.00%	8.03%	0.00%	0.00%	0.00%	1.38%	**1.73%**
Non-Newborn SSI / Disabled	Physician Services - Maternity / Deliveries	0.0%	0.0%	0.0%	0.5%	0.0%	0.0%	0.0%	0.0%	0.0%	99.5%	0.00%	0.00%	0.00%	4.03%	0.00%	0.00%	0.00%	0.00%	0.00%	1.03%	**1.04%**
Non-Newborn SSI / Disabled	Physician Services - Psychiatric / Substance Abuse	0.0%	0.0%	88.6%	0.0%	2.4%	0.0%	0.0%	0.0%	0.0%	9.1%	0.00%	0.00%	2.26%	0.00%	16.35%	0.00%	3.62%	0.00%	0.00%	1.03%	**2.52%**
Non-Newborn SSI / Disabled	Physician Services - All Other	5.6%	0.0%	0.8%	0.5%	0.0%	0.0%	0.0%	0.0%	0.0%	93.0%	4.20%	0.00%	2.62%	4.57%	0.00%	0.00%	3.62%	0.00%	0.00%	2.26%	**2.39%**
Non-Newborn SSI / Disabled	Dental - All Services	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	11.7%	88.3%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	3.88%	0.00%	**0.47%**
Non-Newborn SSI / Disabled	All Other Services	1.2%	8.4%	1.4%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	89.0%	4.28%	4.18%	3.09%	0.00%	0.00%	7.90%	0.00%	0.00%	0.00%	1.51%	**1.79%**
Breast and Cervical Cancer	Inpatient Hospital Services - Maternity / Deliveries	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-1.83%	**0.00%**
Breast and Cervical Cancer	Inpatient Hospital Services - Psychiatric / Substance Abuse	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-1.83%	**0.00%**
Breast and Cervical Cancer	Inpatient Hospital Services - All Other	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-1.83%	**-1.83%**
Breast and Cervical Cancer	Outpatient Hospital Services - Emergency Room	0.0%	0.0%	0.0%	0.8%	0.0%	0.0%	0.0%	0.0%	0.0%	99.2%	0.00%	0.00%	0.00%	-0.44%	0.00%	0.00%	0.00%	0.00%	0.00%	1.38%	**1.37%**
Breast and Cervical Cancer	Outpatient Hospital Services - Pharmacy	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	4.04%	**4.04%**
Breast and Cervical Cancer	Outpatient Hospital Services - All Other	0.0%	0.9%	0.0%	6.2%	0.0%	1.9%	0.0%	0.0%	0.0%	90.9%	0.00%	5.75%	5.94%	4.43%	0.00%	10.75%	0.00%	0.00%	0.00%	1.38%	**1.81%**
Breast and Cervical Cancer	Physician Services - Maternity / Deliveries	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	1.03%	**0.00%**
Breast and Cervical Cancer	Physician Services - Psychiatric / Substance Abuse	0.0%	0.0%	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.00%	0.00%	1.98%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	1.03%	**1.98%**
Breast and Cervical Cancer	Physician Services - All Other	0.0%	0.0%	0.0%	0.4%	0.0%	0.0%	0.0%	0.0%	0.0%	99.5%	0.00%	0.00%	3.15%	3.42%	0.00%	0.00%	0.00%	0.00%	0.00%	2.26%	**2.27%**
Breast and Cervical Cancer	Dental - All Services	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	**0.00%**
Breast and Cervical Cancer	All Other Services	0.0%	0.0%	1.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	99.0%	0.00%	0.00%	3.09%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	1.51%	**1.52%**
MA Adult	Inpatient Hospital Services - Maternity / Deliveries	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	1.54%	**1.54%**
MA Adult	Inpatient Hospital Services - Psychiatric / Substance Abuse	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	1.54%	**1.54%**
MA Adult	Inpatient Hospital Services - All Other	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	1.54%	**1.54%**
MA Adult	Outpatient Hospital Services - Emergency Room	0.0%	0.0%	0.0%	0.2%	0.0%	0.0%	0.0%	0.0%	0.0%	99.8%	0.00%	0.00%	0.00%	10.05%	0.00%	0.00%	0.00%	0.00%	0.00%	2.04%	**2.05%**
MA Adult	Outpatient Hospital Services - Pharmacy	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	3.02%	**3.02%**
MA Adult	Outpatient Hospital Services - All Other	0.0%	0.3%	0.8%	3.9%	0.0%	0.7%	0.0%	0.0%	0.0%	94.3%	0.00%	5.75%	3.09%	4.73%	0.00%	7.94%	0.00%	0.00%	0.00%	2.04%	**2.21%**
MA Adult	Physician Services - Maternity / Deliveries	0.0%	0.0%	0.0%	0.1%	0.0%	0.0%	0.0%	0.0%	0.0%	99.9%	0.00%	0.00%	0.00%	5.11%	0.00%	0.00%	0.00%	0.00%	0.00%	1.37%	**1.37%**
MA Adult	Physician Services - Psychiatric / Substance Abuse	0.0%	0.0%	87.2%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	12.8%	0.00%	0.00%	1.63%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	1.37%	**1.59%**
MA Adult	Physician Services - All Other	0.0%	0.0%	0.5%	0.7%	0.0%	0.0%	0.0%	0.0%	0.0%	98.8%	0.00%	0.00%	2.85%	4.50%	0.00%	0.00%	0.00%	0.00%	0.00%	1.54%	**1.57%**
MA Adult	Dental - All Services	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.2%	99.8%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	3.89%	0.00%	**0.01%**
MA Adult	All Other Services	0.0%	0.0%	1.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	98.9%	0.00%	5.75%	3.09%	0.00%	0.00%	6.33%	0.00%	0.00%	0.00%	1.54%	**1.56%**
Pregnant Women	Inpatient Hospital Services - Maternity / Deliveries	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	1.54%	**1.54%**
Pregnant Women	Inpatient Hospital Services - Psychiatric / Substance Abuse	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	1.54%	**1.54%**
Pregnant Women	Inpatient Hospital Services - All Other	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	1.54%	**1.54%**
Pregnant Women	Outpatient Hospital Services - Emergency Room	0.0%	0.0%	0.0%	0.1%	0.0%	0.0%	0.0%	0.0%	0.0%	99.9%	0.00%	0.00%	0.00%	3.07%	0.00%	0.00%	0.00%	0.00%	0.00%	2.04%	**2.04%**
Pregnant Women	Outpatient Hospital Services - Pharmacy	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	3.02%	**3.02%**
Pregnant Women	Outpatient Hospital Services - All Other	0.0%	0.1%	0.5%	0.6%	0.0%	0.3%	0.0%	0.0%	0.0%	98.5%	0.00%	5.75%	2.99%	5.92%	0.00%	9.71%	0.00%	0.00%	0.00%	2.04%	**2.10%**
Pregnant Women	Physician Services - Maternity / Deliveries	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%	0.00%	0.00%	0.00%	0.18%	0.00%	0.00%	0.00%	0.00%	0.00%	1.37%	**1.37%**
Pregnant Women	Physician Services - Psychiatric / Substance Abuse	0.0%	0.0%	86.9%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	13.1%	0.00%	0.00%	1.50%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	1.37%	**1.49%**
Pregnant Women	Physician Services - All Other	0.0%	0.0%	0.2%	0.1%	0.0%	0.0%	0.0%	0.0%	0.0%	99.8%	0.00%	0.00%	2.89%	4.65%	0.00%	0.00%	0.00%	0.00%	0.00%	1.54%	**1.54%**
Pregnant Women	Dental - All Services	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	1.9%	98.1%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	3.89%	0.00%	**0.08%**
Pregnant Women	All Other Services	0.0%	0.0%	0.2%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	99.8%	0.00%	5.75%	3.09%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	1.54%	**1.54%**
SSI / Disabled Newborn	Inpatient Hospital Services - Maternity / Deliveries	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	3.34%	**3.34%**
SSI / Disabled Newborn	Inpatient Hospital Services - Psychiatric / Substance Abuse	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	3.34%	**3.34%**
SSI / Disabled Newborn	Inpatient Hospital Services - All Other	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	3.34%	**3.34%**
SSI / Disabled Newborn	Outpatient Hospital Services - Emergency Room	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	2.54%	**2.54%**
SSI / Disabled Newborn	Outpatient Hospital Services - Pharmacy	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	5.06%	**5.06%**
SSI / Disabled Newborn	Outpatient Hospital Services - All Other	0.0%	0.4%	0.0%	0.1%	0.0%	1.7%	0.0%	0.0%	0.0%	97.9%	0.00%	5.75%	0.00%	3.73%	0.00%	5.51%	0.00%	0.00%	0.00%	2.54%	**2.60%**
SSI / Disabled Newborn	Physician Services - Maternity / Deliveries	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.32%	**0.00%**
SSI / Disabled Newborn	Physician Services - Psychiatric / Substance Abuse	0.0%	0.0%	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.00%	0.00%	0.60%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.32%	**0.60%**
SSI / Disabled Newborn	Physician Services - All Other	4.3%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	95.7%	3.43%	0.00%	-1.51%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.33%	**0.46%**
SSI / Disabled Newborn	Dental - All Services	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	**0.00%**
SSI / Disabled Newborn	All Other Services	1.2%	15.4%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	83.4%	2.68%	4.48%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	1.70%	**2.15%**
Non-SSI Newborns 0 to 2 Months	Inpatient Hospital Services - Maternity / Deliveries	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	3.34%	**3.34%**
Non-SSI Newborns 0 to 2 Months	Inpatient Hospital Services - Psychiatric / Substance Abuse	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	3.34%	**0.00%**
Non-SSI Newborns 0 to 2 Months	Inpatient Hospital Services - All Other	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	3.34%	**3.34%**
Non-SSI Newborns 0 to 2 Months	Outpatient Hospital Services - Emergency Room	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	2.54%	**2.54%**
Non-SSI Newborns 0 to 2 Months	Outpatient Hospital Services - Pharmacy	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	5.06%	**5.06%**
Non-SSI Newborns 0 to 2 Months	Outpatient Hospital Services - All Other	0.0%	0.1%	0.0%	0.0%	0.0%	0.5%	0.0%	0.0%	0.0%	99.4%	0.00%	5.75%	0.00%	0.00%	0.00%	6.86%	0.00%	0.00%	0.00%	2.54%	**2.56%**
Non-SSI Newborns 0 to 2 Months	Physician Services - Maternity / Deliveries	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.32%	**0.00%**
Non-SSI Newborns 0 to 2 Months	Physician Services - Psychiatric / Substance Abuse	0.0%	0.0%	41.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	59.0%	0.00%	0.00%	3.36%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.32%	**1.58%**
Non-SSI Newborns 0 to 2 Months	Physician Services - All Other	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%	5.75%	0.00%	-1.29%	-14.49%	0.00%	0.00%	0.00%	0.00%	0.00%	0.48%	**0.48%**
Non-SSI Newborns 0 to 2 Months	Dental - All Services	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	**0.00%**
Non-SSI Newborns 0 to 2 Months	All Other Services	0.0%	0.2%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	99.8%	0.00%	5.44%	3.09%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	1.70%	**1.71%**
Non-SSI Newborns 3 to 12 Months	Inpatient Hospital Services - Maternity / Deliveries	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-1.04%	**-1.04%**
Non-SSI Newborns 3 to 12 Months	Inpatient Hospital Services - Psychiatric / Substance Abuse	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-1.04%	**0.00%**
Non-SSI Newborns 3 to 12 Months	Inpatient Hospital Services - All Other	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-1.04%	**-1.04%**
Non-SSI Newborns 3 to 12 Months	Outpatient Hospital Services - Emergency Room	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%	0.00%	0.00%	0.00%	3.41%	0.00%	0.00%	0.00%	0.00%	0.00%	2.54%	**2.54%**
Non-SSI Newborns 3 to 12 Months	Outpatient Hospital Services - Pharmacy	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	5.06%	**5.06%**
Non-SSI Newborns 3 to 12 Months	Outpatient Hospital Services - All Other	0.0%	0.0%	0.0%	1.0%	0.0%	0.1%	0.0%	0.0%	0.0%	98.8%	0.00%	5.75%	-0.64%	6.12%	0.00%	9.92%	0.00%	0.00%	0.00%	2.54%	**2.59%**
Non-SSI Newborns 3 to 12 Months	Physician Services - Maternity / Deliveries	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.00%	0.00%	0.00%	2.53%	0.00%	0.00%	0.00%	0.00%	0.00%	1.47%	**0.00%**
Non-SSI Newborns 3 to 12 Months	Physician Services - Psychiatric / Substance Abuse	0.0%	0.0%	69.7%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	30.3%	0.00%	0.00%	1.14%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	1.47%	**1.24%**
Non-SSI Newborns 3 to 12 Months	Physician Services - All Other	0.4%	0.0%	0.0%	0.1%	0.0%	0.0%	0.0%	0.0%	0.0%	99.5%	4.14%	0.00%	-1.50%	7.65%	0.00%	0.00%	0.00%	0.00%	0.00%	1.69%	**1.70%**
Non-SSI Newborns 3 to 12 Months	Dental - All Services	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	**0.00%**
Non-SSI Newborns 3 to 12 Months	All Other Services	0.5%	9.6%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	89.8%	4.40%	5.70%	3.09%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	1.01%	**1.50%**
Foster Care	Inpatient Hospital Services - Maternity / Deliveries	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-1.04%	**-1.04%**
Foster Care	Inpatient Hospital Services - Psychiatric / Substance Abuse	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	59.1%	0.0%	0.0%	40.9%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	5.25%	0.00%	0.00%	-1.04%	**2.75%**
Foster Care	Inpatient Hospital Services - All Other	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-1.04%	**-1.04%**
Foster Care	Outpatient Hospital Services - Emergency Room	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	2.54%	**2.54%**
Foster Care	Outpatient Hospital Services - Pharmacy	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	5.06%	**5.06%**
Foster Care	Outpatient Hospital Services - All Other	0.0%	0.0%	31.0%	4.5%	0.0%	0.0%	0.0%	0.0%	0.0%	64.5%	0.00%	0.00%	3.07%	4.32%	0.00%	3.43%	0.00%	0.00%	0.00%	2.54%	**2.78%**
Foster Care	Physician Services - Maternity / Deliveries	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	1.47%	**1.47%**
Foster Care	Physician Services - Psychiatric / Substance Abuse	0.0%	0.0%	63.4%	0.0%	1.2%	0.0%	0.0%	30.8%	0.0%	4.7%	0.00%	0.00%	1.27%	0.00%	12.62%	0.00%	3.62%	3.57%	0.00%	1.47%	**2.14%**
Foster Care	Physician Services - All Other	4.0%	0.0%	4.5%	0.5%	0.0%	0.0%	0.0%	3.8%	0.0%	87.2%	4.45%	0.00%	1.69%	3.67%	0.00%	0.00%	3.62%	3.57%	0.00%	1.69%	**1.89%**
Foster Care	Dental - All Services	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	19.0%	81.0%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	3.88%	0.00%	**0.76%**
Foster Care	All Other Services	1.9%	25.8%	2.9%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	69.4%	4.09%	4.13%	3.09%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	1.01%	**1.95%**
MYPAC	Inpatient Hospital Services - Maternity / Deliveries	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-1.04%	**-1.04%**
MYPAC	Inpatient Hospital Services - Psychiatric / Substance Abuse	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	30.1%	0.0%	0.0%	69.9%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	5.38%	0.00%	0.00%	-1.04%	**0.96%**
MYPAC	Inpatient Hospital Services - All Other	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-1.04%	**-1.04%**
MYPAC	Outpatient Hospital Services - Emergency Room	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	2.54%	**2.54%**
MYPAC	Outpatient Hospital Services - Pharmacy	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	5.06%	**5.06%**
MYPAC	Outpatient Hospital Services - All Other	0.0%	0.0%	21.6%	0.6%	0.0%	0.0%	0.0%	0.0%	0.0%	77.8%	0.00%	0.00%	3.00%	3.64%	0.00%	0.00%	0.00%	0.00%	0.00%	2.54%	**2.64%**
MYPAC	Physician Services - Maternity / Deliveries	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	1.47%	**1.47%**
MYPAC	Physician Services - Psychiatric / Substance Abuse	0.0%	0.0%	3.8%	0.0%	0.0%	0.0%	0.0%	94.5%	0.0%	1.6%	0.00%	0.00%	1.74%	0.00%	9.69%	0.00%	3.62%	3.57%	0.00%	0.08%	**3.45%**
MYPAC	Physician Services - All Other	0.0%	0.0%	0.4%	0.0%	0.0%	0.0%	0.0%	91.3%	0.0%	8.2%	0.00%	0.00%	2.11%	6.51%	0.00%	0.00%	3.62%	3.57%	0.00%	0.15%	**3.29%**
MYPAC	Dental - All Services	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	21.7%	78.3%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	3.89%	0.00%	**0.86%**
MYPAC	All Other Services	0.0%	0.0%	3.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	97.0%	0.00%	0.00%	3.09%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	1.01%	**1.08%**
MA Children	Inpatient Hospital Services - Maternity / Deliveries	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-1.04%	**-1.04%**
MA Children	Inpatient Hospital Services - Psychiatric / Substance Abuse	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	39.7%	0.0%	0.0%	60.3%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	5.65%	0.00%	0.00%	-1.04%	**1.69%**
MA Children	Inpatient Hospital Services - All Other	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	2.36%	0.00%	0.00%	-1.04%	**-1.04%**
MA Children	Outpatient Hospital Services - Emergency Room	0.0%	0.0%	0.0%	0.1%	0.0%	0.0%	0.0%	0.0%	0.0%	99.9%	0.00%	0.00%	0.00%	17.98%	0.00%	0.00%	0.00%	0.00%	0.00%	2.54%	**2.56%**
MA Children	Outpatient Hospital Services - Pharmacy	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	5.06%	**5.06%**
MA Children	Outpatient Hospital Services - All Other	0.0%	0.0%	12.9%	2.0%	0.0%	0.1%	0.0%	0.0%	0.0%	85.1%	0.00%	5.75%	3.01%	4.87%	0.00%	7.96%	0.00%	3.57%	0.00%	2.54%	**2.65%**
MA Children	Physician Services - Maternity / Deliveries	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	1.47%	**1.47%**
MA Children	Physician Services - Psychiatric / Substance Abuse	0.0%	0.0%	86.6%	0.0%	0.6%	0.0%	0.0%	9.7%	0.0%	3.1%	0.00%	0.00%	1.29%	0.00%	13.76%	0.00%	3.62%	3.57%	0.00%	1.47%	**1.60%**
MA Children	Physician Services - All Other	0.3%	0.0%	1.5%	0.3%	0.0%	0.0%	0.0%	0.3%	0.0%	97.5%	4.25%	0.00%	2.36%	4.78%	0.00%	0.00%	3.62%	3.57%	0.00%	1.69%	**1.72%**
MA Children	Dental - All Services	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	18.9%	81.1%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	3.88%	0.00%	**0.75%**
MA Children	All Other Services	0.3%	2.4%	3.1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	94.2%	4.02%	3.92%	3.09%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	1.01%	**1.16%**
Quasi-CHIP	Inpatient Hospital Services - Maternity / Deliveries	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-1.04%	**-1.04%**
Quasi-CHIP	Inpatient Hospital Services - Psychiatric / Substance Abuse	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	35.4%	0.0%	0.0%	64.6%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	5.57%	0.00%	0.00%	-1.04%	**1.37%**
Quasi-CHIP	Inpatient Hospital Services - All Other	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-1.04%	**-1.04%**
Quasi-CHIP	Outpatient Hospital Services - Emergency Room	0.0%	0.0%	0.0%	0.4%	0.0%	0.0%	0.0%	0.0%	0.0%	99.6%	0.00%	0.00%	0.00%	2.43%	0.00%	0.00%	0.00%	0.00%	0.00%	2.54%	**2.54%**
Quasi-CHIP	Outpatient Hospital Services - Pharmacy	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	5.06%	**5.06%**
Quasi-CHIP	Outpatient Hospital Services - All Other	0.0%	0.1%	9.4%	7.5%	0.0%	0.1%	0.0%	0.0%	0.0%	82.9%	0.00%	5.75%	2.97%	4.49%	0.00%	8.51%	0.00%	0.00%	0.00%	2.54%	**2.74%**
Quasi-CHIP	Physician Services - Maternity / Deliveries	0.0%	0.0%	0.0%	14.3%	0.0%	0.0%	0.0%	0.0%	0.0%	85.7%	0.00%	0.00%	0.00%	4.93%	0.00%	0.00%	0.00%	0.00%	0.00%	1.47%	**1.98%**
Quasi-CHIP	Physician Services - Psychiatric / Substance Abuse	0.0%	0.0%	86.8%	0.0%	0.8%	0.0%	0.0%	8.2%	0.0%	4.2%	0.00%	0.00%	1.27%	0.00%	17.78%	0.00%	0.00%	3.57%	0.00%	1.47%	**1.62%**
Quasi-CHIP	Physician Services - All Other	0.0%	0.0%	1.8%	1.0%	0.1%	0.0%	0.0%	0.4%	0.0%	96.8%	0.00%	0.00%	2.31%	3.49%	0.00%	0.00%	0.00%	3.57%	0.00%	1.69%	**1.73%**
Quasi-CHIP	Dental - All Services	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	25.0%	75.0%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	3.88%	0.00%	**0.99%**
Quasi-CHIP	All Other Services	0.0%	0.0%	3.3%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	96.7%	0.00%	0.00%	3.09%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	1.01%	**1.08%**

Exhibit 13
Mississippi Division of Medicaid
SFY 2025 MississippiCAN Capitation Rate Development
SFY 2025 MississippiCAN Expenditure Estimate

Rate Cell	a Projected SFY 2025 Member Months	b SFY 2025 Statewide Capitation Rates[1]	c MHAP-FSA PMPM	d Premium Tax on MHAP-FSA PMPM[2]	e MHAP-QIPP PMPM	f Premium Tax on MHAP-QIPP PMPM[2]	g TREAT PMPM	h Premium Tax on TREAT PMPM[2]	i MAPS PMPM	j Premium Tax on MAPS PMPM[2]	k = sum of b through j Total Rate at 1.0 Risk Score after Withhold	l = a × k MississippiCAN Estimated Cost	m FMAP / EFMAP[3]	n = l × m Federal Estimated Cost
Non-Newborn SSI / Disabled	716,865	$870.59	$334.11	$10.33	$151.18	$4.68	$4.59	$0.14	$5.98	$0.18	$1,381.79	$990,454,545	76.99%	$762,575,716
North Region	250,536	764.62	282.43	8.73	151.18	4.68	4.59	0.14	5.98	0.18	1,222.54	306,290,232	76.99%	235,820,507
Central Region	259,238	905.24	349.91	10.82	151.18	4.68	4.59	0.14	5.98	0.18	1,432.72	371,416,984	76.99%	285,963,221
South Region	207,091	954.92	376.86	11.66	151.18	4.68	4.59	0.14	5.98	0.18	1,510.19	312,747,330	76.99%	240,791,988
Breast and Cervical Cancer	912	$3,272.89	$1,320.41	$40.84	$151.18	$4.68	$4.59	$0.14	$5.98	$0.18	$4,800.90	$4,478,386	76.99%	$3,448,021
North Region	186	2,874.53	710.59	21.98	151.18	4.68	4.59	0.14	5.98	0.18	3,773.85	701,973	76.99%	540,467
Central Region	301	3,403.17	1,149.46	35.55	151.18	4.68	4.59	0.14	5.98	0.18	4,754.93	1,430,484	76.99%	1,101,365
South Region	425	3,589.93	1,708.17	52.83	151.18	4.68	4.59	0.14	5.98	0.18	5,517.69	2,345,929	76.99%	1,806,189
MA Adult	690,767	$362.64	$135.76	$4.20	$151.18	$4.68	$4.59	$0.14	$5.98	$0.18	$669.35	$462,088,738	76.99%	$355,773,671
North Region	186,517	360.00	123.80	3.83	151.18	4.68	4.59	0.14	5.98	0.18	654.38	122,053,571	76.99%	93,972,095
Central Region	215,088	372.10	137.33	4.25	151.18	4.68	4.59	0.14	5.98	0.18	680.43	146,352,442	76.99%	112,680,404
South Region	289,162	356.35	142.30	4.40	151.18	4.68	4.59	0.14	5.98	0.18	669.81	193,682,725	76.99%	149,121,172
Pregnant Women	201,312	$628.90	$288.10	$8.91	$151.18	$4.68	$4.59	$0.14	$5.98	$0.18	$1,092.66	$220,240,512	76.99%	$169,568,676
North Region	66,481	624.32	289.56	8.96	151.18	4.68	4.59	0.14	5.98	0.18	1,089.60	72,437,349	76.99%	55,771,326
Central Region	74,991	645.30	287.10	8.88	151.18	4.68	4.59	0.14	5.98	0.18	1,108.04	83,092,979	76.99%	63,975,362
South Region	59,840	618.00	287.73	8.90	151.18	4.68	4.59	0.14	5.98	0.18	1,081.39	64,710,184	76.99%	49,821,988
SSI / Disabled Newborn	5,977	$6,715.37	$3,966.73	$122.68	$151.18	$4.68	$4.59	$0.14	$5.98	$0.18	$10,971.55	$66,173,648	76.99%	$50,948,746
North Region	1,874	6,839.33	3,632.01	112.33	151.18	4.68	4.59	0.14	5.98	0.18	10,750.43	20,146,965	76.99%	15,511,652
Central Region	2,541	7,219.49	4,931.92	152.53	151.18	4.68	4.59	0.14	5.98	0.18	12,470.70	31,683,768	76.99%	24,394,125
South Region	1,562	6,129.93	2,798.50	86.55	151.18	4.68	4.59	0.14	5.98	0.18	9,181.74	14,342,915	76.99%	11,042,969
Non-SSI Newborns 0 to 2 Months	68,675	$2,339.64	$1,521.05	$47.04	$151.18	$4.68	$4.59	$0.14	$5.98	$0.18	$4,074.49	$280,700,126	76.99%	$216,118,045
North Region	21,619	2,382.83	1,494.87	46.23	151.18	4.68	4.59	0.14	5.98	0.18	4,090.69	88,438,494	76.99%	68,091,007
Central Region	25,152	2,515.27	1,586.33	49.06	151.18	4.68	4.59	0.14	5.98	0.18	4,317.43	108,591,409	76.99%	83,607,240
South Region	21,904	2,135.67	1,471.91	45.52	151.18	4.68	4.59	0.14	5.98	0.18	3,819.86	83,670,224	76.99%	64,419,797
Non-SSI Newborns 3 to 12 Months	228,658	$311.68	$82.11	$2.54	$151.18	$4.68	$4.59	$0.14	$5.98	$0.18	$563.09	$129,109,855	76.99%	$99,404,905
North Region	72,261	317.43	92.91	2.87	151.18	4.68	4.59	0.14	5.98	0.18	579.97	41,909,341	76.99%	32,267,049
Central Region	82,830	335.08	77.41	2.39	151.18	4.68	4.59	0.14	5.98	0.18	581.64	48,177,331	76.99%	37,092,932
South Region	73,567	284.51	76.80	2.38	151.18	4.68	4.59	0.14	5.98	0.18	530.44	39,023,183	76.99%	30,044,924
Foster Care	94,542	$623.89	$317.27	$9.81	$151.18	$4.68	$4.59	$0.14	$5.98	$0.18	$1,117.73	$105,207,074	76.99%	$81,001,557
North Region	27,826	635.41	305.39	9.45	151.18	4.68	4.59	0.14	5.98	0.18	1,117.01	31,082,175	76.99%	23,930,943
Central Region	28,079	670.73	433.37	13.40	151.18	4.68	4.59	0.14	5.98	0.18	1,284.26	36,060,200	76.99%	27,763,650
South Region	38,638	569.50	241.44	7.47	151.18	4.68	4.59	0.14	5.98	0.18	985.17	38,064,699	76.99%	29,306,964
MYPAC	10,757	$3,377.43	$537.11	$16.61	$151.18	$4.68	$4.59	$0.14	$5.98	$0.18	$4,097.91	$43,968,469	76.99%	$33,852,424
North Region	3,150	3,439.78	585.93	18.12	151.18	4.68	4.59	0.14	5.98	0.18	4,210.58	13,265,395	76.99%	10,213,359
Central Region	3,523	3,630.97	531.20	16.43	151.18	4.68	4.59	0.14	5.98	0.18	4,345.36	15,306,558	76.99%	11,784,902
South Region	4,084	3,082.99	504.54	15.60	151.18	4.68	4.59	0.14	5.98	0.18	3,769.89	15,396,516	76.99%	11,854,163
MA Children	3,121,602	$205.33	$45.58	$1.41	$151.18	$4.68	$4.59	$0.14	$5.98	$0.18	$419.08	$1,306,709,672	76.99%	$1,006,068,444
North Region	890,157	209.12	41.63	1.29	151.18	4.68	4.59	0.14	5.98	0.18	418.80	372,794,483	76.99%	287,023,792
Central Region	1,053,233	220.75	50.91	1.57	151.18	4.68	4.59	0.14	5.98	0.18	439.99	463,412,635	76.99%	356,792,973
South Region	1,178,213	187.43	43.79	1.35	151.18	4.68	4.59	0.14	5.98	0.18	399.34	470,502,553	76.99%	362,251,678
Quasi-CHIP	366,592	$201.84	$43.20	$1.34	$151.18	$4.68	$4.59	$0.14	$5.98	$0.18	$413.14	$151,678,903	83.90%	$127,251,015
North Region	115,780	205.57	42.28	1.31	151.18	4.68	4.59	0.14	5.98	0.18	415.91	48,154,233	83.90%	40,398,994
Central Region	128,455	217.00	43.48	1.34	151.18	4.68	4.59	0.14	5.98	0.18	428.58	55,053,022	83.90%	46,186,733
South Region	122,356	184.25	43.79	1.35	151.18	4.68	4.59	0.14	5.98	0.18	396.15	48,471,647	83.90%	40,665,289
Total - All Rate Cells	5,506,661	$378.91	$133.17	$4.12	$151.18	$4.68	$4.59	$0.14	$5.98	$0.18	$682.96	$3,760,809,928	77.27%	$2,906,011,220
North Region	1,636,389	382.85	129.17	3.99	151.18	4.68	4.59	0.14	5.98	0.18	682.77	1,117,274,210	77.29%	863,541,192
Central Region	1,873,430	408.60	146.37	4.53	151.18	4.68	4.59	0.14	5.98	0.18	726.25	1,360,577,812	77.27%	1,051,342,907
South Region	1,996,843	347.83	124.07	3.84	151.18	4.68	4.59	0.14	5.98	0.18	642.49	1,282,957,905	77.25%	991,127,121

[1] Capitation rates prior to quality withhold and VBP payments, excluding MHAP, MAPS, and TREAT.
[2] Calculated using a premium tax of 3.00%
[3] For SFY 2025, FMAP is calculated as the blend of three months using an FMAP of 80.36%, three months using an FMAP of 78.77%, and six months using an FMAP of 77.27%. For SFY 2025, EFMAP is calculated as the blend of six months using an EFMAP of 85.00% and six months using an EFMAP of 84.09%. These FMAP and EFMAP projections include the phase-down of the additional federal match as described in the 2023 Consolidated Appropriations Act.

Exhibit 14A
Mississippi Division of Medicaid
SFY 2025 MississippiCAN Capitation Rate Development
High-Cost Pharmacy Risk Corridor
Illustrative Settlement Calculation

Rate Cell	a Illustrative Actual SFY 2025 Membership[1]	b SFY 2025 Regional High-Cost Pharmacy Target PMPM	c Illustrative Actual SFY 2025 High-Cost Pharmacy Costs[2,3]	d = c / a Illustrative Actual SFY 2025 High-Cost Pharmacy PMPM
Non-Newborn SSI / Disabled	717,000	$35.03	$15,000,000	$20.92
Breast and Cervical Cancer	1,000	$0.00	$0	$0.00
MA Adult	691,000	$0.64	$0	$0.00
Pregnant Women	201,000	$0.00	$0	$0.00
SSI / Disabled Newborn	6,000	$0.48	$0	$0.00
Non-SSI Newborns 0 to 2 Months	69,000	$29.66	$1,000,000	$14.49
Non-SSI Newborns 3 to 12 Months	229,000	$17.24	$5,000,000	$21.83
Foster Care	95,000	$5.08	$0	$0.00
MYPAC	11,000	$0.00	$0	$0.00
MA Children	3,122,000	$4.53	$10,000,000	$3.20
Quasi-CHIP	367,000	$0.00	$0	$0.00
Total	**5,509,000**	**$8.39**	**$31,000,000**	**$5.63**

Illustrative Actual Risk Corridor Eligible Costs	$31,000,000	*e = c*
Illustrative Target Risk Corridor Eligible Costs	$46,193,565	*f = a × b*
Difference ($)	($15,193,565)	*g = e - f*
Difference (%)	-32.89%	*h = g / f*

Risk Corridor Bands	**%** *i*	**$** *j = i × f*	**Settlement** k = j × DOM %
< -6%: 0% CCO / 100% DOM	26.89%	$12,421,951	$12,421,951
-6% to -3%: 50% CCO / 50% DOM	3.00%	$1,385,807	$692,903
-3% to 0%: 100% CCO / 0% DOM	3.00%	$1,385,807	$0
0% to 3%: 100% CCO / 0% DOM	0.00%	$0	$0
3% to 6%: 50% CCO / 50% DOM	0.00%	$0	$0
> 6%: 0% CCO / 100% DOM	0.00%	$0	$0
Total Risk Corridor Settlement Received (Paid) by DOM			**$13,114,855**

[1] Illustrative values demonstrate projected regional enrollment mix. Actual values will use CCO-specific regional enrollment mix.
[2] PMPM calculation will be populated with actual SFY 2025 CCO-specific values.
[3] Includes all costs incurred during SFY 2025 eligible for the risk corridor, as outlined in the rate certification. Actual costs, but not target costs, will be populated with actual SFY 2025 CCO-specific experience.

Exhibit 14B
Mississippi Division of Medicaid
SFY 2025 MississippiCAN Capitation Rate Development
Illustrative MLR Development

	a	b	c	d = b × c	e	f = d × (e × 1%) / (1 - 1%)	g	h	i	j	k = d + f + g + h + i + j	l	m	n	o = g + h + i + j - l + n	p	q = g + h + i + j - m + p	r = o / (k - l)	s = q / (k - l)
Rate Cell	**Projected SFY 2025 Membership[1]**	**SFY 2025 Regional Capitation Rates net of Withhold[2]**	**Illustrative Risk Score[1]**	**Risk Adjusted Premium Net of Withhold**	**% of Withhold Returned[1]**	**Withhold Returned PMPM**	**MHAP-FSA PMPM Gross of Premium Tax[1]**	**MHAP-QIPP Gross of Premium Tax[1]**	**MAPS Gross of Premium Tax[1]**	**TREAT Gross of Premium Tax[1]**	**Total Revenue PMPM**	**SFY 2024 High-Cost Pharmacy Target PMPM**	**Illustrative High-Cost Pharmacy Actual SFY 2024 PMPM**	**Projected SFY 2025 Medical Costs PMPM[3]**	**Projected Total Service Costs PMPM**	**Illustrative Actual SFY 2025 Medical Costs PMPM[3]**	**Illustrative Actual Total Service Costs PMPM**	**Illustrative Target MLR**	**Illustrative Actual MLR**
Non-Newborn SSI / Disabled	716,865	$861.88	1.000	$861.88	100%	$8.71	$344.44	$155.86	$7.38	$3.86	$1,382.13	$35.03	$20.92	$765.25	$1,241.77	$800.00	$1,290.62	92.2%	95.8%
Breast and Cervical Cancer	912	$3,240.16	1.000	$3,240.16	100%	$32.73	$1,361.25	$155.86	$7.38	$3.86	$4,801.24	$0.00	$0.00	$2,904.47	$4,432.82	$3,050.00	$4,578.35	92.3%	95.4%
MA Adult	690,767	$359.01	1.000	$359.01	100%	$3.63	$139.95	$155.86	$7.38	$3.86	$669.69	$0.64	$0.00	$312.93	$619.35	$330.00	$637.05	92.6%	95.2%
Pregnant Women	201,312	$622.61	1.000	$622.61	100%	$6.29	$297.01	$155.86	$7.38	$3.86	$1,093.01	$0.00	$0.00	$550.03	$1,014.14	$580.00	$1,044.11	92.8%	95.5%
SSI / Disabled Newborn	5,977	$6,648.22	1.000	$6,648.22	100%	$67.15	$4,089.42	$155.86	$7.38	$3.86	$10,971.89	$0.48	$0.00	$5,969.95	$10,225.99	$6,270.00	$10,526.52	93.2%	95.9%
Non-SSI Newborns 0 to 2 Months	68,675	$2,316.24	1.000	$2,316.24	100%	$23.40	$1,568.09	$155.86	$7.38	$3.86	$4,074.83	$29.66	$14.49	$2,073.43	$3,778.95	$2,180.00	$3,900.70	93.4%	96.4%
Non-SSI Newborns 3 to 12 Months	228,658	$308.56	1.000	$308.56	100%	$3.12	$84.65	$155.86	$7.38	$3.86	$563.43	$17.24	$21.83	$267.56	$502.07	$280.00	$509.92	91.9%	93.4%
Foster Care	94,542	$617.66	1.000	$617.66	100%	$6.24	$327.08	$155.86	$7.38	$3.86	$1,118.08	$5.08	$0.00	$545.58	$1,034.68	$570.00	$1,064.18	93.0%	95.6%
MYPAC	10,757	$3,343.66	1.000	$3,343.66	100%	$33.77	$553.72	$155.86	$7.38	$3.86	$4,098.25	$0.00	$0.00	$2,997.56	$3,718.38	$3,150.00	$3,870.82	90.7%	94.5%
MA Children	3,121,602	$203.28	1.000	$203.28	100%	$2.05	$46.99	$155.86	$7.38	$3.86	$419.42	$4.53	$3.20	$172.86	$382.41	$180.00	$390.88	92.2%	94.2%
Quasi-CHIP	366,592	$199.82	1.000	$199.82	100%	$2.02	$44.54	$155.86	$7.38	$3.86	$413.48	$0.00	$0.00	$169.75	$381.39	$180.00	$391.64	92.2%	94.7%
Total	**5,506,661**	**$375.12**	**1.000**	**$375.12**	**100%**	**$3.79**	**$137.29**	**$155.86**	**$7.38**	**$3.86**	**$683.30**	**$8.39**	**$5.63**	**$327.43**	**$623.43**	**$342.83**	**$641.59**	**92.4%**	**95.1%**

Illustrative Actual MLR	95.06%
Illustrative Target MLR	92.37%
MLR Difference	-2.69%
MLR Difference Exceeding Corridor	-0.69%
Total Revenue[5]	$3,716,524,337
Risk Corridor Settlement Received (Paid) by DOM	($25,684,267)

[1] MLR calculation will be populated with actual SFY 2025 CCO-specific values.
[2] Illustrative values demonstrate projected regional enrollment mix. Actual values will use CCO-specific regional enrollment mix.
[3] Includes all services incurred during SFY 2025 with payments made to providers as defined in Exhibit C of the CCO Contract, including fee-for-service payments, subcapitation payments, and settlement payments. Actual MLR, but not target MLR, will be populated with actual SFY 2025 CCO-specific values. Additionally, both actual and target costs will use CCO-specific regional enrollment mix. Actual MLR will include adjustments for items found in MLR audits and adjustments to remove services not covered by the Mississippi state plan.
[4] Excluding high-cost pharmacy target PMPM.

Exhibit 14C
Mississippi Division of Medicaid
SFY 2025 High Cost Pharmacy Risk Corridor Development

		Non-Newborn SSI / Disabled		Breast and Cervical Cancer		MA Adult		Pregnant Women		SSI / Disabled Newborn		Non-SSI Newborns 0 to 2 Months		Non-SSI Newborns 3 to 12 Months		Foster Care		MYPAC		MA Children		Quasi-CHIP	
		PMPM	Total	PMPM	Total	PMPM	Total	PMPM	Total	PMPM	Total	PMPM	Total	PMPM	Total	PMPM	Total	PMPM	Total	PMPM	Total	PMPM	Total
Step One: Remove cost of program changes from SFY 2025 risk corridor eligible PMPM																							
	Eligible Spend Rate Categories PMPM																						
	Outpatient Hospital - Pharmacy	$58.84		$982.51		$13.94		$8.77		$56.97		$2.66		$1.92		$2.83		$3.40		$2.09		$2.47	
	Outpatient Hospital - Other	$137.57		$631.30		$64.24		$50.89		$207.63		$32.31		$34.92		$40.77		$51.02		$25.66		$21.32	
	Physician - Other	$228.02		$1,060.03		$108.60		$151.30		$1,483.56		$438.96		$154.57		$96.77		$875.01		$85.77		$56.95	
(a)	**Projected SFY 2025 Eligible Risk Corridor Spend[1]**	$424.44	$305,896,338	$2,673.85	$2,569,567	$186.78	$84,385,400	$210.96	$20,425,764	$50.60	$254,989	$473.93	$32,027,399	$191.42	$44,503,317	$140.38	$11,575,907	$929.43	$9,863,161	$93.53	$239,293,235	$80.74	$22,901,107
(b)	**Hemophilia Population Carve-In Eligible Spend[2]**	$0.02	$12,906	$0.00	$0	$0.02	$7,807	$0.00	$0	$0.00	$0	$0.00	$0	$0.00	$0	$0.00	$195	$0.00	$0	$0.01	$32,383	$0.02	$5,600
	Hemophilia A Gene Therapy																						
(c)	Gross Risk Corridor Eligible Costs	*$4.02*	*$2,900,000*	*$0.00*	*$0*	*$0.00*	*$0*	*$0.00*	*$0*	*$0.00*	*$0*	*$0.00*	*$0*	*$0.00*	*$0*	*$0.00*	*$0*	*$0.00*	*$0*	*$1.13*	*$2,900,000*	*$0.00*	*$0*
	Hemophilia B Gene Therapy																						
(d)	Gross Risk Corridor Eligible Costs	*$0.00*	*$0*	*$0.00*	*$0*	*$0.00*	*$0*	*$0.00*	*$0*	*$0.00*	*$0*	*$0.00*	*$0*	*$0.00*	*$0*	*$0.00*	*$0*	*$0.00*	*$0*	*$1.37*	*$3,500,000*	*$0.00*	*$0*
	Sickle Cell Disease Gene Therapy																						
(e)	Gross Risk Corridor Eligible Costs	*$22.06*	*$15,900,000*	*$0.00*	*$0*	*$0.00*	*$0*	*$0.00*	*$0*	*$0.00*	*$0*	*$0.00*	*$0*	*$0.00*	*$0*	*$0.00*	*$0*	*$0.00*	*$0*	*$0.00*	*$0*	*$0.00*	*$0*
	Duchene Muscular Dystrophy Gene Therapy																						
(f)	Gross Risk Corridor Eligible Costs	*$0.00*	*$0*	*$0.00*	*$0*	*$0.00*	*$0*	*$0.00*	*$0*	*$0.00*	*$0*	*$0.00*	*$0*	*$0.00*	*$0*	*$0.00*	*$0*	*$0.00*	*$0*	*$1.25*	*$3,200,000*	*$0.00*	*$0*
	Spinal Muscular Atrophy Gene Therapy																						
(g)	Gross Risk Corridor Eligible Costs	*$0.00*	*$0*	*$0.00*	*$0*	*$0.00*	*$0*	*$0.00*	*$0*	*$0.00*	*$0*	*$33.36*	*$2,254,412*	*$19.39*	*$4,508,824*	*$0.00*	*$0*	*$0.00*	*$0*	*$0.00*	*$0*	*$0.00*	*$0*
	Beta-Thalassemia Gene Therapy																						
(h)	Gross Risk Corridor Eligible Costs	*$0.00*	*$0*	*$0.00*	*$0*	*$0.00*	*$0*	*$0.00*	*$0*	*$0.00*	*$0*	*$0.00*	*$0*	*$0.00*	*$0*	*$0.00*	*$0*	*$0.00*	*$0*	*$1.09*	*$2,800,000*	*$0.00*	*$0*
(i) = (a) - sum[(b) to (h)]	**Adjusted SFY 2025 Risk Corridor Eligible Spend**	**$398.34**	**$287,083,432**	**$2,673.85**	**$2,569,567**	**$186.76**	**$84,377,593**	**$210.96**	**$20,425,764**	**$50.60**	**$254,989**	**$440.57**	**$29,772,987**	**$172.02**	**$39,994,493**	**$140.37**	**$11,575,712**	**$929.43**	**$9,863,161**	**$87.42**	**$223,660,852**	**$80.72**	**$22,895,507**
Step Two: Using CY 2022 encounter data, estimate the percentage of eligible costs that will exceed the risk corridor threshold.																							
(j)	Applicable to Eligible Spend[3]	18.3%	18.3%	48.9%	48.9%	6.4%	6.4%	3.6%	3.6%	2.9%	2.9%	0.1%	0.1%	0.3%	0.3%	7.3%	7.3%	0.8%	0.8%	2.0%	2.0%	4.3%	4.3%
(k)	Historical Percentage of Claims Over Threshold[3]	13.3%	13.3%	0.0%	0.0%	5.4%	5.4%	0.0%	0.0%	32.7%	32.7%	0.0%	0.0%	0.0%	0.0%	49.8%	49.8%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
(l) = (i) x (j) x (k)	**Anticipated SFY 2025 Risk Corridor Eligible Cost Over Threshold, Prior to Program Ch**	**$9.71**	**$6,996,399**	**$0.00**	**$0**	**$0.64**	**$288,688**	**$0.00**	**$0**	**$0.48**	**$2,415**	**$0.00**	**$0**	**$0.00**	**$0**	**$5.08**	**$419,221**	**$0.00**	**$0**	**$0.00**	**$0**	**$0.00**	**$0**
Step Three: Add the cost of new eligible covered services for SFY 2025 to Step Two.																							
	Hemophilia A Gene Therapy																						
(m)	*Risk Corridor Eligible Spend[4]*	*$3.68*	*$2,650,000*	*$0.00*	*$0*	*$0.00*	*$0*	*$0.00*	*$0*	*$0.00*	*$0*	*$0.00*	*$0*	*$0.00*	*$0*	*$0.00*	*$0*	*$0.00*	*$0*	*$1.04*	*$2,650,000*	*$0.00*	*$0*
	Hemophilia B Gene Therapy																						
(n)	*Risk Corridor Eligible Spend[4]*	*$0.00*	*$0*	*$0.00*	*$0*	*$0.00*	*$0*	*$0.00*	*$0*	*$0.00*	*$0*	*$0.00*	*$0*	*$0.00*	*$0*	*$0.00*	*$0*	*$0.00*	*$0*	*$1.27*	*$3,250,000*	*$0.00*	*$0*
	Sickle Cell Disease Gene Therapy																						
(o)	*Risk Corridor Eligible Spend[4]*	*$21.65*	*$15,600,000*	*$0.00*	*$0*	*$0.00*	*$0*	*$0.00*	*$0*	*$0.00*	*$0*	*$0.00*	*$0*	*$0.00*	*$0*	*$0.00*	*$0*	*$0.00*	*$0*	*$0.00*	*$0*	*$0.00*	*$0*
	Duchene Muscular Dystrophy Gene Therapy																						
(p)	*Risk Corridor Eligible Spend[4]*	*$0.00*	*$0*	*$0.00*	*$0*	*$0.00*	*$0*	*$0.00*	*$0*	*$0.00*	*$0*	*$0.00*	*$0*	*$0.00*	*$0*	*$0.00*	*$0*	*$0.00*	*$0*	*$1.15*	*$2,950,000*	*$0.00*	*$0*
	Spinal Muscular Atrophy Gene Therapy																						
(q)	*Risk Corridor Eligible Spend[4]*	*$0.00*	*$0*	*$0.00*	*$0*	*$0.00*	*$0*	*$0.00*	*$0*	*$0.00*	*$0*	*$29.66*	*$2,004,412*	*$17.24*	*$4,008,824*	*$0.00*	*$0*	*$0.00*	*$0*	*$0.00*	*$0*	*$0.00*	*$0*
	Beta-Thalassemia Gene Therapy																						
(r)	*Risk Corridor Eligible Spend[4]*	*$0.00*	*$0*	*$0.00*	*$0*	*$0.00*	*$0*	*$0.00*	*$0*	*$0.00*	*$0*	*$0.00*	*$0*	*$0.00*	*$0*	*$0.00*	*$0*	*$0.00*	*$0*	*$1.07*	*$2,750,000*	*$0.00*	*$0*
(s) = sum[(l) to (r)]	**Anticipated SFY 2025 Risk Score Eligible Cost Over Threshold, Including Program Ch**	**$35.03**	**$25,246,399**	**$0.00**	**$0**	**$0.64**	**$288,688**	**$0.00**	**$0**	**$0.48**	**$2,415**	**$29.66**	**$2,004,412**	**$17.24**	**$4,008,824**	**$5.08**	**$419,221**	**$0.00**	**$0**	**$4.53**	**$11,600,000**	**$0.00**	**$0**

[1] PMPM amounts tie to the final row of Exhibit 2A.
[2] CY 2022 claims for anticipated members transitioning from FFS to MSCAN trended forward to SFY 2025.
[3] See Exhibit 15B for the development of the risk corridor eligible spend for each gene therapy

Exhibit 14D
Mississippi Division of Medicaid
SFY 2025 High Cost Pharmacy Risk Corridor Development - Gene Therapy Supplemental Support

		Non-Newborn SSI / Disabled	Breast and Cervical Cancer	MA Adult	Pregnant Women	SSI / Disabled Newborn	Non-SSI Newborns 0 to 2 Months	Non-SSI Newborns 3 to 12 Months	Foster Care	MYPAC	MA Children	Quasi-CHIP
Hemophilia A Gene Therapy												
(a)	Expected Number of Therapies	1	0	0	0	0	0	0	0	0	1	0
(b)	Net Pharmacy Cost for Gene Therapy[1]	$2,900,000	$0	$0	$0	$0	$0	$0	$0	$0	$2,900,000	$0
(c)	Applicable Inpatient Hospital Cost for Gene Therapy	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
(d) = (b) + (c)	*Total Gene Therapy Cost*	*$2,900,000*	*$0*	*$0*	*$0*	*$0*	*$0*	*$0*	*$0*	*$0*	*$2,900,000*	*$0*
(e) = (d) / (a)	Total Cost per Therapy	$2,900,000	$0	$0	$0	$0	$0	$0	$0	$0	$2,900,000	$0
(f)	Pharmacy RC Threshold per Member	$250,000	$0	$0	$0	$0	$0	$0	$0	$0	$250,000	$0
(g) = max[(e) - (f), 0]	*RC Eligible Dollars per Member*	*$2,650,000*	*$0*	*$0*	*$0*	*$0*	*$0*	*$0*	*$0*	*$0*	*$2,650,000*	*$0*
(h) = (g) x (a)	*Total RC Eligible Dollars*	*$2,650,000*	*$0*	*$0*	*$0*	*$0*	*$0*	*$0*	*$0*	*$0*	*$2,650,000*	*$0*
Hemophilia B Gene Therapy												
(a)	Expected Number of Therapies	0	0	0	0	0	0	0	0	0	1	0
(b)	Net Pharmacy Cost for Gene Therapy[1]	$0	$0	$0	$0	$0	$0	$0	$0	$0	$3,500,000	$0
(c)	Applicable Inpatient Hospital Cost for Gene Therapy	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
(d) = (b) + (c)	*Total Gene Therapy Cost*	*$0*	*$0*	*$0*	*$0*	*$0*	*$0*	*$0*	*$0*	*$0*	*$3,500,000*	*$0*
(e) = (d) / (a)	Total Cost per Therapy	$0	$0	$0	$0	$0	$0	$0	$0	$0	$3,500,000	$0
(f)	Pharmacy RC Threshold per Member	$0	$0	$0	$0	$0	$0	$0	$0	$0	$250,000	$0
(g) = max[(e) - (f), 0]	*RC Eligible Dollars per Member*	*$0*	*$0*	*$0*	*$0*	*$0*	*$0*	*$0*	*$0*	*$0*	*$3,250,000*	*$0*
(h) = (g) x (a)	*Total RC Eligible Dollars*	*$0*	*$0*	*$0*	*$0*	*$0*	*$0*	*$0*	*$0*	*$0*	*$3,250,000*	*$0*
Sickle Cell Disease Gene Therapy												
(a)	Expected Number of Therapies	6	0	0	0	0	0	0	0	0	0	0
(b)												
(c)	Net Pharmacy Cost for Gene Therapy[1]	$15,900,000	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
(d) = (b) + (c)	Applicable Inpatient Hospital Cost for Gene Therapy	$1,200,000	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
	Total Gene Therapy Cost	*$17,100,000*	*$0*	*$0*	*$0*	*$0*	*$0*	*$0*	*$0*	*$0*	*$0*	*$0*
(e) = (d) / (a)												
(f)	Total Cost per Therapy	$2,850,000	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
(g) = max[(e) - (f), 0]	Pharmacy RC Threshold per Member	$250,000	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
(h) = (g) x (a)	*RC Eligible Dollars per Member*	*$2,600,000*	*$0*	*$0*	*$0*	*$0*	*$0*	*$0*	*$0*	*$0*	*$0*	*$0*
	Total RC Eligible Dollars	*$15,600,000*	*$0*	*$0*	*$0*	*$0*	*$0*	*$0*	*$0*	*$0*	*$0*	*$0*
Duchene Muscular Dystrophy Gene Therapy												
(a)	Expected Number of Therapies	0	0	0	0	0	0	0	0	0	1	0
(b)	Net Pharmacy Cost for Gene Therapy[1]	$0	$0	$0	$0	$0	$0	$0	$0	$0	$3,200,000	$0
(c)	Applicable Inpatient Hospital Cost for Gene Therapy	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
(d) = (b) + (c)	*Total Gene Therapy Cost*	*$0*	*$0*	*$0*	*$0*	*$0*	*$0*	*$0*	*$0*	*$0*	*$3,200,000*	*$0*
(e) = (d) / (a)	Total Cost per Therapy	$0	$0	$0	$0	$0	$0	$0	$0	$0	$3,200,000	$0
(f)	Pharmacy RC Threshold per Member	$0	$0	$0	$0	$0	$0	$0	$0	$0	$250,000	$0
(g) = max[(e) - (f), 0]	*RC Eligible Dollars per Member*	*$0*	*$0*	*$0*	*$0*	*$0*	*$0*	*$0*	*$0*	*$0*	*$2,950,000*	*$0*
(h) = (g) x (a)	*Total RC Eligible Dollars*	*$0*	*$0*	*$0*	*$0*	*$0*	*$0*	*$0*	*$0*	*$0*	*$2,950,000*	*$0*
Spinal Muscular Atrophy Gene Therapy												
(a)	Expected Number of Therapies	0	0	0	0	0	1	2	0	0	0	0
(b)	Net Pharmacy Cost for Gene Therapy[1]	$0	$0	$0	$0	$0	$2,254,412	$4,508,824	$0	$0	$0	$0
(c)	Applicable Inpatient Hospital Cost for Gene Therapy	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
(d) = (b) + (c)	*Total Gene Therapy Cost*	*$0*	*$0*	*$0*	*$0*	*$0*	*$2,254,412*	*$4,508,824*	*$0*	*$0*	*$0*	*$0*
(e) = (d) / (a)	Total Cost per Therapy	$0	$0	$0	$0	$0	$2,254,412	$2,254,412	$0	$0	$0	$0
(f)	Pharmacy RC Threshold per Member	$0	$0	$0	$0	$0	$250,000	$250,000	$0	$0	$0	$0
(g) = max[(e) - (f), 0]	*RC Eligible Dollars per Member*	*$0*	*$0*	*$0*	*$0*	*$0*	*$2,004,412*	*$2,004,412*	*$0*	*$0*	*$0*	*$0*
(h) = (g) x (a)	*Total RC Eligible Dollars*	*$0*	*$0*	*$0*	*$0*	*$0*	*$2,004,412*	*$4,008,824*	*$0*	*$0*	*$0*	*$0*
Beta-Thalassemia Gene Therapy												
(a)	Expected Number of Therapies	0	0	0	0	0	0	0	0	0	1	0
(b)	Net Pharmacy Cost for Gene Therapy[1]	$0	$0	$0	$0	$0	$0	$0	$0	$0	$2,800,000	$0
(c)	Applicable Inpatient Hospital Cost for Gene Therapy	$0	$0	$0	$0	$0	$0	$0	$0	$0	$200,000	$0
(d) = (b) + (c)	*Total Gene Therapy Cost*	*$0*	*$0*	*$0*	*$0*	*$0*	*$0*	*$0*	*$0*	*$0*	*$3,000,000*	*$0*
(e) = (d) / (a)	Total Cost per Therapy	$0	$0	$0	$0	$0	$0	$0	$0	$0	$3,000,000	$0
(f)	Pharmacy RC Threshold per Member	$0	$0	$0	$0	$0	$0	$0	$0	$0	$250,000	$0
(g) = max[(e) - (f), 0]	*RC Eligible Dollars per Member*	*$0*	*$0*	*$0*	*$0*	*$0*	*$0*	*$0*	*$0*	*$0*	*$2,750,000*	*$0*
(h) = (g) x (a)	*Total RC Eligible Dollars*	*$0*	*$0*	*$0*	*$0*	*$0*	*$0*	*$0*	*$0*	*$0*	*$2,750,000*	*$0*

[1] Reconciles to Exhibit 15C items (b) through (h).

Exhibit 15A
Mississippi Division of Medicaid
Procedure Codes for Non-Psychiatric Physician Visits

90000	90066	90541	90642
90001	90067	90542	90643
90002	90068	90543	90650
90003	90069	90544	90651
90004	90070	90545	90652
90005	90071	90546	90653
90006	90072	90547	90654
90007	90073	90548	92002
90008	90074	90549	92004
90009	90075	90550	92012
90010	90076	90551	92014
90011	90077	90552	99062
90012	90078	90553	99063
90013	90079	90554	99064
90014	90080	90555	99065
90015	90500	90556	99201
90016	90501	90557	99202
90017	90502	90558	99203
90018	90503	90559	99204
90019	90504	90560	99205
90020	90505	90561	99212
90040	90506	90562	99213
90041	90507	90563	99214
90042	90508	90564	99215
90043	90509	90565	99241
90044	90510	90566	99242
90045	90511	90567	99243
90046	90512	90568	99244
90047	90513	90569	99245
90048	90514	90570	99271
90049	90515	90571	99272
90050	90516	90572	99273
90051	90517	90573	99274
90052	90518	90574	99275
90053	90519	90575	99281
90054	90520	90576	99282
90055	90530	90577	99283
90056	90531	90578	99284
90057	90532	90579	99285
90058	90533	90580	99341
90059	90534	90600	99342
90060	90535	90605	99343
90061	90536	90610	99344
90062	90537	90620	99345
90063	90538	90630	99347
90064	90539	90640	99350
90065	90540	90641	

Exhibit 15B Mississippi Division of Medicaid Procedure Codes for Psychiatric Physician Visits
90791
90792
90832
90834
90837
90846
90847
90849
90853
90870
99201
99202
99203
99204
99205
99212
99213
99214
99215

EXHIBIT C: MEDICAL LOSS RATIO (MLR) REQUIREMENTS

The Contractor is required to rebate a portion of the Capitation Payment to the Division in the event the Contractor does not meet the ninety-one percent (91.3%) minimum MLR standard. This Exhibit describes requirements for 1) reporting MLR, 2) methodology for calculation of MLR, 3) record retention 4) payment of any rebate due to the Division, and 5) liquidated damages that may be assessed against the Contractor for failure to meet requirements.

These requirements are adapted from 42 C.F.R. Part 438.8 Federal Register, including requirements incorporated into the Medicaid and Children's Health Insurance Program Managed Care Final Rules published May 6, 2016 and effective July 5, 2016 and published May 10, 2024 and effective July 9, 2024.

A. Reporting Requirements

1. General Requirements

   For each MLR Reporting Quarter and Year, the Contractor must submit to the Division a report which complies with the requirements that follow concerning Capitation Payments received and expenses related to MississippiCAN Members [42 CFR 438.8(a)] (referred to hereafter as MLR Report). A run-out period of 180 days is required for the filing of the final annual MLR report. For the audit of the annual MLR report, the Division's external auditors will request additional runout sufficient to allow for medical claims expense and other financial items to be accurately reflected in the MLR audit report.

   For the quarterly report, use the state fiscal year-to-date information with a 30-day run-out period.

2. Timing and Form of Report

   The report for each MLR Reporting Year must be submitted to the Division by April 1st of the year following the end of an MLR Reporting Year, in a format and in the manner prescribed by the Division.

   The report for each MLR Reporting Quarter must be submitted to the Division by the sixtieth (60th) calendar day following the end of the MLR Reporting Quarter, in a format and in the manner prescribed by the Division.

3. Premium Revenue

   A Contractor must report to the Division the total Premium Revenue received from

the Division for each MLR Reporting Year. Premium Revenue includes, but is not limited to, all monies paid by the Division to the Contractor for providing benefits and services as defined in the terms of the Contract and is inclusive of Capitation Payments, Capitation Premium Withhold amounts earned, State Directed Payments, Health Insurer Fee reimbursement, Risk Corridor adjustments, and any other Medicaid Managed Care Program Revenues, but is exclusive of any Value-Based Payment Incentive Program receipts or amounts received from the DOM PBA. (Note: Other revenues may be inclusive of payments made for services such as high-cost drugs paid outside the capitation rate.)

4. Additional Reporting

   During each MLR Reporting Year, Contractor must submit the following additional reports to the Division in a manner that meets the definition of 42 C.F.R. § 438.8 (k) at the time of the submission of the Annual MLR Report:

   a. Total incurred claims
   b. Expenditures on quality improving activities
   c. Expenditures related to activities compliant with 42 C.F.R. § 438.608(a) (1) through (5), (7), (8) and (b)
   d. Non-claims costs
   e. Premium revenue
   f. Taxes, licensing and regulatory fees
   g. Methodologies for allocation of expenditures
   h. Any credibility adjustment applied
   i. Supporting schedules/documentation for any adjustments made to items a-h.
   j. Reconciling supplemental schedule(s) supporting the amounts claimed for all third parties (including related parties) and/or sub-capitated vendors included in amounts reported on the MLR Report for items a-i. Obtained in accordance with the requirements of 42 C.F.R. § 438.8(k)(3)
   k. The Calculated MLR
   l. Any remittance owed to the State
   m. A comparison of the information reported in the MLR Report to the Audited Financial Statement
   n. A description of the aggregation method used
   o. The number of Member Months

5. Attestation

   Contractor must attest to the accuracy of the calculation of the MLR in accordance with the requirements of 42 C.F.R. § 438.8(n) when submitting reports required under this section.

6. Recalculation of MLR

   In any instance where the Division makes a retroactive change to the Capitation Payments for an MLR Reporting Year where the MLR Report has already been submitted to the Division, Contractor must re-calculate the MLR for all MLR Reporting Years affected by the change and submit a new MLR Report meeting the requirements of this section. Refer to 42 C.F.R. § 438.8(m). Any recalculated MLR Report identified in this section must be provided to the Division no later than sixty (60) days after the reported retroactive change has been provided by the Division.

B. <u>Reimbursement for Clinical Services Provided to Members</u>

The MLR Report must include direct claims paid to or received by Providers (including under capitated contracts with Network Providers), whose services are covered by the Subcontract for clinical services or supplies covered by the Division's Contract with the Contractor. Reimbursement for clinical services as defined in this section is referred to as "incurred claims." (Note: Services covered under the Contract are inclusive of services paid through the capitation rate or separately reimbursed by the Division, but are exclusive of Value-Based Incentive Program distributions or payments to the DOM PBA.)

1. Specific requirements include:

   a. Unpaid claims liabilities for the MLR Reporting Year, including claims reported that are in the process of being adjusted or claims incurred but not reported;

   b. Withholds from payments made to network providers;

   c. Claims that are recoverable for anticipated coordination of benefits;

   d. Claims payments recoveries received as a result of subrogation;

   e. Incurred but not reported claims based on past experience, and modified to reflect current conditions, such as changes in exposure or claim frequency or severity;

   f. Changes in other claims-related reserves; and

   g. Reserves for contingent benefits and the medical claim portion of lawsuits.

Note: Incurred claims for capitated payments to third-party subcontracted vendors, should reflect all adjustments as required in Section J.

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

    a. Overpayment recoveries received from Network Providers;

    b. Prescription drug rebates received and accrued by the Contractor, as well as rebates available and retained by the pharmacy benefit manager

3. Expenditures that must be included in incurred claims include:

    a. The amount of incentive and bonus payments made, or expected to be made, to Network Providers that are tied to clearly-defined, objectively measurable, and well-documented clinical or quality improvement standards that apply to providers;

    b. The amount of claims payments recovered through fraud reduction efforts, not to exceed the amount of fraud reduction expenses. The amount of fraud reduction expenses must not include activities specified in paragraph 42 C.F.R. § 438.8(e)(4); (This allows for a potential offset against a portion of the recovery amounts deducted from the incurred claims as required in Section B.2.a.)

    Note: DOM will only allow fraud prevention expenses in the MLR calculation for program integrity activities as they are aligned with standards adopted in the private market rule. In addition, claim payment recoveries must be separately distinguishable as a result of fraud reduction efforts versus other types of claim payment recoveries.

    Fraud Prevention Expenses are defined as expenses incurred <u>prior</u> to the payment of a claim to prevent fraudulent claim payments These expenses are considered routine program integrity activities that the Contractor should be performing and are to be classified as non-claims costs.

    Fraud Reduction Expenses are defined as expenses incurred <u>subsequent</u> to the payment of a claim to specifically identify and detect fraudulent claims for recoupment. (Note: all other post payment claim review activities ensuring proper claim payment performed by the Contractor as part of their program integrity duties are to be considered non-claims cost.)

4. Amounts that must either be included in or deducted from incurred claims include, respectively, net payments or receipts related to State mandated solvency funds.

5. Amounts that must be excluded from incurred claims:
    a. Non-claims Costs, as defined in this Contract, which include amounts paid to third party vendors for secondary network savings; amounts paid to third party vendors for network development, administrative fees, claims processing, and utilization management; amounts paid, including amounts paid to a provider, for professional or administrative services that do not represent compensation or reimbursement for State plan services or services meeting the definition in 42 C.F.R. § 438.3(e) and provided to a Member; and fines and penalties assessed by regulatory authorities;
    b. Amounts paid to the State as remittance under 42 C.F.R. § 438.8(j);
    c. Amounts paid to network providers under 42 C.F.R. § 438.6(d);
    d. Amounts identified during the analysis of third-party subcontractors as specified in Section J;
    e. Spread Pricing amounts paid to a pharmacy benefit manager (PBM); and
    f. The amount of reinsurance premiums that exceed the reinsurance recoveries, as these are non-claims costs.

C. Activities that Improve Health Care Quality

1. General Requirements

    The MLR Report may include expenditures for activities that improve health care quality, as described in this section. The expenditures must be directly related to activities that improve healthcare quality and meet the following requirements:
    a. An activity that meets the requirements of 45 C.F.R. § 158.150(b) and is not excluded under 45 C.F.R. § 158.150(c).
    b. An activity related to any EQR-related activity as described in 42 C.F.R. § 438.358(b) and (c).
    c. Any expenditure that is related to Health Information Technology and meaningful use, meets the requirements placed on issuers found in 45 C.F.R. § 158.151, and is not considered incurred claims.

2. Activity Requirements

    Activities conducted by the Contractor to improve quality must meet the following requirements:
    a. The activity must be designed to:

i. Improve health quality;

ii. Increase the likelihood of desired health outcomes in ways that are capable of being objectively measured and of producing verifiable results and achievements;

iii. Be directed toward individual Members or incurred for the benefit of specified segments of Members or provide health improvements to the population beyond those enrolled in coverage as long as no additional costs are incurred due to the non-Members;

iv. Be grounded in evidence-based medicine, widely accepted best clinical practice, or criteria issued by recognized professional medical associations, accreditation bodies, government agencies or other nationally recognized health care quality organizations;

b. The activity must be primarily designed to:

i. Improve health outcomes including increasing the likelihood of desired outcomes compared to a baseline and reduce health disparities among specified populations. Examples include the direct interaction of the Contractor (including those services delegated by Subcontract for which the Contractor retains ultimate responsibility under the terms of the Contract with the Division) with Providers and the Member or the Member's representative (for example, face-to-face, telephonic, web- based interactions or other means of communication) to improve health outcomes, including activities such as:

(a) Effective Care Management, Care Coordination, chronic disease management, and medication and care compliance initiatives including through the use of the Medical Homes model as defined in the section 3502 of PPACA;

(b) Identifying and addressing ethnic, cultural or racial disparities in effectiveness of identified best clinical practices and evidence based medicine;

(c) Quality reporting and documentation of care in non-electronic format;

(d) Health information technology to support these activities;

ii. Accreditation fees directly related to quality of care activities;

iii. Commencing with the 2012 reporting year and extending through the first reporting year in which the Secretary requires ICD-10 as the

standard medical data code set, implementing ICD-10 code sets that are designed to improve quality and are adopted pursuant to the Health Insurance Portability and Accountability Act (HIPAA),42 U.S.C. 1320d-2, as amended, limited to 0.3 percent of an issuer's earned premium as defined in § 158.130.

iv. Prevent hospital readmissions through a comprehensive program for hospital discharge. Examples include:

(a) Comprehensive discharge planning (for example, arranging and managing transitions from one setting to another, such as hospital discharge to home or to a rehabilitation center) in order to help assure appropriate care that will, in all likelihood, avoid readmission to the hospital;

(b) Patient-centered education and counseling;

(c) Personalized post-discharge reinforcement and counseling by an appropriate health care professional;

(d) Any quality reporting and related documentation in non-electronic form for activities to prevent hospital readmission; and,

(e) Health information technology to support these activities.

v. Improve patient safety, reduce medical errors, and lower infection and mortality rates. Examples of activities primarily designed to improve patient safety, reduce medical errors, and lower infection and mortality rates include:

(a) The appropriate identification and use of best clinical practices to avoid harm;

(b) Activities to identify and encourage evidence-based medicine in addressing independently identified and documented clinical errors or safety concerns;

(c) Activities to lower the risk of facility-acquired infections;

(d) Prospective prescription drug utilization review aimed at identifying potential adverse drug interactions;

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

(f) Health information technology to support these activities.

vi. Implement, promote, and increase wellness and health activities. Examples of activities primarily designed to implement, promote, and increase wellness and health include, but are not limited to:

(a) Wellness assessments;

(b) Wellness/lifestyle coaching programs designed to achieve specific and measurable improvements;

(c) Coaching programs designed to educate individuals on clinically effective methods for dealing with a specific chronic disease or condition;

(d) Public health education campaigns that are performed in conjunction with State or local health departments;

(e) Actual rewards, incentives, bonuses, reductions in copayments (excluding administration of such programs), that are not already reflected in premiums or claims may be allowed as a quality improvement activity for the group market to the extent permitted by section 2705 of the PHS (Public Health Service) Act and as approved by DOM;

(f) Any quality reporting and related documentation in non-electronic form for wellness and health promotion activities;

(g) Coaching or education programs and health promotion activities designed to change Member behavior and conditions (for example, smoking or obesity); and,

(h) Health information technology to support these activities.

vii. Enhance the use of health care data to improve quality, transparency, and outcomes and support meaningful use of health information technology consistent with 45 C.F.R. § 158.151.

3. Exclusions:

Expenditures and activities that must not be included in quality improving activities are:

a. Those that are designed primarily to control or contain costs;

b. The pro rata shares of expenses that are for lines of business or products other than those being reported, including but not limited to, those that are for or benefit self-funded plans;

c. Those which otherwise meet the definitions for quality improvement activities, but which were paid for with grant money or other funding separate from premium revenue:

d. Those activities that can be billed or allocated by a Provider for care delivery and which are, therefore, reimbursed as clinical services;

e. Establishing or maintaining a claims adjudication system, including costs directly related to upgrades in health information technology that are designed primarily or solely to improve claims payment capabilities or to meet regulatory requirements for processing claims, including maintenance of ICD-10 code sets adopted pursuant to the Health Insurance Portability and Accountability Act (HIPAA), 42 U.S.C. 1320d-2, as amended;

f. That portion of the activities of health care professional hotlines that does not meet the definition of activities that improve health quality;

g. All retrospective and concurrent utilization review;

h. Fraud prevention activities;

i. The cost of developing and executing Provider contracts and fees associated with establishing or managing a Provider Network, including fees paid to a vendor for the same reason;

j. Provider credentialing;

k. Marketing expenses;

l. Costs associated with calculating and administering individual Member or employee incentives;

m. That portion of prospective utilization that does not meet the definition of activities that improve health quality;

n. Any cost that is not directly applicable to providing measurable quality improving activities such as corporate administrative allocations, amounts

exceeding actual cost of providing service, or other overhead expenses that do not directly support the healthcare quality initiative;

o. State and federal taxes, licensing and regulatory fees; and

p. Any function or activity not expressly included in paragraph one (1) or two (2) of this section, unless otherwise approved by and within the discretion of the Division, upon adequate showing by the Contractor that the activity's costs support the definitions and purposes described above or otherwise support monitoring, measuring or reporting health care quality improvement.

Note: The Contractor must also possess documentation for the source expense, methodology for determining how the expense meets the above definition of an expense that improves healthcare quality improvement, the allocation methodology and statistics utilized for any allocation.

Note: DOM has adopted the definitions and guidelines provided in the Patient Protection and Affordable Care Act, 45 CFR Parts 144, 147, 153, 155, 156, and 158 as recorded in the Federal Register, Vol. 87, No. 88, issued on May 6, 2022. Qualifying direct quality improvement activity (QIA) expense is limited to the QIA portion of salaries and benefits for employees directly performing QIA functions for inclusion in the MLR calculation. Expenses for items such as office space (including rent or depreciation, facility maintenance, janitorial, utilities, property taxes, insurance, wall art), human resources, salaries of counsel and executives, equipment, computer and telephone usage, travel and entertainment, company parties and retreats, IT infrastructure and systems, and software licenses do not qualify as direct QIA expense. Please reference the guidance provided in PPACA regulation, as well as the remainder of this section when determining reportable QIA expense.

D. <u>Activities Related to External Quality Review</u>

1. General rule. The State, its agent that is not a Contractor or PIHP, or an EQRO may perform the mandatory and optional EQR-related activities in this section.

2. Mandatory activities. For each Contractor and PIHP, the EQR must use information from the following activities:

   a. Validation of performance improvement projects required by the State to comply with requirements set forth in § 438.240(b)(1) and that were underway during the preceding 12 months.

   b. Validation of Contractor or PIHP performance measures reported (as required by the State) or Contractor or PIHP performance measure calculated by the

State during the preceding 12 months to comply with requirements set forth in § 438.240(b)(2).

c. A review, conducted within the previous 3-year period, to determine the Contractor's or PIHP's compliance with standards (except with respect to standards under § 438.240(b)(1) and (2), for the conduct of performance improvement projects and calculation of performance measures respectively) established by the State to comply with the requirements of § 438.204(g).

3. Optional activities. The EQR may also use information derived during the preceding 12 months from the following optional activities:

   a. Validation of Member Encounter Data reported by a Contractor or PIHP.

   b. Administration or validation of consumer or provider surveys of quality of care.

   c. Calculation of performance measures in addition to those reported by a Contractor or PIHP and validated by an EQRO.

   d. Conduct of performance improvement projects in addition to those conducted by a Contractor or PIHP and validated by an EQRO.

   e. Conduct of studies on quality that focus on a particular aspect of clinical or nonclinical services at a point in time.

4. Technical assistance. The EQRO may, at the State's direction, provide technical guidance to groups of Contractors or PIHPs to assist them in conducting activities related to the mandatory and optional activities that provide information for the EQR.

E. Expenditures Related to Health Information Technology and Meaningful Use Requirements

1. General Requirements

   Contractor may include as activities that improve health care quality such Health Information Technology (HIT) expenses as are required to accomplish the activities allowed in 45 C.F.R. § 158.150 and that are designed for use by the Contractor, health care Providers, or Members for the electronic creation, maintenance, access, or exchange of health information, as well as those consistent with Medicare and/or Medicaid meaningful use requirements, and which may in whole or in part improve quality of care, or provide the technological infrastructure to enhance current quality improvement or make new quality improvement initiatives possible by doing one or more of the following:

a. Making incentive payments to health care Providers for the adoption of certified electronic health record technologies and their "meaningful use" as defined by HHS to the extent such payments are not included in reimbursement for clinical services; as defined in 45 C.F.R. § 158.140;

b. Implementing systems to track and verify the adoption and meaningful use of certified electronic health records technologies by health care Providers, including those not eligible for Medicare and Medicaid incentive payments;

c. Providing technical assistance to support adoption and meaningful use of certified electronic health records technologies;

d. Monitoring, measuring, or reporting clinical effectiveness including reporting and analysis of costs related to maintaining accreditation by nationally recognized accrediting organizations such as NCQA or URAC, or costs for public reporting of quality of care, including costs specifically required to make accurate determinations of defined measures (for example, CAHPS surveys or chart review of HEDIS measures) and costs for public reporting mandated or encouraged by law;

e. Tracking whether a specific class of medical interventions or a bundle of related services leads to better patient outcomes;

f. Advancing the ability of Members, Providers, the Contractor or other systems to communicate patient centered clinical or medical information rapidly, accurately and efficiently to determine patient status, avoid harmful drug interactions or direct appropriate care, which may include electronic health records accessible by Members and appropriate Providers to monitor and document an individual patient's medical history and to support Care Management;

g. Reformatting, transmitting or reporting data to national or international government-based health organizations, as may be required by the Division, for the purposes of identifying or treating specific conditions or controlling the spread of disease; and,

h. Provision of electronic health records, patient portals, and tools to facilitate patient self-management.

F. <u>Non-Claims Costs</u>

1. General Requirements

The MLR Report must include non-claims costs, which are those expenses for administrative services that are not: incurred claims (as defined in section B), expenditures for activities that improve health care quality (as defined in section C) or licensing and regulatory fees or Federal and State taxes (as defined in section L).

2. Non-Claims Costs Other

   The MLR Report must include any expenses for administrative services that do not constitute adjustments to capitation payments for clinical services to Members, or expenditures on quality improvement activities as defined above. Expenses for administrative services include the following:

   a. Cost-containment expenses not included as an expenditure related to a qualifying quality activity;

   b. Loss adjustment expenses not classified as a cost containment expense;

   c. Workforce salaries and benefits;

   d. General and administrative expenses; and

   e. Community benefit expenditures.

   Revenue and expenses for administrative services should exclude the Health Insurer Tax, any allocation for premium taxes and any other revenue based assessments.

   Expenses for administrative services may include amounts that exceed a third party's costs (profit margin), but these amounts must be justified and consistent with prudent management and fiscal soundness requirements to be includable when these transactions are between related parties. Refer to Medicare Final Rule 42 C.F.R. § 422.516(b).

3. Expenses Not Allowable as Non-Claims Costs

   The following expenses are not allowable to be included in non-claims costs or for consideration by the Division's actuaries for capitation rate setting purposes:

   a. charitable contributions made by Contractor;

   b. any penalties or fines assessed against Contractor;

   c. any indirect marketing or advertising expenses of the Contractor, including but not limited to costs to promote the managed care plan, costs of facilities used for special events, and costs of displays, demonstrations, donations, and promotional items such as memorabilia, models, gifts, and souvenirs. The

Division may classify an item listed in this clause as an allowable administrative expense for rate-setting purposes, if the Division determines that the expense is incidental to an activity related to state public health care programs that is an allowable cost for purposes of rate setting;

d. any lobbying and political activities, events, or contributions;

e. administrative expenses related to the provision of services not covered under any state plan or waiver;

f. alcoholic beverages;

g. memberships in any social, dining, or country club or organization;

h. entertainment, including amusement, diversion, and social activities, and any costs directly associated with these costs, including but not limited to tickets to shows or sporting events, meals, lodging, rentals, transportation, and gratuities;

i. Bad Debts of the Contractor;

j. Liquidated Damages paid to the Division, the State, or any other entity;

k. Capital Expenditures- Expenditures for items requiring capitalization are unallowable (Depreciation of these capital expenditures, and maintenance expenses, in accordance with GAAP, are allowable);

l. Abnormal or mass severance pay where payments of salaries and wages or any benefit arrangements exceed two months of compensation;

m. Cost of unallowable financing expenses (interest, bond issuance, bond discounts, etc.) as determined by applying the principles included in CMS Publication 15.1 Chapter 2, interest expense;

n. Defense and Prosecution (of criminal proceedings, civil proceedings, and claims are generally unallowable) – Exceptions are costs relating to Contractors' obligation to identify, investigate, or pursue recoveries relating to suspected Fraud, Waste, or Abuse of providers or Subcontractors and the reasonable legal costs related to subrogation, third party recoveries and provider credentialing matters, if incurred directly in administration of the Contract;

o. Income Taxes (Federal, state, and local taxes) and State Franchise Taxes - (Other taxes are generally allowable);

p. Investment Management Costs;

q. Proposal Costs;

r. Rebates and Profit Sharing (Profit sharing or rebate arrangements between the Contractor and a Subcontractor resulting in fees or assessments which are not tied to specifically identified services that directly benefit the Contract are unallowable unless specifically allowed by Contract. This fee effectively becomes a form of profit payment or rebate);

s. Royalty Agreements (associated fees, payments, expenses, and premiums);

t. Losses in excess of the remaining depreciable basis for the disposition of depreciable property;

u. Costs in excess of what a reasonable or prudent buyer would pay for goods or services.

For the purposes of this subsection, compensation includes salaries, bonuses and incentives, other reportable compensation on an IRS 990 form, retirement and other deferred compensation, and nontaxable benefits.

Charitable contributions under clause (a) include payments for or to any organization or entity selected by the Contractor that is operated for charitable, educational, political, religious, or scientific purposes that are not related to medical and administrative services covered under and state plan.

G. State Directed Payments

The MLR Report will include all state directed payments paid pursuant to 42 CFR § 438.6(c) to include payments received by the Contractor reported as Capitation Revenue on the MLR Report for dates of service within the Rating Period, including any adjustments. The same amounts reported in the denominator as capitation revenues for all state directed payments shall be reported in the numerator as medical expenses.

H. Allocation of Expenses

1. General Requirements
   Each expense must be reported under only one type of expense, unless a portion of the expense fits under the definition of or criteria for one type of expense and the remainder fits into a different type of expense, in which case the expense must be pro-rated between types of expenses. Expenditures that benefit multiple contracts or populations, or contracts other than those being reported, must be reported on a pro rata basis.

I. Description of the Methods Used to Allocate Expenses

1. General Requirements

   The report required must include a detailed description of the methods used to allocate expenses, including incurred claims, quality improvement expenses, and other non-claims costs resulting from Contractor activities in Mississippi. A detailed description of each expense element must be provided, including how each specific expense meets the criteria for the type of expense in which it is categorized, as well as the method by which it was aggregated.

   a. Allocation to each category must be based on a generally accepted accounting method that is expected to yield the most accurate results. Specific identification of an expense with an activity that is represented by one of the categories above will generally be the most accurate method. If a specific identification is not feasible, the Contractor must provide an explanation of why it believes the more accurate result will be gained from allocation of expenses based upon pertinent factors or ratios such as studies of employee activities, salary ratios or similar analyses;

   b. Many entities operate within a group where personnel and facilities are shared. Shared expenses, including expenses under the terms of a management contract, must be apportioned pro rata to the entities incurring the expense; and,

   c. Any basis adopted to apportion expenses must be that which is expected to yield the most accurate results and may result from special studies of employee activities, salary ratios, Capitation Payment ratios or similar analyses. Expenses that relate solely to the operations of a reporting entity, such as personnel costs associated with the adjusting and paying of claims, must be borne solely by the reporting entity and are not to be apportioned to other entities within a group.

J. Third Party Subcontractors

Third party Subcontractors or vendors providing claims adjudication activity services to enrollees are required to supply all underlying data to the Contractor within 180 days of the end of the MLR reporting period or within 30 days of such data being requested by the Contractor in accordance with the requirements of 42 C.F.R. § 438.8(k)(3). The Contractor should validate the cost allocation reported by third parties to ensure the MLR accurately reflects the breakdown of amounts paid to the vendor between incurred claims, activities to improve health care quality, and non-claims cost.

1. Sub-Capitated Vendors

   The Contractor must report to the Division the total expenses incurred by the third party vendor for clinical services provided to members, activities that Improve Health Care Quality, activities related to external Quality review, expenditures related to Health Information Technology and Meaningful Use Requirements, and non-claims cost incurred by the sub-capitated vendors. The sub-capitated payments should be adjusted to reflect the aforementioned expenses to the third party. When the sub- capitation payments to the third party vendor exceed third party vendor's actual costs, the excess (profit margin), should be considered administrative non-claim costs from non-related vendors. When these transactions occur between related parties, there must be justification that these higher costs are consistent with prudent management and fiscal soundness policies to be included as allowable administrative non-claim costs. Refer to Medicare Final Rule 42 C.F.R. § 422.516(b).

2. Management Fee Arrangement

   The Contractor is encouraged to report to the Division the total expenses incurred by the management organization for the plan. These costs should be adjusted for any non-allowable activities. In the absence of specific State guidance, the Contractor should refer to other Federal regulations concerning the identification of non- allowable costs.

K. Maintenance of Records

The Contractor must maintain and retain, and require Subcontractors to retain, as applicable, for a period of no less than ten (10) years, in accordance with 42 C.F.R. § 438.3(u), and make available to the Division upon request the data used to allocate expenses reported, together with all supporting information required to determine that the methods identified and reported as required under this Exhibit C were accurately implemented in preparing the MLR Report.

L. Formula for Calculating Medical Loss Ratio

1. Medical Loss Ratio

   a. Contractor's MLR is the ratio of the numerator and the denominator, as defined:

      i. The numerator of the Contractor's MLR for an MLR Reporting Year must equal: (1) the Contractor's incurred claims, plus (2) the Contractor's expenditures for activities that improve health care quality, plus (3) the Contractor's expenditures for fraud reduction activities (as discussed in subsection d below).

      ii. The denominator of the Contractor's MLR for an MLR Reporting Year must equal the Contractor's Adjusted Premium Revenue. The Adjusted

Premium Revenue is Premium Revenue minus the Contractor's Federal, State, and local taxes, licensing and regulatory fees (as defined in subsection c of this Section), any Liquidated Damages paid by Contractor during the MLR Reporting Year, and is aggregated in accordance with subsection f below.

b. A Contractor's MLR shall be rounded to three decimal places. For example, if an MLR is 0.7988, it shall be rounded to 0.799 or 79.9 percent. If an MLR is 0.8253 or 82.53 percent, it shall be rounded to 0.825 or 82.5 percent.

c. Federal, State, and local taxes and licensing and regulatory fees. Taxes, licensing and regulatory fees for the MLR Reporting Year include:

   i. Statutory assessments to defray the operating expenses of any State or Federal department.

   ii. Examination fees in lieu of premium taxes as specified by State law.

   iii. Federal taxes and assessments allocated to Contractor, excluding Federal income taxes on investment income and capital gains and Federal employment taxes.

   iv. State and local taxes and assessments including:

      (a) Any industry wide (or subset) assessments (other than surcharges on specific claims) paid to the State or locality directly.

      (b) Guaranty fund assessments.

      (c) Assessments of state or locality industrial boards or other boards for operating expenses or for benefits to sick employed persons in connection with disability benefit laws or similar taxes levied by states.

      (d) State or locality income, excise, and business taxes other than premium taxes and State employment and similar taxes and assessments.

      (e) State or locality premium taxes plus State or locality taxes based on reserves, if in lieu of premium taxes.

   v. Payments made by Contractor that are otherwise exempt from Federal income taxes, for community benefit expenditures as defined in 45 C.F.R. § 158.162(c), limited to the highest of either:

(a) Three percent (3%) of earned premium; or

(b) The highest premium tax rate in the State for which the report is being submitted, multiplied by Contractors earned premium in the State.

d. Fraud Prevention Activities: The Contractor's expenditures on activities related to fraud prevention as adopted for the private market at 45 C.F.R. Part 158. Such expenditures must not include expenses for fraud reduction efforts associated with "incurred claims" wherein the amount of claims payments recovered through fraud reduction efforts, not to exceed the amount of fraud reduction expenses.

e. Credibility Adjustment: The Contractor may add a Credibility Adjustment to a calculated MLR if the MLR Reporting Year experience is Partially Credible. The Credibility Adjustment is added to the reported MLR calculation before calculating any remittance due. The Contractor may not add a Credibility Adjustment to a calculated MLR if the MLR Reporting Year experience is fully credible. If the Contractor's experience in "non-credible, the Contractor is presumed to meet or exceed the MLR calculation standards.

f. Aggregation of Data: Contractor will aggregate data for all Medicaid eligibility groups covered under the Contract with the State unless the State requires separate reporting and a separate MLR calculation for specific populations.

2. Rebating Capitation Payments if the ninety-one percent (91.3%) Medical Loss Ratio Standard is Not Met

a. General Requirement

For each MLR Reporting Year, the Contractor must provide a rebate to the Division if the Contractor's MLR does not meet or exceed the ninety-one percent (91.3%) minimum requirement.

b. Amount of Rebate

For each MLR Reporting Year, the Contractor must rebate to the Division the difference between the total amount of Adjusted Premium Revenue received by the Contractor from the Division multiplied by the required minimum MLR of ninety-one percent (91.3%) and the Contractor's actual MLR.

c. Timing of Rebate

The Contractor must provide any rebate owing to the Division no later than the tenth (10th) business day of May following the year after the MLR Reporting Year.

d. Late Payment Interest

If Contractor that fails to pay any rebate owing to the Division in accordance within the time periods set forth in this Exhibit, then, in addition to providing the required rebate to the Division, Contractor must pay the Division interest at the current Federal Reserve Board lending rate or ten percent (10%) annually, whichever is higher, on the total amount of the rebate, accruing from May 1.

MSCAN SFY25 Emergency Contract
EXHIBIT H: REPORTING REQUIREMENTS

Additional reporting requirements will be provided to the Contractor in the Reporting Manual. The requirements listed herein may be amended by mutual agreement by both parties. Any modifications will be reflected in the Reporting Manual.

Contractor Report	Frequency	Timeframe
Care Management		
Unduplicated Number of Newly Enrolled Members in Care Management Program	Monthly	5th business day of the second month following the reporting period
Unduplicated Number of Disenrolled Care Management Members		
Unduplicated Number of Members Contacted for Purposes of Care Management		
Number of Successful Care Management Contacts		
Health Risk Assessment (HRA)		
Adult Physical Exams		
Medical Care Management		
Unduplicated Number of Newly Enrolled Members in Medical Care Management Program	Monthly	5th business day of the second month following the reporting period
Unduplicated Number of Disenrolled Medical Care Management Members		
Unduplicated Number of Members Enrolled in the Medical Care Management Program and Contracted for Purposes of Care Management		
Number of Successful Care Management Contacts to Members Enrolled in the Medical Care Management Program		
Identification and Monitoring of Over-and Under-Utilization of Services for Members Enrolled in the Medical Care Management Program	Quarterly	15th business day after the close of the quarter
Care Management Staffing Ratios for Members Enrolled in the Medical Care Management Program	Monthly	5th business day of the second month following the reporting period
Medical Home Linkage for Members Enrolled in the Medical Care Management Program		

Contractor Report	Frequency	Timeframe
Behavioral Health Care Management		
Unduplicated Number of Newly Enrolled Members in Behavioral Health Care Management Program	Monthly	5th business day of the second month following the reporting period
Unduplicated Number of Disenrolled Behavioral Health Care Management Members		
Unduplicated Number of Members Enrolled in the Behavioral Health Care Management Program and Contacted for the Purposes of Care Management		
Number of Successful Care Management Contacts to Members Enrolled in the Behavioral Health Care Management Program		
Identification and Monitoring of Over-and Under-Utilization of services for Members Enrolled in the Behavioral Health Care Management Program	Quarterly	15th business day after the close of the quarter
Care Management Staffing Ratios for Members Enrolled in the Behavioral Health Care Management Program	Monthly	5th business day of the second month following the reporting period
Medical Home Linkage for Members Enrolled in the Behavioral Health Care Management Program		
Maternal Health Care Management		
Unduplicated Number of Newly Enrolled Members in Maternal Health Care Management Program	Monthly	5th business day of the second month following the reporting period
Unduplicated Number of Disenrolled Maternal Health Care Management Members		
Unduplicated Number of Members Enrolled in the Maternal Health Care Management Program and Contacted for Purposes of Care Management		
Number of Successful Care Management Contacts to Members Enrolled in the Maternal Care Management Program		
Identification and Monitoring of Over-and Under-Utilization of Services for Members Enrolled in the Maternal Health Care Management Program	Quarterly	15th business day after the close of the quarter
Care Management Staffing Ratios for Members Enrolled in the Maternal Health Care Management Program	Monthly	5th business day of second month following reporting period

Contractor Report	Frequency	Timeframe
Medical Home Linkage for Members Enrolled in the Maternal Health Care Management Program		
Number of Pre-Term Deliveries for Members Enrolled in the Maternal Health Care Management Program		
Type of Delivery for High-Risk Pregnant Members Enrolled in the Maternal Health Care Management Program		
Very Low Birth Weight Babies		
Foster Children Care Management		
Unduplicated Number of Newly Enrolled Members in the Care Management Program for Foster Care Members	Monthly	5th business day of second month following reporting period
Unduplicated Number of Disenrolled Foster Care Members in Care Management		
Unduplicated Number of Foster Care Members Enrolled in the Care Management Program and Contacted for Purposes of Care Management		
Number of Successful Care Management Contacts to Foster Care Members Enrolled in the Care Management Program		
Identification and Monitoring of Over-and Under-Utilization of Services for Foster Care Members Enrolled in the Care Management Program	Quarterly	15th business day after the close of the quarter
Care Management Staffing Ratios for Foster Care Members Enrolled in Care Management Program	Monthly	5th business day of second month following reporting period
Medical Home Linkage for Foster Care Members Enrolled in the Care Management Program		
Screenings and Assessments Completed within Timeframe Identified in Settlement Agreement	Quarterly	15th business day after the close of the quarter
Utilization of Ongoing Assessments and Examinations		
Utilization of Medications Categorized by Antidepressant, Antipsychotic, Attention Deficit Hyperactivity Disorder (ADHD), and Psychotropic		
Member Enrollment Statistics and Trends		
Member Enrollment Statistics and Trends	Monthly	5th business day of second month

Contractor Report	Frequency	Timeframe
Description of Any Member Enrollment Trends		following reporting period
Medical Utilization Statistics and Trends		
Medical Utilization Statistics and Trends		
Medical Utilization Statistics and Trends	Monthly	5th business day of second month following reporting period
Description of Any Utilization Trends		
Physician Administered Drugs and Implantable Drug System Devices		
Advanced Imaging Services Utilized		
Behavioral Health Utilization Statistics and Trends		
Behavioral Health Utilization Statistics and Trends	Monthly	5th business day of second month following reporting period
Behavioral Health Utilization Statistics and Trends – Injectable Anti-Psychotics		
Description of Behavioral Health Utilization Trends		
Medical and Pharmacy Claims Processing Statistics and Trends		
Claims Processing Statistics	Monthly	5th business day of second month following reporting period
Pended and Suspended Claims	Ad Hoc	Within 7 days of request by Division
Physician Administered Drugs (PAD), Number Administered	Monthly	5th business day of second month following reporting period
Physician Administered Drug Claims, Denied Claims – Other	Ad Hoc	Within 7 days of request by Division
Medical Claims Denial Reason	Monthly	5th business day of second month following reporting period
Behavioral Health Claims Processing Statistics and Trends		
Behavioral Health Claims	Monthly	5th business day of second month following reporting period
Pended and Suspended Behavioral Health Claims	Ad Hoc	Within 7 days of request by Division
Behavioral Health Claims Denial Reason	Monthly	5th business day of second month following reporting period

Contractor Report	Frequency	Timeframe
Medical Call Center Statistics and Trends		
Call Center Statistics	Monthly	5th business day of second month following reporting period
Call Center Statistics – Member Hotline Calls		
Member Hotline – Types of Calls		
Call Center Statistics – Provider Hotline Calls		
Provider Hotline – Types of Calls		
Call Center Statistics – Member Nurse Line Calls		
Member Nurse Line – Types of Nurse Line Calls		
Behavioral Health Call Center Statistics and Trends		
Call Center Statistics	Monthly	5th business day of second month following reporting period0
Call Center Statistics – Member Hotline Calls		
Member Hotline – Types of Calls		
Call Center Statistics – Provider Hotline Calls		
Provider Hotline – Types of Calls		
Call Center Statistics – Behavioral Health Clinical Line Calls		
Member Nurse Line – Types of Behavioral Health Clinical Line Calls		
Provider Network Statistics		
Medical Provider Network	Monthly	5th business day of second month following reporting period
Terminated Provider Report	Ad Hoc	Within 7 days of request by Division
Behavioral Health Provider Network	Monthly	5th business day of second month following reporting period
Terminated Provider Report	Ad Hoc	Within 7 days of request by Division
Medical Prior Authorization		
Overall Prior Authorization Requests Received	Monthly	5th business day of second month following reporting period
Prior Authorization Ad-Hoc Report	Ad Hoc	Within 7 days of request by Division

Contractor Report	Frequency	Timeframe
Prior Authorization Turn Around Time Report	Monthly	5th business day of second month following reporting period
Prior Authorization Turn Around Time Ad Hoc Report	Ad Hoc	Within 7 days of request by Division
Authorized Delivery Report	Monthly and Quarterly	5th business day of each month 30th calendar day after close of the quarter
Member Encounter Data Acceptance Rate		
Member Encounter Data Acceptance Rate	Monthly	5th business day of second month following reporting period
Description of Member Encounter Data Acceptance Rate Trends		
Medical Member Grievances and Appeals		
Medical Member Grievances Summary	Monthly	5th business day of second month following reporting period
Medical Member Grievances Detail		
Medical Member Appeals Summary		
Medical Member Appeals Detail		
Behavioral Health Member Grievances and Appeals		
Behavioral Health Member Grievance Summary	Monthly	5th business day of second month following reporting period
Behavioral Health Member Grievance Detail		
Behavioral Health Member Appeals Summary		
Behavioral Health Member Appeals Detail		
Provider Grievances and Appeals		
Provider Grievance Summary	Monthly	5th business day of second month following reporting period
Provider Appeals Summary		
Provider Grievances Detail		
Provider Appeals Detail		
Behavioral Health Provider Grievances Summary		
Behavioral Health Provider Appeals Summary		
Behavioral Health Provider Grievances Detail		
Behavioral Health Provider Appeals Detail		
State Issues and Medicaid Investigative Grievances		

Contractor Report	Frequency	Timeframe
Provider State Issues/MIG Summary	Monthly	5th business day of second month following reporting period
Provider State Issues/MIG Detail		
Member State Issues/MIG Summary		
Member State Issues/MIG Detail		
Provider Network Access		
Appointment Availability – PCPs	Quarterly and Annually	30th calendar day after the close of the quarter April 1st
Appointment Availability – Behavioral Health Providers		
Appointment Availability – OB/GYN Providers		
Contracted Hospitals	Quarterly	30th calendar day after the close of the quarter
GeoAccess Reporting Requirements		
Insure Kids Now Provider Data	Quarterly	CMS Deadlines
Call Center Operations		
Provider Call Center Audit	Quarterly	5th business day after the close of the quarter
Provider Call Center Issues	Ad Hoc	Within 7 days of request by Division
Contractor Member Call Center Audit	Quarterly	15th business day after the close of the quarter
Contractor Member Call Center Issues	Ad Hoc	Within 7 days of request by Division
Contractor Provider Services Call Center Training Report	Quarterly	15th business day after the close of the quarter
Contractor Member Services Call Center Training Report		
Contractor Nurse Line Call Center Training Report		
Marketing		
Marketing Work Plan	Annually and Quarterly	January 15th for current calendar year 30th calendar day after the close of the quarter
Marketing Activities Log	Quarterly	15th business day after the close of the quarter
Marketing Complaints Tracking Log		

Contractor Report	Frequency	Timeframe
Enrollment Reports		
New Member Card Report	Monthly	5th business day after the close of the reporting period
Returned Card Report		
Provider Services Report		
Provider Credentialing	Quarterly	30th calendar day after the close of the quarter
List of Provider Credentialed Over 90 Days		
Member Materials and Education		
Health Education and Prevention Work Plan	Annually and Quarterly	January 15th for the current calendar year 30th calendar day after the close of the quarter
EPSDT and PHRM/ISS		
EPSDT Report	Quarterly and Annually	February 15th for prior reporting year 30th calendar day after the close of the quarter
Pharmacy Lock-In		
Pharmacy Lock-In Program Report	Monthly	5th business day of the month following reporting period
Provider Incentive and Patient-Centered Medical Home		
Provider Incentive Plan	Semi-Annually	April 30th following the October thru March reporting period October 31st following the April thru September reporting period
Patient-Centered Medical Home	As specified by the Division	As specified by the Division
Performance Measures		
HEDIS Compliance Audit	Annually	July 31st for prior calendar year
CAHPS Survey Report	Annually	September 30th

Contractor Report	Frequency	Timeframe
Performance Measure Results and Updates	Annually and Quarterly	August 1st following the reporting calendar year 30th calendar day after the close of the quarter
Quality Management (QM) Program		
Quality Management Program Description	Annually	August 1st for the current calendar year
Quality Management Work Plan and Updates	Annually and Quarterly	August 1st for current calendar year 30th calendar day after the close of the quarter
Quality Management Program Evaluation	Annually	August 1st following the reporting calendar year
Performance Improvement Project Updates	Quarterly	30th calendar day after the close of the quarter
Performance Improvement Project Results	Annually	August 1st of the following reporting year
Quality Management (QM) Program (Behavioral Health)		
Quality Management Program Description	Annually	August 1st for the current calendar year
Quality Management Work Plan and Updates	Annually and Quarterly	August 1st for current calendar year 30th calendar day after the close of the quarter
Quality Management Program Evaluation	Annually	August 1st following the reporting calendar year
Utilization Management Program		
Utilization Management Program Description	Annually	August 1st for the current calendar year
Provider Satisfaction and Training		
Provider Satisfaction Survey Questions and Methodology	Annually	March 1st for the current calendar year

Contractor Report	Frequency	Timeframe
Provider Satisfaction Survey Results	Annually	At least 90 calendar days following the completion of the survey and no later than December 1st for the current calendar year
Provider Services Representative Visit Log	Monthly	5th business day after the close of the reporting period
Member Encounter Data		
Member Encounter Data	Weekly	Within two (2) business days of the end of a payment cycle. The Contractor shall submit the Encounter Data to the Division no less frequently than on a weekly basis.
Cash Disbursement Journal	Monthly	15th business day of second month following the reporting period
Member Encounter Data Completeness Plan	Annually	January 15th of the calendar year following the reporting period
Provider Preventable Conditions	Quarterly	15th business day after the close of the quarter
Fraud and Abuse and Third Party Liability		
New Provider Investigations/Complaints	Quarterly	Each Friday 15th business day after the close of the quarter
New Member Investigations/Complaints		
Annual Provider Report of New Investigations/Complaints	Annually	30th calendar day following the year in which the cases/ complaints were reported.
Annual Member Report of New Investigations/Complaints		

Contractor Report	Frequency	Timeframe
Fraud Waste & Abuse Report	Quarterly	15th business day after the close of the quarter
Fraud and Abuse Compliance Plan	Annually	January 30th for the current calendar year
Third Party Casualty	Monthly	15th business day of the second month following reporting period
Third Party Leads	Monthly	Submit all leads by the 30th calendar day of each month
Cost Avoidance & TPL Recoveries	Monthly	30th calendar day of every month
Medical Loss Ratio: MSCAN		
Medical Loss Ratio Rebate Calculation – MSCAN	Quarterly and Annually	60th calendar day following the end of the MLR Reporting quarter April 1st of the year following the MLR Reporting year
Disenrollment Survey		
Disenrollment Survey	Annually	Prior to Contract go-live and by August 1st for current contract year

Contractor Report	Frequency	Timeframe
Disenrollment Survey Results	Quarterly	30th business day after the close of the quarter
Administrative		
Department of Insurance (DOI) Filings	Quarterly and Annually	15th business day after the close of the quarter January 15th of the calendar year following the reporting period
Contractor Licensures	Annually	April 1st
Small and Minority Business Reporting	Annually	Contract signature date anniversary
Fee Schedule Validation Systems Updates of PDL Indicators	Monthly	28 Calendar days from receipt of the monthly comprehensive Division Fee Schedule
Provider Licensure Information NCCI Savings Report	Quarterly	15th business day after the close of the quarter
Mississippi Hospital Access Payments (MHAP)		
MHAP Distribution Report	Monthly	1st business day of the month following the date of payment
Annual MHAP Distributions Report	Annually	May 1st
Provider Statistical and Reimbursement Report		
Inpatient Provider Statistical and Reimbursement Report	Annually, Ad Hoc	Annually: Three separate
Outpatient Provider Statistical and Reimbursement Report		submissions (February, March & June); Ad Hoc: Within 7 days of request by Division
Claims Denial Report		
Claims Denial Report	Monthly	15th business day of the second month following reporting period

Contractor Report	Frequency	Timeframe
Hospice Report		
Hospice Report	Monthly	15th business day of the second month following reporting period
Web Portal Usage Report		
Web Portal Usage Report	Monthly	15th business day of the second month following reporting period
Non-Emergency Transportation Operations		
NET Operations Summary	Monthly	5th business day of second month following the reporting period
Denials		
Top Five Denial Reasons		
NET Call Center Statistics		
Subcontractor Oversight Report		
Overall Vendor Timeliness	Monthly	Due Monthly for reporting period 3 months prior
Hospital Discharge Timeliness		
Will Call Timeliness		
To Trips Pickup Timeliness		
From Trips Drop Off Timeliness		
Daily Vendor Late/No-Shows		
Appointment Timeliness Detail		
Monthly Vendor Timeliness Detail		
Trip Processing Time Report	Monthly	Due by the 15th day of the month following the reporting period
Trip Processing Time Report Summary		
Pre and Post Transportation Validation Report		
Pre/Post Fixed/Non Fixed Verification Report	Quarterly	15th day of the month following the reporting period
Net Vehicle Inspections and Validation Check Report	Quarterly	30th calendar day after the close of the quarter
Net Driver Report		

Contractor Report	Frequency	Timeframe
Routine Refreshable Reports		
Summary of Allowed Amount by Medicaid Category	Monthly	5th business day of second month following reporting period
Summary of Allowed Amount by APR-DRG, Top 50 DRGs by Stays		
Summary of Allowed Amount by APR-DRG, Top 50 DRGs by Allowed Amount		
Summary of Allowed Amount by Peer Group-Top 8 Providers		
Summary of Allowed Amount by All Hospitals sorted by Peer Group		
Highest Paying Claims-Top 100 Claims by Allowed Amount		
DRG Cost Outlier Allowed Amount-Top 25		
Allowed Amount by Patient Discharge Status		
Long Stays, Top 50 by Length of Stay		
Short Stays, Days < National ALOS * 10%		
Allowed Amount by Provider by Behavioral/Mental Health DRGs, Pediatric		
Allowed Amount by Provider by Behavioral/Mental Health DRGs, Adult		