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

(UnitedHealthcare of Mississippi, Inc. Children's Health Insurance Program (CHIP))

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" or "Division," and **UNITEDHEALTHCARE OF MISSISSIPPI, INC.,** a corporation qualified to do business in Mississippi, hereinafter referred to as "CCO" or "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 CHIP beneficiaries.

WHEREAS, DOM is charged with the administration of the Mississippi State Plan for Medical Assistance in accordance with the requirements of Title XXI of the Social Security Act of 1935, as amended, (the "Act") and Miss. Code Ann. §§ 41-86-1, *et seq*., and 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 457.1201 and is engaged in the business of providing comprehensive services as defined in 42 C.F.R. § 457.10. 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 contracted with the CCO to obtain services for the benefit of a separate child health program in accordance with Section 2102(a)(1) of the Social Security Act and 42 C.F.R § 457.70 and the CCO has provided to DOM continuing proof of the CCO's financial responsibility, including adequate protection against the risk of insolvency, and its capability to provide quality services efficiently to eligible Mississippi children, hereinafter referenced as the "Base CHIP Contract";

WHEREAS, the original term of the Base CHIP Contract began on August 1, 2019, and has a final end date of July 31, 2024 pursuant to the terms of the Base CHIP Contract;

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, during the administrative protest and appeal process at the agency and PPRB levels, inclusive of Protective Order actions in Hinds County Chancery Court, DOM was able to continue delivery of CHIP services through the Base CHIP Contract; however, DOM will seek to terminate the Base CHIP Contract prior to its natural end date to align the start and end dates of the separate MSCAN and CHIP service contracts with the dates of the state fiscal year calendar for financial reporting;

WHEREAS, any contracts executed pursuant to the RFQ will contain an initial 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 deliver any managed care services. All services and activities during implementation and Readiness Review are performed at no costs 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;

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 CHIP 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; and,

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 CHIP 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 and (2) the Base CHIP Contract. The Parties agree to be bound by all terms and conditions of the Base CHIP Contract and any amendments thereto 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) Base CHIP 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 SFY25 in accordance the Base CHIP Contract and any modified provisions to the BASE CHIP Contract as follows:

1. Section 1.S., GENERAL PROVISIONS, Data Exchange Requirements is hereby amended to add the following as a new sub-section:

S. <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;

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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 15, Non-Compliance and Termination, of the Base CHIP Contract for non-compliance with these requirements.

2. Section 2.A., DEFINITIONS, Definitions is hereby amended to replace definition Number 67 with the following, and to add the below additional definitions for: "Physician-Administered Drugs and Implantable Drug System Devices (PADs);" "Pharmacy Benefits Administrator (PBA);" "Pharmacy Benefit Manager (PBM);" and "Beneficiary Health Management Program (BHMP)" as definition numbers 96, 97, 98, and 99 respectively:

67. **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 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.
96. **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.
97. **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.
98. **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.
99. **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 CHIP 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:

54. BHMP – Beneficiary Health Management Program
55. 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 CHIP in accordance with the State Health Plan. Coverage includes the Mississippi Division of CHIP State Plan, also known as the Benchmark Plan, plus additional coverage and the Contractor shall provide Covered services set forth in Exhibit B, Covered Services, of this Contract. The Contractor shall ensure that all covered services are accessible to Members (in terms of timeliness, amount, duration, and scope); that no incentive is provided, monetary or otherwise, to Providers for withholding Medically Necessary covered services from a Member. The Contractor guarantees it will not avoid costs for covered services by referring Members to publicly supported resources, in accordance with 42 C.F.R. § 457.1201(p). 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 will not impose any pre-existing medical condition exclusion for covered services contained in this Contract, in accordance with 42 C.F.R. § 457.480 and Section 2102(b)(1)(B)(ii) of the Social Security Act.

The Division will annually review the cost and utilization of high-cost medications to determine whether such medications should be excluded from the capitation

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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.

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 CHIP. 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 Medicaid claims. A unique network reimbursement ID must also be established and maintained for CHIP 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 CHIP pharmacy Provider for the purpose of redirecting the prescription to the Contractor's mail order pharmacy and/or contracted specialty pharmacy.

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The Contractor shall provide PADs to Members enrolled in the CHIP Program pursuant to the requirements in the 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), Contractor 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.I. 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 CHIP claims.

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.

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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.

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 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 CHIP 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 CHIP members. The Division shall submit one (1) drug utilization review annual report to CMS inclusive of CHIP and FFS data.

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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.

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 CHIP 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 CHIP claims. Contractor must also maintain the same unique network reimbursement ID for CHIP claims.

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 shall process claims for PADs to Members enrolled in the CHIP 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.I 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.

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 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 10, 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

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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.G., COVERED SERVICES AND BENEFITS – Pharmacy Lock-In Program is deleted in its entirety and hereby designated as follows:

G. RESERVED

7. Section 5.I.2., COVERED SERVICES AND BENEFITS, Medical Prior Authorizations – Pharmacy Prior Authorizations is hereby amended to read as follows:

4. Pharmacy Prior Authorizations

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

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.I.2 shall remain unchanged and in full force and effect.

8. 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.

9. 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 CHIP, 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 CHIP changes and requirements, including "Late Breaking News" articles, Provider Bulletins, State Plan Amendments, Administrative Code Filings, the Division's Provider Reference Guide and CHIP 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.

10. 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.

11. 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:

D. <u>Member Handbook</u>

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.

12. 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. <u>Provider Directory</u>

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.

13. 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. <u>Communication Standards</u>

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.

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

A. <u>General Requirements</u>

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

   The Contractor shall recruit and maintain a Provider Network, using Provider contracts as approved by the Division. 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 and shall provide payment that is not less than the level and amount of payment for which the Contractor would make for the services if the services were furnished by a Provider which is not a FQHC or RHC. 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

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FQHC and RHC access at any time, the Contractor must allow its Members to seek care from non-contracting FQHCs and RHCs and must reimburse these Providers at CHIP fees.

In the case of specialty pharmacies, the Contractor shall 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 Division in accordance with Miss. Code Ann. § 83-9-6.

If a female Member's designated primary care physician is not a women's health specialist, the Contractor shall provide Members with direct access to women's health specialist within the network for covered routine and preventive women's health care services.

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 without prior approval from the Division. The Contractor must ensure that Provider selection policies and procedures do not discriminate against particular Providers that serve high-risk populations or specialize in conditions that require costly treatment.

Contractor shall provide sufficient supporting documentation demonstrating Contractor's capacity to serve the expected enrollment in its service area in accordance with the Division's standards for access to care as required herein, including the standards at 42 C.F.R. § 438.68 and § 438.206(c)(1). Pursuant to 42 C.F.R. § 438.207(c), Such Contractor documentation shall demonstrate Contractor's ability to: (1) offer an appropriate range of preventative, primary care, specialty services, and LTSS that is adequate for the anticipated number of enrollees for the service area; and (2) maintain a network of providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of enrollees in the service area.

Contractor's documentation shall be submitted no less frequently than:

(1) At the time it enters into a contract with the State;
(2) On an annual basis;
(3) At any time there has been a significant change (as defined by the State which would include, but not be limited to, anything that impacts network adequacy and/or member access to care) in the Contractor's operations that would affect the adequacy of capacity and services including:
    (a) Changes in Contractor's services, benefits, geographic service area, composition of or payments to its provider network; or

(b) Enrollment of a new population in the Contractor.

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 CHIP Members to seek care from non-contracting FQHCs and RHCs and must reimburse these Providers at CHIP 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.

Contractor shall provide sufficient supporting documentation demonstrating Contractor's capacity to serve the expected enrollment in its service area in accordance with the Division's standards for access to care as required herein, including the standards at 42 C.F.R. § 438.68 and § 438.206(c)(1). Pursuant to 42 C.F.R. § 438.207(c), Such Contractor documentation shall demonstrate Contractor's ability to: (1) offer an appropriate range of preventative, primary care, specialty services, and LTSS that is adequate for the anticipated number

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of enrollees for the service area; and (2) maintain a network of providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of enrollees in the service area.

Contractor's documentation shall be submitted no less frequently than:

(1) At the time it enters into a contract with the State;
(2) On an annual basis;
(3) At any time there has been a significant change (as defined by the State which would include, but not be limited to, anything that impacts network adequacy and/or member access to care) in the Contractor's operations that would affect the adequacy of capacity and services including:
(a) Changes in Contractor's services, benefits, geographic service area, composition of or payments to its provider network; or
(b) Enrollment of a new population in the Contractor.

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

15. 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:

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.

16. 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.(3) shall remain unchanged and in full force and effect.

17. Section 10.G., 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:

G. <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 either 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 CHIP Program, or
    d. Provider is terminated from participation in the CHIP 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 CHIP-Fee-For-Service Program and those of other CHIP-participating CCOs, utilizing BMHP

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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.

9. 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 10.G shall remain unchanged and in full force and effect.

18. Section 10.Q.1 and 10.Q.3., REPORTING REQUIREMENTS, Encounter Data – Data Format; and Encounter Submissions, respectively, are hereby amended to read as follows with all other sub sections within this section unchanged:

Q. <u>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.

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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:

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. Encounter Submissions

A. Requirements Prior to the Effective Date of Operations of Division's PBA

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 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;

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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 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 15.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

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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 15, Non-Compliance 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.

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 15, Non-Compliance 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.

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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 15, Non-Compliance 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

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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 Contractor's noncompliance with this requirement, and the Division may impose liquidated damages or other available remedies under Section 15, Non-Compliance and Termination, of this Contract for non-compliance.

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

19. Section 12.A.9., FINANCIAL REQUIREMENTS – Capitation Payments – Capitation Rate, is hereby amended to add the following for SFY25:

9. <u>Capitation Rate</u>

The established Coordinated Care Organization capitation rate per member per month (PMPM) for Children's Health Insurance Program (CHIP) for the period from July 1, 2024 through June 30, 2025 is $227.37. (See Exhibit 1 to this CHIP SFY25 Emergency Contract).

20. Section 12.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.

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

Some CHIP 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.

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Mississippi Division of Medicaid Risk Corridor Parameters for Pharmacy High-Cost Drugs CHIP 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 85.0% 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 12.A.10 shall remain unchanged and in full force and effect.

21. Section 12, FINANCIAL REQUIREMENTS is hereby amended to add the following as new sub-section:

I. <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.

22. Section 14, 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.

23. EXHIBIT D: MEDICAL LOSS RATIO (MLR) REQUIREMENTS is hereby amended and replaced with "EXHIBIT D: MEDICAL LOSS RATIO (MLR) REQUIREMENTS" as attached and incorporated herein by reference to this SFY 25 Emergency Contract.

IV. COST FOR SERVICES: DOM shall remit payment to Contractor as a monthly capitation fee pursuant to Section 12 – FINANCIAL REQUIREMENTS of the Base CHIP 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.

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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

UnitedHealthcare of Mississippi, Inc.

By: _____

J. Michael Parnell
Chief Executive Officer

Date: 27 June 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 Madison

THIS DAY personally came and appeared before me, the undersigned authority, in and for the aforesaid jurisdiction, the within named, **J. Michael Parnell,** in his respective capacity as **Chief Executive Officer of UnitedHealthcare of Mississippi, Inc.,** who acknowledged to me, being first duly authorized by said corporation that he 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 28 day of June, A.D., 2024

Shalaundrea White

NOTARY PUBLIC

MY COMMISSION EXPIRES:

1/27/25

EXHIBIT D: 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 eighty-five percent (85%) 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 Rule published May 6, 2016 and effective July 5, 2016.

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 CHIP 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, Health Insurer Fee reimbursement, Risk Corridor adjustments, and any other Medicaid Managed Care Program Revenues, but is exclusive of any amounts received from 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 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.

h. Identify and reduce incurred expenses by all realizable rebates or discounts available.

Note: Incurred claims for capitated payments to third-party subcontracted vendors, should reflect all adjustments as required in Section I.

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. <u>Activities that Improve Health Care Quality</u>

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. 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.

H. 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.

I. 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.

J. 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 D were accurately implemented in preparing the MLR Report.

K. 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 eighty-five percent (85%) 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 eighty-five percent (85%) 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 eighty-five percent (85%) 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.