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AMENDMENT NUMBER TWO
TO THE MISSISSIPPI MEDICAID COORDINATED CARE CONTRACT
BETWEEN
THE MISSISSIPPI DIVISION OF MEDICAID
IN THE OFFICE OF THE GOVERNOR
AND
MAGNOLIA HEALTH PLAN, INC.

THIS AMENDMENT NUMBER TWO hereby modifies, revises, and amends the Contract entered into by and between the **MISSISSIPPI DIVISION OF MEDICAID IN THE OFFICE OF THE GOVERNOR**, an administrative agency of the **STATE OF MISSISSIPPI**, hereinafter referred to as "the Division," and **MAGNOLIA HEALTH PLAN, INC.,** a private entity, hereinafter referred to as "the Contractor" or "Contractor;" and hereinafter collective referenced as "the Parties."

WHEREAS, the State of Mississippi, Office of the Governor, Division of Medicaid is charged with the administration of the Mississippi State Plan for Medical Assistance in accordance with the requirements of Title XIX of the Social Security Act of 1935, as amended, (the "Act" or "the Social Security Act") and Miss. Code Ann. § 43-13-101 et seq. (1972, as amended), and the Division may administrate certain populations as defined in this Contract under a coordinated care organization (CCO) program referred to as the Mississippi Coordinated Access Network (MississippiCAN);

WHEREAS, the Division is charged with the administration of the Child Health Plan for the Children's Health Insurance Program (CHIP), a separate child health program, in accordance with the requirements of Title XXI of the Act, as amended; Section 2101(a)(1) and 2103 of the Act; 42 C.F.R. § 457.70; and Miss. Code Ann. § 41-86-1, et. seq., and §43-13-101 et. seq., and the Division may administrate CHIP under a CCO program as authorized under Miss. Code Ann. §41-86-9;

WHEREAS, the Division is authorized under Miss. Code Ann. § 43-13-117(H) to administrate MississippiCAN and CHIP under the same Contract;

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

WHEREAS, the Division had contracted with the Contractor to obtain services for MississippiCAN and CHIP beneficiaries, and the Contractor has provided to the Division continuing proof of the Contractor's financial responsibility, including adequate protection against the risk of insolvency, and its capability to provide quality services efficiently, effectively, and

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economically during the term of this Contract, upon which the Division relies in entering into this Contract;

WHEREAS, the Parties previously modified the Contract in Amendment No. 1;

WHEREAS, pursuant to Section 1.2.1 of the Contract, no modification or change to any provision of the Contract shall be made unless it is mutually agreed upon in writing by both parties, approved by the Public Procurement Review Board (PPRB), and signed by a duly authorized representative of the Contractor and the Division as an amendment to the Contract; and

NOW THEREFORE, in consideration of the foregoing recitals and of the mutual promises contained herein, the Division and Contractor agree the Contract is amended as follows:

1. The Contract, in its entirety, is hereby amended by replacing the Original Contract with Exhibit A which is hereby attached and incorporated through this Amendment Number Two; and shall become binding upon PPRB approval.

All other provisions of the Contract are unchanged and it is further the intent of the parties that any inconsistent provisions not addressed by the above amendment are modified and interpreted to conform with this Amendment No. 2.

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IN WITNESS WHEREOF, the Parties have executed this Amendment Number Two by their duly authorized representatives as follows:

Mississippi Division of Medicaid

By: Cindy Bradshaw
Cindy Bradshaw
Executive Director

Date: 8-7-2025

Magnolia Health Plan, Inc.

By: Aaron Sisk
Aaron Sisk
President & Chief Executive Officer

Date: 7/24/2025 | 2:05:11 PM PDT

MS Division of Medicaid Coordinated Care Services Agreement
Amendment 2
EXHIBIT A

CONTRACTUAL AGREEMENT

BETWEEN

THE DIVISION OF MEDICAID
IN THE OFFICE OF THE GOVERNOR

AND

MAGNOLIA HEALTH PLAN, INC.

FOR ADMINISTRATION OF MISSISSIPPI MEDICAID COORDINATED CARE SERVICES

State of Mississippi
Office of the Governor
Division of Medicaid
550 High Street, Suite 1000
Jackson, Mississippi 39201

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MISSISSIPPI DIVISION OF
MEDICAID

Preamble

THIS AGREEMENT is 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 "the Division," and **MAGNOLIA HEALTH PLAN, INC.** a private entity, hereinafter referred to as "the Contractor" or "Contractor."

WHEREAS, the State of Mississippi, Office of the Governor, Division of Medicaid is charged with the administration of the Mississippi State Plan for Medical Assistance in accordance with the requirements of Title XIX of the Social Security Act of 1935, as amended, (the "Act" or "the Social Security Act") and Miss. Code Ann. § 43-13-101 et seq. (1972, as amended), and the Division may administrate certain populations as defined in this Contract under a coordinated care organization (CCO) program referred to as the Mississippi Coordinated Access Network (MississippiCAN);

WHEREAS, the Division is charged with the administration of the Child Health Plan for the Children's Health Insurance Program (CHIP), a separate child health program, in accordance with the requirements of Title XXI of the Act, as amended; Section 2101(a)(1) and 2103 of the Act; 42 C.F.R. § 457.70; and Miss. Code Ann. § 41-86-1, et. seq., and §43-13-101 et. seq., and the Division may administrate CHIP under a CCO program as authorized under Miss. Code Ann. §41-86-9;

WHEREAS, the Division is authorized under Miss. Code Ann. § 43-13-117(H) to administrate MississippiCAN and CHIP under the same Contract;

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

WHEREAS, the Division had contracted with the Contractor to obtain services for MississippiCAN and CHIP beneficiaries, and the Contractor has provided to the Division continuing proof of the Contractor's financial responsibility, including adequate protection against the risk of insolvency, and its capability to provide quality services efficiently, effectively, and economically during the term of this Contract, upon which the Division relies in entering into this Contract.

NOW THEREFORE, in consideration of the monthly payment of predetermined capitation rates by the Division, the full assumption of risk by the Contractor, and the mutual promises and benefits contained herein, the parties hereby agree as follows:

1. General Provisions

1.1 Term

The term of the Mississippi Medicaid Coordinated Care Contract ("Contract") shall commence on August 12, 2024 and shall terminate August 11, 2028 thereafter, unless this Contract is terminated under the circumstances stated in Section 14, Remedies. The implementation phase shall begin on August 12, 2024 and shall end on June 30, 2025. The operational phase will begin on July 1, 2025 and shall end on August 11, 2028. The Division may exercise, under the same terms and conditions as the existing Contract, an option for either one or both of two (2) one-year extensions.

1.2 Definitions and Construction

References to numbered Sections refer to the designated Sections contained in this Contract. Titles of Sections used herein are for reference only and shall not be deemed a part of this Contract. The headings used throughout the Contract are for convenience only and shall not be resorted to for interpretation of the Contract.

The Contractor was chosen through the Mississippi Medicaid Coordinated Care Request for Qualifications ("RFQ"). This Contract incorporates the following:

1. Any amendments to this document ("Contract Amendment(s)");

2. Written directives and memoranda clarifying the contractual relationship between the Division and the Contractor, written on Division letterhead and signed by the Division's Executive Director or the Executive Director's designee ("Written Directives and Memoranda");

3. Written questions from the Division answered by the Contractor in writing during the Evaluation Process ("Written Qualification Clarifications");

4. The Contractor's Qualification submitted in response to the RFQ and any attachments, in their entirety, all of which are incorporated into this Contract ("Contractor's Qualification"); and

5. The RFQ and any amendments thereto, in their entirety, including the RFQ Questions and Answers.

1.2.1 Conflict in Language, the Division's Right to Clarify, and Contract Amendments

In the event of a conflict in language among the five (5) documents referenced above, or any ambiguities, conflicts, or questions of interpretation of the Contract, any such instances shall be resolved as follows:

1. First, by reference to this document and any Contract Amendments thereto. If Contract Amendments exist, they are referenced first, in order from most recent to least recent. If the matter is still unresolved, then reference shall be made to the original, unamended Contract.

2. Second, Written Directives and Memoranda from the Division, in order from most recent to least recent.

3. Third, the Written Qualification Clarifications.

4. Fourth, the Contractor's Qualification and its attachments, in their entirety.

5. Fifth, the RFQ, in its entirety, including any amendments thereto. Amendments to the RFQ include RFQ Questions and Answers.

If an issue is addressed in one (1) document that is not addressed in another document, no conflict in language shall be deemed to occur. All the documents shall be read and construed as far as possible to be one harmonious whole; however, in the event of a conflict or dispute, Section 1.2.1 of this Contract dictates priority.

This Contract represents the entire agreement between the Contractor and the Division, and it supersedes all prior negotiations, representations, or agreements between the parties hereto relating to the subject matter hereof.

The Division reserves the right to review the existing Contract as needed to address contract and/or program vulnerabilities and discrepancies. No modification or change of any provision in the Contract shall be made, or construed to have been made, unless such modification or change is mutually agreed upon in writing by the Contractor and the Division. The agreed upon modification or change will be incorporated as a written Contract Amendment and shall be processed as required by state and/or federal law.

A Contract Amendment must first be approved by the Mississippi Public Procurement Review Board (PPRB). Once approved by PPRB, an Amendment is effective upon execution unless an effective date is specified. An amendment may be repealed under two circumstances:

1. By a later Contract Amendment that either explicitly repeals the initial Contract Amendment or conflicts with the initial Contract Amendment, or

2. If a Contract Amendment is not approved or requires changes by the Centers for Medicaid and Medicare Services (CMS) during its review process.

The only representatives authorized to modify this Contract on behalf of the Division and the Contractor are shown below:

Contractor: Plan President and Chief Executive Officer

Division of Medicaid: Executive Director

1.3 Applicable Law

This 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 that State. The Contractor shall comply with applicable federal, state, and local laws and regulations.

The Contractor shall comply with all applicable Federal statutes, including but not limited to the Social Security Act of 1935 and amendments thereto (the Act); Title VI of the Civil Rights Act of 1964; Title IX of the Education Amendments of 1972; the Age Discrimination Act of 1975; the Rehabilitation Act of 1973; the Americans with Disabilities Act of 1990, as amended; the Health Insurance Portability and Accountability Act of 1996 (HIPAA); the Balanced Budget Act of 1997; the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA), Section 1557 of the Patient Protection and Affordable Care Act (PPACA); the Health Care and Education Reconciliation Act of 2010 (HCERA); the Helping Ensure Access for Little Ones, Toddlers and Hopeful Youth by Keeping Insurance Delivery Stable Act (HEALTHY KIDS Act); and any other laws and regulations enacted throughout the life of the Contract, specifically including without limitation privacy and confidentiality rules, and the policies, rules, and regulations of the Division.

If the Contractor requests that the Executive Director of the Division or the Executive Director's designee issue policy determinations or operating guidelines required for proper performance of the Contract, the Division shall do so in a timely manner. The Contractor shall be entitled to rely upon and act in accordance with such policy determinations and operating guidelines unless the Division determines that the Contractor has acted negligently, maliciously, fraudulently, or in bad faith.

1.4 Representatives for the Division and Contractor

The Executive Director, or the Executive Director's designee, shall serve as the Contract Officer, representing the Division of Medicaid, with full decision-making authority. All statewide policy

decisions or Contract interpretation will be made through the Executive Director, or the Executive Director's designee. The Executive Director, or the Executive Director's designee, shall be responsible for the interpretation of all Federal and State laws and regulations governing or in any way affecting this Contract. The Contractor shall not interpret general Medicaid policy. When interpretations are required, the Contractor must submit written requests to the Division. The Division will make the final decision.

The Chief Executive Officer or a comparable designated representative shall serve as Contract Officer for the Contractor, with full decision-making authority for the Contractor, and will be required to be physically located in the State of Mississippi. Each Contract Officer reserves the right to delegate such duties as may be appropriate to others in the Officer's employment or under the Officer's supervision and located in the State of Mississippi.

1.5 Notices

Whenever, under this Contract or associated RFQ, one party is required to give notice to the other, except under Section 14.3, Notice of Termination, such notice shall be deemed given upon delivery under the following circumstance:

1. Upon delivery by hand;

2. Upon the date of receipt or refusal, if sent by registered or certified mail, return receipt requested or by other carriers that require signature upon receipt; or

3. Upon transmission or facsimile confirmation that notice has been received when delivered by electronic mail or facsimile transmission, with original to follow by certified mail, return receipt requested, or by other carriers that require signature upon receipt.

Notices shall be addressed as follows:

In case of notice to the Division:

Executive Director
Division of Medicaid
Walter Sillers Building, Suite 1000
550 High Street
Jackson, MS 39201-1399

In case of notice to the Contractor:

Aaron Sisk, President & Chief Executive Officer
Phone: (601) 653-9467, Email: asisk@centene.com
1020 Highland Colony Pkwy., Ste. 502
Ridgeland, Mississippi 39157

1.6 Contractor Representations

The Contractor hereby represents and warrants to the Division that:

1. The Contractor has the background and knowledge necessary to deliver the services described in the RFQ and described in this Contract;

2. The Contractor is licensed in the State of Mississippi by the Mississippi Insurance Department or is in the process of obtaining licensing in Mississippi to be effective prior to the completion of the Readiness Review;

3. All information and statements contained in the Contractor's Qualification and responses to additional letter inquiries submitted by the Contractor to the Division are true and correct as of the date of this Contract;

4. A copy of the Contractor's Qualification, as approved by the Division, is on file in the Contractor's office in Mississippi; and any revisions to the RFQ Proposal, as approved by the Division, are posted in the Contractor's copy;

5. There have been no material adverse changes in the financial condition or business operations of the Contractor since the date of submission of the Qualification and the closing date of the most recent financial statements of the Contractor submitted to the Division;

6. That the Contractor, its corporate parent, or a subsidiary of its corporate parent performing managed care services in another state has not been sanctioned, as defined by 42 C.F.R. § 438.702, by a State or Federal government within the last ten (10) years;

7. All covered services provided by the Contractor will meet the quality management standards of the Division, and services will be furnished to Members as promptly as necessary to meet each Member's needs.

8. The Contractor shall have, or obtain, any license(s)/permit(s) required to do the work described in this Contract prior to and during the performance of work under this Contract.

1.7 Assignment of the Contract

The Contractor shall not sell, transfer, assign, or otherwise dispose of this Contract or any portion thereof or of any right, title, or interest therein without prior written consent of the Division. Any such purported assignment or transfer shall be void. If approved, any assignee shall be subject to all terms and conditions of this Contract and other supplemental contractual documents. No approval by the Division of any assignment may be deemed to obligate the

Division beyond the provisions of this Contract. This requirement includes reassignment of the Contract due to change in ownership of the Contractor. The Division shall be entitled to assign or transfer its rights, duties, and/or obligations under this Contract to another governmental agency in the State of Mississippi upon giving prior written notice to the Contractor.

1.8 Notice of Legal Action

The Contractor shall provide written notice to the Division's Senior Counsel and the Executive Director, or the Executive Director's designee, of any legal action or notice listed below within five (5) calendar days following the date the Contractor receives notice of the following:

1. Any action, suit, or counterclaim filed against the Contractor;

2. Any regulatory action, or proposed action, respecting the Contractor's business or operations;

3. Any notice received from the Department of Insurance or the State Health Officer;

4. Any claim made against the Contractor by any Member, Subcontractor, or supplier having the potential to result in litigation related in any way to this Contract;

5. The filing of a petition in bankruptcy by or against a principal Subcontractor or the Insolvency of a principal Subcontractor;

6. The conviction of any person who has an ownership or control interest in the Contractor, any Subcontractor or supplier, or any individual who is an agent or managing employee of the Contractor, any Subcontractor or supplier, of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or Titles XIX or XXI of the Social Security Act; and

7. Malpractice action against any Provider delivering service under the Contract.

The Contractor must give notice to the Division immediately (no later than the calendar day in which the filing is made) upon its filing of a petition for relief under the United States Bankruptcy code, or of receiving notice of a filing of involuntary bankruptcy, regardless of whether that filing regards the Contractor itself, a parent company of the Contractor, or both. The Contractor must pursue notification of the Division until written notice from the Executive Director, Senior Counsel for the Division, or the Executive Director's designee is received.

A complete copy of all filings and other documents generated in connection with any above-referenced legal action shall be provided to the Division with the notice required herein. The Mississippi Division of Medicaid should be listed as a party of notice for any filings made in the

case. Additionally, any filings and other documents generated in the course of the legal action after notice has been provided to the Division shall be provided to the Division within two (2) business days following the filing and/or generation of the document.

1.9 Ownership and Financial Disclosure

The Contractor shall comply with §1318 of the Health Maintenance Organization Act (42 U.S.C. § 300e, et seq.), as amended, which requires the disclosure and justification of certain transactions between the Contractor and any related party, referred to as a Party in Interest, and make reports of the same available to Members upon reasonable request. Transactions reported under 42 U.S.C. § 300e, et seq., as amended, must be justified as to their reasonableness and potential adverse impact on fiscal soundness. The Contractor is required to obtain all relevant ownership and financial disclosure information from their own employees, subcontractors, and network providers.

The Contractor shall not knowingly have any persons, managing employee(s), agent(s), or their affiliate(s) who is debarred, suspended, or otherwise excluded from participating in State or Federal procurement activities as a director, officer, partner, or person with a beneficial ownership interest of more than five percent (5%) of the Contractor's equity or have an employment, consulting, or other agreement with a person who has been convicted for the provision of items and services that are significant and material to the Contractor's obligations under this Contract, in accordance with 42 C.F.R. § 438.610.

1.9.1 Information to be Disclosed

The Contractor must disclose all information in accordance with 42 C.F.R. § 455.104(b) including:

a. The name and address of any person (individual or corporation) with an ownership or control interest in the Contractor. The address for corporate entities must include as applicable primary business address, every business location, and P.O. Box address;

b. Date of birth and Social Security Number (in the case of an individual);

c. Other tax identification number (in the case of a corporation) with an ownership or control interest in the Contractor or in any Subcontractor in which the Contractor (or Division's Agent or managed care entity) has a five percent (5%) or more interest;

d. Whether the person (individual or corporation) with an ownership or control interest in the Contractor is related to another person with ownership or control interest in the Contractor as a spouse, parent, child, or sibling; or whether the person (individual or corporation) with an ownership or control interest in any Subcontractor in which the

Contractor has a five percent (5%) or more interest is related to another person with ownership or control interest in the disclosing entity as a spouse, parent, child, or sibling;

e. The name of any other disclosing entity (or the Division's fiscal agent or other managed care entity) in which an owner of the Contractor has an ownership or control interest; and

f. The name, address, date of birth, and Social Security Number of any managing employee of the Contractor.

1.9.2 When Information Will be Disclosed

In accordance with 42 C.F.R. § 455.104(c), disclosures from the Contractor are due at any of the following times:

a. Upon the Contractor submitting a Qualification in accordance with the State's procurement process;

b. Annually, including upon execution, renewal, or extension of the Contract with the State; and

c. Within thirty-five (35) calendar days after any change in ownership of the Contractor.

Additionally, the Contractor is required to update the Division regarding any changes to 42 C.F.R. § 455.104(b) disclosures at the time of any such changes during the term of the Contract, within seven (7) calendar days of the change.

1.9.3 To Whom Information Will Be Disclosed

In accordance with 42 C.F.R. § 455.104(d), all disclosures must be provided to the Division, the State's designated Medicaid agency.

1.9.4 Federal Financial Participation

In accordance with 42 C.F.R. § 455.104(e), Federal Financial Participation (FFP) is not available in payments made to a Contractor that fails to disclose ownership or control information as required by said section. As described in 42 C.F.R. § 438.808, FFP is not available for any amounts paid to the Contractor that could be excluded from participation in Medicare or Medicaid for any of the following reasons:

a. The Contractor is controlled by a sanctioned individual;

b. The Contractor has a contractual relationship that provides for the administration, management, or provision of medical services; or the establishment of policies; or the provision of operational support for the administration, management, or provision of medical services, either directly or indirectly, with an individual convicted of certain crimes as described in section 1128(b)(8)(B) of the Act; or

c. The Contractor employs or contracts, directly or indirectly, for the furnishing of health care, utilization review, medical social work, or administrative services with one of the following:

    1. Any individual or entity excluded from participation in Federal health care programs, and/or

    2. Any entity that would provide those services through an excluded individual or entity.

1.9.5 Information Related to Business Transactions

In accordance with 42 C.F.R. § 455.105, the Contractor must fully disclose all information by entities related to business transactions. The Contractor must submit, within thirty-five (35) calendar days of the date of a request by the Secretary of the Department of Health and Human Services (HHS) or the Division, full and complete information about:

a. The ownership of any Subcontractor with whom the Contractor has had business transactions totaling more than $25,000 during the twelve (12) month period ending on the date of the request; and

b. Any significant business transactions between the Contractor and any wholly owned supplier, or between the Contractor and any Subcontractor, during the five (5) year period ending on the date of the request.

Any disclosing entity that is subject to periodic survey and certification of its compliance with Medicaid standards must supply the information listed above to any State survey agency at the time the Contractor is surveyed.

A managed care entity that is not subject to periodic survey and certification and has not supplied the information specified above to the Secretary within the prior twelve (12)-month period must submit the information to the Division before entering into a contract or agreement to participate in the program.

1.9.6 Disclosure of Identity of Any Person Convicted of a Criminal Offense

At the time of Contract execution and Contract renewal, or within five (5) calendar days after the Contractor becomes aware of the information during the term the Contract, the Contractor must submit information for any person who has ownership and control interest of each Network Provider entity or who is an agent or managing employee of the Provider (as defined by 42 C.F.R. § 455.101) and who has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the title XIX and title XXI services programs since the inception of those programs, as required in 42 C.F.R. § 455.106. The Division may refuse to enter into or may terminate this agreement if it determines that the Contractor did not fully and accurately make any disclosure required under 42 C.F.R. § 455.106.

1.9.7 Disclosure to the Inspector General

In accordance with 42 C.F.R. § 455.106(b), the Division must notify the Inspector General of the United States Department of Health and Human Services of any disclosures under 42 C.F.R. § 455.106(a) within twenty (20) business days from the date it receives the information. The Division must also promptly notify the Inspector General of any action it takes on the Contractor's contractual agreement and participation in the program.

1.9.8 Division's Right of Refusal

In accordance with 42 C.F.R. § 455.106(c), the Division may refuse to enter into or renew an agreement with the Contractor if any person who has an ownership or control interest in the Contractor, or who is an agent or managing employee of the Contractor, has been convicted of a criminal offense related to that person's involvement in any program established under Medicare, Medicaid, or titles XIX or XXI services programs. Further, the Division may refuse to enter into or may terminate the Contractor's agreement if it determines that the Contractor did not fully and accurately make any disclosure required under 42 C.F.R. § 455.106(a).

The Contractor must fully disclose all information in accordance with 42 C.F.R. § 1002.3.

The Division may refuse to enter into, or terminate, this Contract if it determines that the Contractor did not fully and accurately make any disclosure required under 42 C.F.R. § 1002.3(a). Each Contractor, except Federally Qualified Contractors, shall provide defined information on specified transactions with specified "parties in interest" for specified time periods as defined in the Public Health Services Act, § 1903(m)(2)(A)(viii) and 1903(m) (4), which are defined as:

a. Any director, officer, partner, employee, or assignee responsible for management or administration of the Contractor; any person who is directly or indirectly the beneficial owner of more than five percent (5%) of the equity of the Contractor; any person who is the beneficial owner of a mortgage, deed of trust, note or other interest secured by, and valuing more than five percent (5%) of the Contractor; or in the case of a Contractor

organized as a nonprofit corporation, an incorporator or Member of such corporation under applicable State corporation law;

b. Any organization in which a person is a director, officer, or partner; has directly or indirectly a beneficial interest of more than five percent (5%) of the equity of the Contractor; or has a mortgage, deed of trust, note, or other interest valuing more than five percent (5%) of the assets of the Contractor;

c. Any person directly or indirectly controlling, controlled by, or under common control with the Contractor; or

d. Any spouse, child, parent, or authorized agent of an individual described in subsections a, b, or c.

The information provided for transactions between the Contractor and a Party in Interest will include the following:

a. The name of the Party in Interest in each transaction;

b. A description of each transaction and, if applicable, the quantity of units involved;

c. The accrued dollar value of each transaction during the calendar year; and

d. A justification of the reasonableness of each transaction.

The Contractor shall notify the Division within five (5) calendar days after any publicly announced acquisition agreement, pre-merger agreement, or pre-sale agreement affecting the Contractor's ownership. Business transactions to be disclosed include but are not limited to:

a. Any sale, exchange, or lease of any property between the Contractor and a Party in Interest;

b. Any lending of money or other extension of credit between the Contractor and a Party in Interest; and

c. Any furnishing for consideration of goods, services (including management services), or facilities between the Contractor and a Party in Interest. Business transactions for purposes of this section do not include salaries paid to employees for services provided in the normal course of employment by the Contractor.

At least five (5) calendar days prior to any change in ownership, the Contractor must provide to the Division information concerning each person with Ownership or Control Interest as defined in this Contract. This information includes but is not limited to the following:

a. Name, address, and official position;

b. A biographical summary;

c. A statement as to whether the person with ownership or control interest is related to any other person with ownership or control interest such as a spouse, parent, child, or sibling;

d. The name of any organization in which the person with ownership or control interest in the Contractor also has an ownership or control interest, to the extent obtainable from the other organization by the Contractor through reasonable written request; and

e. The identity of any person, principal, agent, managing employee, or key Provider of health care services who (1) has been convicted of a criminal offense related to that individual's or entity's involvement in any program under Medicaid, CHIP, or Medicare since the inception of those programs or (2) has been excluded from the Medicare, CHIP, and Medicaid programs for any reason. This disclosure must comply with § 1128, as amended, of the Social Security Act, 42 USC § 1320a-7, as amended, and 42 C.F.R. § 455.106, as amended, and must be submitted on behalf of the Contractor and any Subcontractor as well as any Provider of health care services or supplies.

Federal regulations contained in 42 C.F.R. § 455.104 and 42 C.F.R. § 455.106 also require disclosure of all entities with which a Medicaid Provider has an ownership or control relationship. The Contractor shall provide information concerning each Person with Ownership or Control.

The Contractor shall advise the Division, in writing, within five (5) business days of any organizational change or major decision affecting its Medicaid coordinated care business in Mississippi or other states. This includes, but is not limited to, sale of existing business to other entities or a complete exit from the State of Mississippi to another state or jurisdiction.

1.9.9 Change of Ownership

A change of ownership of the Contractor includes, but is not limited to inter vivo gifts, purchases, transfers, lease arrangements, case and/or stock transactions, or other comparable arrangements whenever the person or entity acquires a majority interest (50.1%) of the Contractor. The change of ownership must be an arm's length transaction consummated in the open market between non-related parties in a normal buyer-seller relationship.

The Contractor must comply with all laws and regulations of the State of Mississippi and requirements of the Mississippi Insurance Department, Mississippi Secretary of State, Mississippi Department of Health, the Division, and/or any other applicable state or federal requirements regarding change of ownership of the Contractor.

Should the Contractor undergo a change of ownership, the Contractor must notify the Division in writing within thirty-five (35) calendar days prior to the effective date of the sale. The new owner must complete a new Contract with the Division and shall be responsible for notifying all Members of the change. Any change of ownership does not relieve the previous owner of liability under the previous Contract.

If the Contractor's parent company is publicly traded, changes in beneficial ownership must be reported to the Division in writing within sixty (60) calendar days of any such change.

1.9.10 Prohibited Affiliations

The Contractor shall not knowingly have any affiliation with prohibited individuals or entities, defined as follows:

a. An individual or entity that is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549; and

b. An individual or entity that is an affiliate, as defined in the Federal Acquisition Regulation at 48 C.F.R. § 2.101, of an individual or entity described in a., above.

The above applies to the following affiliations:

a. A director, officer, or partner of the Contractor;

b. A Subcontractor of the Contractor as governed by 42 C.F.R. § 438.230;

c. A person with beneficial ownership of five (5) percent or more of the Contractor's equity;

d. A network provider or person with an employment, consulting, or other arrangement with the Contractor for the provision of items and services that are significant and material to the Contractor's obligations under this Contract; and

e. The Contractor may not have a relationship with an individual or entity that is excluded from participation in any Federal healthcare program under Section 1128 or 1128A of the Act.

If the Division finds that Contractor is not in compliance with the provisions of this Section, the Division:

a. Must notify the HHS Secretary of Contractor's non-compliance;

b. May continue this Contract with the Contractor unless the Secretary directs otherwise; or

c. May not renew or otherwise extend this Contract unless the Secretary provides to the State of Mississippi and to the United States Congress a written statement describing compelling reasons that exist for renewing or extending this Contract despite the prohibited affiliations.

Nothing in this section must be construed to limit or otherwise affect other remedies available to the United States under Sections 1128, 1128A, or 1128B of the Act.

Any action by the Secretary described herein is taken in consultation with the HHS Office of the Inspector General.

1.10 Responsiveness to the Division

The Contractor must perform all of the services stated in this Contract and must develop, produce, and deliver to the Division all of the statements, reports, data, accountings, claims, and documentation described herein, in compliance with all the provisions and requirements of this Contract.

The Contractor must acknowledge receipt of the Division's written, electronic, or oral requests for assistance no later than one (1) business day from receipt of the request from the Division, and the request shall be completed by Contractor to the satisfaction of the Division within five (5) business days from the date of receipt unless another time frame is specified by the Division. Requests by the Contractor for extension of the time frame may be granted by the Division at its discretion. If the request is urgent, the Contractor must immediately, without unreasonable delay, acknowledge the Division's urgent requests for assistance and must give such requests priority. Urgent requests must be completed by the Contractor to the satisfaction of the Division within the time frame specified by the Division. If no timeframe is specified, urgent requests must be completed within five (5) business days from the date of receipt. Such urgent requests include but are not limited to issues involving legislators, legislative committees (e.g., Joint Committee on Performance Evaluation and Expenditure Review), other governmental bodies, and Care Management evaluation requests involving Members or Providers requiring an expeditious response based on the Member's health condition. Requests from the Executive Director and Division Senior Leadership must also be considered urgent.

The Contractor's acknowledgement of Division requests for assistance must include the required date of resolution, as described above. If the request is received from the Division in writing or

electronically, the Contractor must acknowledge receipt in the same manner the request was received, either in writing or electronically. If the request was received from the Division orally, the Contractor must acknowledge receipt of the request orally and immediately follow-up with a written or electronic acknowledgement. Upon completion of the request, the Contractor must submit to the Division, on or before the required date of completion, a detailed completion summary advising the Division of the Contractor's action and resolution. The completion summary must contain all information necessary for the Division to adequately determine whether a request has been completed and must conform to specifications requested by the Division concerning form, format, or content of the summary, if any. Division requests will not be considered completed if the Contractor fails to submit the completion summary, and completion will not be considered timely if the Contractor fails to submit the summary on or before the required completion date. Submission of the completion summary in and of itself does not constitute completion of the Division request.

1.11 Division Policies and Procedures

The Contractor must comply with all applicable policies and procedures of the Division, such as Mississippi Administrative Code, Title 23, as well as the Mississippi Medicaid State Plan, Mississippi CHIP State Health Plan, and any other federal or state laws and regulations, all of which are incorporated into this Contract by reference and form an integral part of this Contract. In instances of disagreement, the interpretation of policy is under the Division's discretion. In no instance may the limitations or exclusions imposed by the Contractor with respect to covered services, including prior authorization and utilization review standards, be more stringent than those permitted in the applicable laws, policies, and procedures. Changes in applicable policies and procedures can be made via updates to the Administrative Code, State Plan, CHIP State Health Plan, or through Written Directives and Memoranda from the Division to the Contractor.

1.12 Data Exchange Requirements

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; and
10. Any files related to pharmacy and/or drug benefits and/or services as directed by and in a timeframe determined by the Division.
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 the 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 14, Remedies, of this contract for non-compliance with these requirements.

1.13 Administration Management, Facilities, and Resources

The Contractor must maintain at all times during the term of this Contract adequate staffing, equipment, facilities, and resources sufficient to serve the needs of Members, as specified in this Contract, the RFQ, the Contractor's Qualification, and in accordance with appropriate standards of both specialty and sub-specialty care.

The Contractor must be responsible for the administration and management of all aspects of the Contractor and the performance of all covenants, conditions, and obligations imposed upon the Contractor pursuant to this Contract. No delegation of responsibility, whether by Subcontract or

otherwise, will terminate or limit in any way the liability of the Contractor to the Division for the full performance of this Contract.

The Contractor must have, at a minimum, the following personnel with comparable qualifications, as listed below, employed within ninety (90) days after the award of this Contract.

Certain positions listed below are required to be located in the State of Mississippi. Should the Contractor wish to fill a position with an individual located outside of the state, any such request requires written approval by the Division.

For the purposes of this section, "full-time" employment is considered at least forty (40) work hours per week and/or 2,080 work hours per year. Anything less is considered "part-time." Employees designated herein as "full-time" must be hired with that work commitment expectation. Any other employees may be hired as full-time or part-time, at the Contractor's discretion.

1.13.1 Key Personnel

Key Personnel are defined as positions listed in 1.13.1.1, Executive Positions, and 1.13.1.2, Administrative Positions, below. The Division must approve Key Personnel required to be located in Mississippi prior to assignment. The Division reserves the right to approve additional key positions as needed. Approvals must be submitted to the Division no later than fifteen (15) business days before the replacement's start date.

Key Personnel positions cannot be vacant for more than ninety (90) calendar days. The Contractor must notify the Division within five (5) business days of learning that any key position is vacant or anticipated to be vacant within the next thirty (30) calendar days.

Prior to diverting any of the specified Key Personnel for any reason, the Contractor must notify the Division in writing and must submit justification (including proposed substitutions) in sufficient detail to permit evaluation of the impact on the delivery of covered services. These changes are to be reported when individuals either leave or are added to these positions.

1.13.1.1 Executive Positions

1. Chief Executive Officer (CEO): A full-time designated CEO, located in Mississippi, with decision-making authority, to administer the day-to-day business activities conducted pursuant to this Contract and to serve as the Contract Officer for the Contractor. The Mississippi CEO or person with comparable qualifications must be authorized and empowered to make operational and financial decisions, including rate negotiations for Mississippi business, claims payment, and Provider relations/contracting. The CEO or

comparable person must be able to make decisions about coordinated care activities and must represent the Contractor at meetings required by the Division.

2. Chief Operating Officer (COO): A full-time designated Chief Operating Officer located in Mississippi to oversee day-to-day business activities conducted pursuant to this Contract.

3. Chief Financial Officer (CFO): A full-time designated Chief Financial Officer located in Mississippi to oversee financial-related functions of the Contractor.

4. Medical Director: A Mississippi-licensed physician employed on a full-time basis to serve as the Medical Director, who shall be responsible for all clinical decisions of the Contractor, and who shall oversee and be responsible for the proper provision of covered services to Members. The Medical Director must be either an actively practicing physician in Mississippi or have been an actively practicing physician in Mississippi in the past five (5) years and be located in Mississippi. The Medical Director will also serve as a liaison between Contractor and providers; be available to Contractor's staff for consultation on referrals, denials, Grievances, and Appeals; review potential quality of care problems; and participate in the development and implementation of corrective action plans. The Medical Director must serve on Quality Workgroups as required by the Division.

5. Perinatal Health Director: A Mississippi-licensed physician to serve as the Perinatal Medical Director, who shall report to the Contractor's Medical Director, and who shall oversee and be responsible for the development and implementation of Perinatal Health policy through covered services to Members. The Perinatal Health Director must be either an actively practicing physician with a specialty in obstetrics and gynecology in Mississippi or have been an actively practicing physician in Mississippi with a specialty in obstetrics and gynecology in the past five (5) years and be located in Mississippi. The Perinatal Health Director will also serve as a liaison between Contractor and providers; be available to Contractor's staff for consultation on referrals, denials, Grievances, and Appeals; review potential quality of care problems, and participate in the development and implementation of corrective action plans. The Perinatal Health Director must serve on Quality Workgroups as required by the Division.

6. Behavioral Health Director: A Mississippi-licensed physician to serve as the Behavioral Medical Director, who shall report to the Contractor's Medical Director, and who shall oversee and be responsible for the development and implementation of Behavioral Health policy through covered services to Members. The Behavioral Health Director must be either an actively practicing physician with a specialty in behavioral health in Mississippi or have been an actively practicing physician in Mississippi with a specialty in behavioral health in the past five (5) years and be located in Mississippi. The Behavioral Health

Director will also serve as a liaison between Contractor and providers; be available to Contractor's staff for consultation on referrals, denials, Grievances, and Appeals; review potential quality of care problems, and participate in the development and implementation of corrective action plans. The Behavioral Health Director must serve on Quality Workgroups as required by the Division.

7. Chief Information Officer: A professional who will oversee information technology and systems to support Contractor operations, including submission of accurate and timely Member Encounter Data.

8. Compliance Officer: A full-time professional located in Mississippi who will be the individual designated by the Contractor to act as a primary point of contact for the Division.

9. Project Manager: A professional responsible for overseeing the implementation of the contract requirements during the implementation phase. The Project Manager must possess knowledge of Medicaid programs, particularly with Medicaid managed care programs, with relevant experience navigating similar complex projects. Another executive key staff member may serve as the Project Manager for purposes of overseeing the Implementation Phase of the Contract. The Project Manager must be a full-time professional located in Mississippi during the Implementation Phase of the Contract.

1.13.1.2 Administrative Positions

The following Administrative Positions must be filled within ninety (90) calendar days prior to the beginning of the operational period of the Contract:

1. Provider Services Manager: A dedicated, full-time professional located in Mississippi to be responsible for Provider Services.

2. Network/Contracting Manager: A dedicated, full-time professional located in Mississippi to be responsible for Network Development.

3. Member Services Manager: A dedicated, full-time professional located in Mississippi to be responsible for Member Services functions.

4. Quality Management Director: A dedicated, full-time health care practitioner located in Mississippi to implement and oversee quality management and improvement activities.

5. Care Management Director: A dedicated, full-time professional located in Mississippi to be responsible for Care Management services.

6. Population Health Director: A dedicated, full-time professional located in Mississippi to be responsible for Population Health initiatives.

7. Utilization Management Coordinator: A designated health care practitioner to be responsible for utilization management functions.
8. Grievance and Appeals Coordinator: A dedicated person for the processing and resolution of Grievances and Appeals.
9. Claims Administrator: A dedicated professional to oversee claims administration.
10. Data and Analytics Manager: A dedicated professional responsible for data and analytics management.
11. Clinical Pharmacist: A dedicated professional responsible for coordination of all pharmacy services and reporting.
12. Other Key Personnel as identified by the Division.

1.13.2 Additional Staff Requirements

The Contractor shall also have the following staff located in Mississippi by the beginning of the term of the Contract:

1. A designated person or person(s) to be responsible for data processing and the provision of accurate and timely reports and Member Encounter Data to the Division;
2. Designated staff to be responsible for ensuring that all Network Providers, and all Out-of-Network Providers to whom Members may be referred, are properly licensed in accordance with Federal and State law and regulations;
3. Designated staff to be responsible for Marketing, Member communications, and/or public relations;
4. Sufficient support staff to conduct daily business in an orderly manner;
5. Sufficient medical management staffing to perform all necessary medical assessments and to meet all Members' Care Management needs at all times;
6. All Care Managers; and
7. A designee or designees who can respond to issues involving systems and reporting, Member Encounter Data, Grievances and Appeals, quality assessment, Member services, Provider services, EPSDT services management, Well-Baby and Well-Child Care assessments and immunization services, Mental Health, medical management, Care Management, and management of any other services rendered under this Contract.

1.14 Base of Operations

The Contractor, its staff assigned to service this Contract, and any subcontractors must not be located outside of the United States.

The Contractor must have an Administrative Office within fifteen (15) miles of the Division of Medicaid's High Street location in Jackson, Mississippi. The office must also have space for Division staff to work. The Division will provide twenty-four (24) hours' notice if private workspace at the Contractor's office is needed, including specific technology and supply requirements.

The Contractor must use its best efforts to ensure that its employees and agents will comply with Division site rules and regulations while on Division premises.

The Contractor must ensure that no claims paid by the Contractor to a network Provider, out-of-network Provider, or financial institution located outside of the United States are considered in the development of actuarially sound capitation rates.

1.15 Cultural Competency

The Contractor must demonstrate cultural competency in its communications, both written and verbal, with Members and must ensure that cultural differences between the Provider and the Member do not present barriers to access and quality health care. Both the Contractor and its Providers must demonstrate the ability and commitment to provide and deliver quality health care across a variety of cultures.

The Contractor must promote access and delivery of services in a culturally competent manner to all Medicaid beneficiaries and Members regardless of race, color, religion, sex, sexual orientation, gender identity, disability, national origin, limited English proficiency, marital status, political affiliation, or level of income, and must not use any policy or practice that has the effect of discrimination on the basis of race, color, religion, national origin, sex, sexual orientation, gender identity, disability, limited English proficiency, marital status, political affiliation, or level of income. The Contractor must ensure that Members have access to covered services that are delivered in a manner that meets their unique needs.

1.16 Representatives for Division and the Contractor

At its discretion, the Division may rely on contracted Agents to perform selected activities under the direction of the Division. Some of these Agents may include but are not limited to the Utilization Management Contractor(s) that will perform designated Prior Authorization, data analyses, and related functions; the Fiscal Agent that will process Contractor Member Encounter

Data, provide Enrollment assistance to Members, and manage Provider credentialing; Auditors; the Pharmacy Benefits Administrator that will manage pharmacy prior authorization, claims management, and network; and the External Quality Review Organization.

1.17 Risk Management

1.17.1 Required Insurance

On or before beginning performance under this Contract, the Contractor must obtain from an insurance company, duly authorized to do business in Mississippi, absolving the Division from liability as associated with any of the following in perpetuity, insurance as follows, for each line of business:

1.17.1.1 Workers' Compensation

The Contractor must obtain, purchase, and maintain during the life of this Contract workers' compensation insurance for all employees employed under the Contract in Mississippi. Such insurance must fully comply with the Mississippi Workers' Compensation Law. In case any class of employees and/or agents engaged in work under this Contract is not protected under the Mississippi Workers' Compensation Laws, the Contractor must provide adequate insurance satisfactory for protection of the Contractor's employees not otherwise protected.

1.17.1.2 Liability Insurance

The Contractor must ensure that professional staff and other decision-making staff are required to carry professional liability insurance, including but not limited to errors and omissions (E&O) insurance, insurance required by federal and/or state law, and insurance required by professional associations, in an amount commensurate with the professional responsibilities and liabilities under the terms of this Contract and other supplemental contractual documents.

During the Contract period, the Contractor must obtain, purchase, and maintain general liability insurance against bodily injury or death in an amount commensurate with the responsibilities and liabilities under the terms of this Contractor and insurance against property damage and fire insurance including contents coverage for all records maintained, both physical and electronic, pursuant to this Contract in an amount commensurate with the responsibilities and liabilities under the terms of this Contract. The Contractor must furnish to the Division certificates evidencing such insurance is in effect after award of the Contract is accepted and annually thereafter.

1.17.1.3 Cyber Liability Insurance

The Contractor must maintain sufficient cyber insurance to cover any and all losses, security breaches, privacy breaches, unauthorized distributions, or releases or uses of any data transferred to or accessed by Contractor under or as a result of this Contract.

This insurance must provide sufficient coverage(s) for the Contractor and affected third parties for the review, repair, notification, remediation, and other response to such events, including but not limited to breaches or similar incidents under Miss. Code Ann. § 75-24-29.

The Division may, in its sole discretion, confer with the Mississippi Department of Insurance to review such coverage(s) prior to approving them as acceptable under this Contract.

The Contractor must obtain modified coverage(s) as reasonably requested by the Division within ten (10) calendar days of the Contractor's receipt of such request from the Division.

This insurance must have a retroactive date that equals or precedes the effective date of this Contract. The Contractor must maintain such coverage until the later of: (1) a minimum period of three (3) years following termination or completion this Contract, or (2) until the Contractor has returned or destroyed all Confidential Information in its possession, care, custody or control, including any copies maintained for archival or record-keeping processes.

1.17.1.4 Financial Insurance

The Contractor must insure the risk of the Contract based upon the Contractor's ability (size and financial reserves included) to survive a series of adverse experiences, including withholding of payment by the Division, or imposition of liquidated damages by the Division.

1.17.2 Indemnification and Insurance

The Contractor agrees to indemnify, defend, save, and hold harmless the Division, the State of Mississippi, their officers, agents, employees, representatives, assignees, Members and eligible dependents, and Agents. Specifically, the Contractor agrees:

1. To indemnify and hold harmless the State, its officers, Agents and employees, and the Members and their eligible dependents from any and all claims or losses accruing or resulting from Contractor's negligence to any participating Provider or any other person, firm, or corporation furnishing or supplying work, services, materials, or supplies in connection with the performance of this Contract.

2. To indemnify and hold harmless the State, its officers, Agents, and employees, and the Members and their eligible dependents from liability deriving or resulting from the Contractor's Insolvency or inability or failure to pay or reimburse participating Providers

or any other person, firm, or corporation furnishing or supplying work, services, materials, or supplies in connection with the performance of this Contract.

3. To indemnify and hold harmless the State, its officers, Agents, and employees, and the Members and their eligible dependents from any and all claims for services for which the Contractor receives monthly Capitation Payments, Value-Based Purchasing Payments, and/or Incentive Payments, and shall not seek payments other than these payments from the State, its officers, Agents, and/or employees, and/or the Members and/or their eligible dependents for such services, either during or subsequent to agreement termination.

4. Any and all liability, loss, damages, costs, or expenses that the Division or the State may incur, sustain or be required to pay by reason of the Contractor, its employees, Agents or assigns:

    a. Failing to honor copyright, patent or licensing rights to software, programs, or technology of any kind in providing services to the Division, or

    b. Breaching in any manner the privacy and/or confidentiality required pursuant to federal and State law(s) and regulations.

5. Any and all liability, loss, damage, costs, or expenses that the Division may sustain, incur or be required to pay:

    a. By reason of any person suffering personal injury, death, or property loss or damage of any kind either while participating with or receiving services from the Contractor under this Contract; or while on premises owned, leased, or operated by the Contractor; or while being transported to or from said premises in any vehicle owned, operated, leased, chartered, or otherwise contracted for or in the control of the Contractor or any officer, agent, or employee thereof; or

    b. By reason of the Contractor or its employee, agent, or person within its scope of authority of this Contract causing injury to, or damage to the person or property of a person, including but not limited to the Division or the Contractor, their employees, or agents, during any time when the Contractor or any officer, agent, employee thereof has undertaken or is furnishing the services called for under this Contract.

6. All claims, demands, liabilities, and suits of any nature whatsoever arising out of the Contract because of any breach of the Contract by the Contractor, its agents or employees, including but not limited to any occurrence of omission or commission or negligence of the Contractor, its agents, or employees.

7. All claims and losses accruing or resulting to any and all of the Contractor's employees, agents, Subcontractors, laborers, and any other person, association, partnership, entity, or corporation furnishing or supplying work, services, materials, or supplies in connection with performance of this Contract, and from any and all claims and losses accruing or resulting to any such person, association, partnership, entity, or corporation that may be injured, damaged, or suffer any loss by the Contractor in the performance of the Contract.

The Contractor, Providers, and other Contractor vendors must not hold Members liable for payments for covered services furnished under a contract, referral, or other arrangement, to the extent that those payments are in excess of the amount that the Member would owe if the Contractor authorized the services directly.

If in the reasonable judgment of the Division a default by the Contractor is not so substantial as to require termination, and reasonable efforts to induce the Contractor to cure the default are unsuccessful, and the default is capable of being cured by the Division or by another resource without unduly interfering with the continued performance of the Contractor, the Division may provide or procure such services as are reasonably necessary to correct the default. In such event, the Contractor shall reimburse the Division for the cost of those services in accordance with Section 14.13, Retainage, of this Contract.

1.17.3 Limitation of Liability

Nothing in this Contract shall be interpreted as excluding or limiting any liability of the Contractor for harm caused by the intentional, reckless, or negligent conduct of the Contractor, or for damages incurred in the negligent performance of duties by the Contractor, or for the delivery by the Contractor of products and/or services that are defective, or for breach of contract or any other duty by the Contractor. Nothing in the Contract shall be interpreted as waiving the liability of the Contractor for consequential, special, indirect, incidental, punitive, or exemplary loss, damage, or expense related to the Contractor's conduct or performance under this Contract.

1.18 Readiness Review

The Contractor must comply with all requirements related to the evaluation of the Contractor's performance prior to implementation. The Division may, at its discretion, complete a Readiness Review of the Contractor prior to implementation of expansions and Contract renewals. This includes evaluation of all program components including but not limited to information technology, administrative services, Provider Network management, and medical management. The readiness reviews will include desk reviews of materials the Contractor must develop and on-site visits at the Contractor's administrative offices. The Division may also conduct on-site visits to the office of any Subcontractor(s).

The Readiness Review shall commence on after execution of this Contract and will be completed at a date to be determined at the discretion of the Division. Following completion of the Readiness Review and subject to approval by the Division, the Special Open Enrollment Period shall commence to allow assignment of beneficiaries to the Contractors as described in Section 3 of this Contract.

1.19 Contractor Agreements Outside of This Contract

The Division enters into this Contract with the Contractor only. Any responsibilities, warranties, duties, and/or obligations borne by the Contractor through any contracts, agreements, affiliations, or other relationships outside of this Contract are not transferrable and/or applicable to the Division without express written agreement and approval by the Division.

1.20 Records Retention

The Division and CMS require the Contractor to retain records for ten (10) years. This requirement is available, with required records enumerated, at 42 C.F.R. § 422.504 (d)(2).

1.21 Remedies

Failure to comply with any of the requirements of this Contract as determined by the Division will subject the Contractor to sanctions, termination, and/or liquidated damages permitted by 42 C.F.R. Part 438, Subpart I and as enumerated in Section 14, Remedies, and Exhibit G, Liquidated Damages.

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MISSISSIPPI DIVISION OF MEDICAID

2. Definitions

The definitions included in this section may appear in the Contract as both capitalized and uncapitalized terms. The definitions apply to the defined terms, no matter if the terms are capitalized in the Contract.

2.1 Definitions

1. **Abuse**: Provider practices that are inconsistent with sound fiscal, business, and/or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards of healthcare. It also includes Member practices that result in unnecessary cost to the Medicaid program.

2. **Actuary**: An individual who meets the qualification standards established by the American Academy of Actuaries for an actuary and follows the practice standards established by the Actuarial Standards Board. Actuary also refers to an individual who is acting on behalf of the State when used in reference to the development and certification of capitation rates.

3. **Administrative Service**: Administrative Service means the performance of services or functions, other than the direct delivery of Covered Services, necessary for the management of, the delivery of, and payment for Covered Services, including but not limited to network utilization, clinical or quality management, service authorization, claims processing, management information systems operation, reporting, and infrastructure development for, preparation of, and delivery of, all required Deliverables under the Contract.

4. **Advance Beneficiary Notification (ABN)**: A notice to the Member indicating that an item(s) and/or service(s) rendered is/are non-covered item(s) and/or service(s) and that the Member will be financially responsible for the item(s) and/or services(s).

5. **Adverse Benefit Determination**: The denial or limited authorization as applied to a Member's requested service, including determinations on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit; the reduction, suspension, or termination of a previously authorized services; the denial, in whole or in part, of payment for a service; the failure to provide services in a timely manner, as defined by the Division; the failure of the Contractor to act within the timeframes provided in 42 C.F.R. § 438.408(b)(1) and (2) regarding the standard resolution of grievances and appeals; for residents in a rural

area with only one MCO, the denial of an enrollee's request to exercise his or her right, under 42 C.F.R. § 438.52(b)(2)(ii); the denial of an enrollee's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other enrollee financial liabilities; and determinations by skilled nursing facilities and nursing facilities to transfer or discharge residents and adverse determinations made by a State with regard to the preadmission screening and annual resident review requirements of Section 1919(e)(7) of the Act, if applicable. This definition applies to Members and is not to be confused with denials of claims as applied to Providers or other actions with which a Provider may disagree and file a Grievance and/or an Appeal. Additionally, denial, in whole or in part, of a payment for a service solely because the claim does not meet the definition of a "clean claim" at 42 C.F.R. § 447.45(b) is not an adverse benefit determination.

6. **Adverse Provider Determination:** The denial of a Provider's claim or other action taken by the Contractor with which the Provider may disagree and file a Grievance and/or an Appeal. This definition applies to Providers only and is not be to confused or conflated with an Adverse Benefit Determination.

7. **Agent**: An authorized entity or individual that acts on behalf of the Division of Medicaid. When the Division's Agent makes a request of the Contractor, the Contractor is to treat that request as if it came directly from the Division.

8. **Allowable Charge**: The lesser of the submitted charge or the amount established by the Contractor, as provided through Provider Network contracts or based on analysis of Provider charges, as the maximum amount for all such Provider services covered under the terms of this Contract.

9. **Alternative Payment Model (APM)**: A payment approach that gives added incentive payments to provide high-quality and cost-efficient care.

10. **Appeal**: A formal request made by a Medicaid member or provider to challenge a determination made by a Contractor or its subcontractors. The appeal process allows members or providers to seek a review and potential reversal of these determinations. In the case of a Member, the Adverse Benefit Determination may include determinations on the health care services a Member believes he or she is entitled to receive, including delay in providing, arranging for, or approving the health care services (such that a delay would adversely affect the health of the Member). In the case of a Provider, the Adverse Provider Determination may include, but is not limited to, delay or non-payment for covered services..

11. **Authorized Representative**: A person or entity acting on behalf of a Member with the Member's written consent or through the appointment by a court, legal guardian, or other body holding legal standing to act on behalf of the Member.

12. **Auto Enrollment of Members**: The process by which Members who have not voluntarily selected a Contractor are assigned to a Contractor. Also referred to as Passive Auto Enrollment.

13. **Behavioral/Mental Health/Substance Use Disorder Services**: Behavioral/Mental health and/or substance and alcohol use disorder treatment services that are provided by the county mental health/intellectual disability/developmental disability programs, the single county authority administrators, or other appropriately licensed health care practitioners.

14. **Beneficiary Health Management Program (BHMP)**: the program implemented by the Division to: (1) closely monitor program usage and to identify beneficiaries who may be potentially over utilizing or misusing their Medicaid services and benefits; (2) restrict beneficiaries whose utilization of medical and/or pharmacy services is documented at a frequency or amount that is not medically necessary; and (3) prevent beneficiaries from obtaining non-medically necessary quantities of prescribed drugs through multiple visits to physicians and pharmacies.

15. **Benefit Period**: A period of one (1) calendar year, commencing each July 1.

16. **Capitation Payments**: A payment the Division makes periodically to the Contractor on behalf of each Member enrolled under this Contract and based on the actuarially sound capitation rate developed as defined in 42 C.F.R. § 438.4 for the provision of services under the State Plan and CHIP State Health Plan. The Division makes the payment regardless of whether the each particular Member covered receives services during the period covered by the payment. Capitation Payments may only be made by the Division and retained by the Contractor for eligible Members.

17. **Care Management**: A set of Member-centered, goal-oriented, culturally relevant, and logical steps to assure that a Member receives needed services in a supportive, effective, efficient, timely, and cost-effective manner. Care Management is also sometimes referred to as Care Coordination.

18. **Case Identification Number**: With respect to a CHIP Member, includes Immediate Family Members and individuals living with the Member.

19. **Category of Eligibility (COE)**: Defines the services that the Member is eligible for based on federal and state statutes and regulations.

20. **Certified Community Behavioral Health Clinic (CCBHC)**: a specially designated clinic that provides a comprehensive range of mental health and substance use services in accordance with federal criteria and with the requirements of the Protecting Access to Medicare Act of 2014 (PAMA). Certified Community

Behavioral Health Clinic (CCBHC) as defined in Section 223 PAMA and Section 3814 CARES Act.

21. **CHIP**: The Children's Health Insurance Program as defined in Title XXI of the Social Security Act.

22. **CHIP State Health Plan**: State of Mississippi's plan submitted to HHS for the administration of CHIP, this is a detailed agreement between the State of Mississippi and the Federal Government that describes the nature and scope of Mississippi's CHIP Program. The CHIP State Health Plan is based on the federal requirements and regulations found in Title XXI of the Social Security Act.

23. **Choice Counseling**: The provision of information and services designed to assist Members in making enrollment decisions; it includes answering questions and identifying factors to consider when choosing among Contractors and Primary Care Providers. Choice counseling does not include making recommendations for or against enrollment into a specific Contractor.

24. **Claim**: (1) a bill for services; (2) a line item of services; or (3) all services for one beneficiary within a bill.

25. **Clean Claim**: A claim received from provider that can be processed without obtaining additional information from the provider of the service or from a third party. It includes a claim with errors that may occur in a State's claims system. It does not include a claim from a provider who is under investigation for fraud or abuse, or a claim under review for medical necessity.

26. **Closed Panel**: Providers who are no longer accepting new Members for the Contractor.

27. **Community-Based Organization**: A trusted organization in a community, usually a nonprofit, that works at a local level to improve life for residents in a myriad of different sectors, including but not limited to health, housing, employment, and food assistance.

28. **Comprehensive Health Assessment**: An extended Member assessment conducted by a Care Manager, either telephonically or face-to-face, to evaluate the level of Care Management needed by a Member. The Comprehensive Health Assessment takes place after a Health Risk Screening, and it evaluates several different metrics that can be indicative of overall health, including but not limited to current and previous health conditions, demographic characteristics, emotional and physical health.

29. **Continued Stay Reviews**: Continued stay reviews are subsequent reviews performed to determine if continuation of services is medically necessary and appropriate.

30. **Contract Officer**: A representative of the Contractor with full decision-making authority for the Contractor who reserves the right to delegate such duties as may be appropriate to others in the Officer's employment or under the Officer's supervision.

31. **Contractor**: Per 42 C.F.R. Part 438, a managed care Contractor providing services through various delivery systems may be a Managed Care Organization (MCO) as authorized under 1932(a)(1)(A) of the Social Security Act. The Contractor is eligible to enter a full risk capitated contract in accordance with Section 1903(m) of the Social Security Act and is engaged in the business of providing prepaid comprehensive health care services as defined in 42 C.F.R. § 438.2. The Division references the Contractor as the party responsible for the delivery of all services as outlined in this Contract. Should the Contractor delegate any duty under this Contract to a Subcontractor or other entity, the Contractor is still ultimately responsible for the execution of that duty.

32. **Coordinated Care Organization**: An organization that meets the requirements for participation as a Contractor in MississippiCAN and CHIP and manages the purchase and provision of health care services for MississippiCAN and CHIP populations.

33. **Cost Sharing**: In accordance with 42 C.F.R. § 457.10, premium charges, enrollment fees, deductibles, coinsurance, co-payments, or other similar fees that the Member has responsibility for paying.

34. **Covered Service**: All health care services and benefits the Contractor must arrange to provide to Members, including all services required by the Contract and state and federal law, and all other services negotiated by the Parties.

35. **Credentialing Verification Organization:** An entity contracted by the Division to determine the qualifications and ascribed privileges of providers to render specific health care services. The entity will make all decisions regarding whether a provider meets requirements to enroll in Medicaid, MississippiCAN, and/or CHIP.

36. **Creditable Coverage**: Prior health insurance coverage as defined under Section 2701(c) of the Public Health Service Act (42 U.S.C. § 300gg(c)). Creditable Coverage includes coverage under group or individual health plans or health insurance, Medicare, Medicaid, other governmental plans, and state health benefit risk pools.

37. **Credibility Adjustment**: An adjustment to the Medical Loss Ratio (MLR) provided by the Contractor in accordance with 42 C.F.R. § 438.8 to account for a difference between the actual and target MLR that may be due to random statistical variation.

38. **Credible Allegation of Fraud**: An allegation of fraud, which has been verified by the State (Division) and the Contractor, from any source, including but not limited to the following:

    a. Fraud hotline Complaints;

    b. Claims data mining;

    c. Patterns identified through provider audits, civil false claims cases, and law enforcement investigations. Allegations are considered to be credible when they have indicia of reliability and the State Medicaid agency has reviewed all allegations, facts, and evidence carefully and acts judiciously on a case-by-case basis.

39. **Custodial Nursing Home**: Residential designation after a Member has exhausted skilled services. However, the Member continues to have the need for non-skilled, personal care, including assistance with activities of daily living such as bathing, dressing, eating, toileting, ambulating, and transferring in a nursing facility.

40. **Deliverables**: The documents, records, reports, and other items required to be furnished to the Division for review and/or approval pursuant to the terms of the RFQ and this Contract.

41. **Direct Paid Claims**: Claims payments before ceded Reinsurance and excluding assumed Reinsurance except as otherwise provided in Exhibit C, Medical Loss Ratio Requirements, of this Contract.

42. **Directed Payment**: Payment arrangement through which the Division directs the Contractor in the manner and method in which an expenditure is made as defined in in 42 C.F.R. § 438.6.

43. **Disenrollment**: Action taken by the Division, or its Agent, to remove a Member's name from the monthly Member Listing report following the Division's receipt and approval of a request for Disenrollment or a determination that the Member is no longer eligible for Enrollment in the Contractor.

44. **Division**: The Division of Medicaid, Office of the Governor, State of Mississippi. The Division utilizes Agents for certain services. When the Division's Agent makes a request of the Contractor, the Contractor is to treat that request as if it came directly from the Division. Where the Division is referenced herein, the reference covers both requests made by the Division and any of its Agents, regardless of whether the Division's Agent is referenced in the requirement or provision of this Contract.

45. **Early and Periodic, Screening, Diagnosis and Treatment (EPSDT) Services**: As defined by Sections 1902(a)(43) and 1905(a)(4)(B) and 1905(r) of the Social Security Act and Federal regulations at 42 C.F.R. Part 441 Subpart B and in Mississippi State Plan, Administrative Code, and written communication to the Contractor. The Early and Periodic Screening, Diagnosis and Treatment (EPSDT) benefit provides comprehensive and preventive health care services for EPSDT eligible Members who are enrolled in Medicaid. EPSDT is key to ensuring that children and adolescents receive appropriate preventive, dental, behavioral/mental health, substance use, developmental, and specialty services.

46. **Emergency Care**: Covered inpatient or outpatient hospital services for an emergency medical condition.

47. **Emergency Medical Condition**: In accordance with Section 1932(b) of the Act, and 42 C.F.R. § 457.10, a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in (i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, (ii) serious impairment to bodily functions, or (iii) serious dysfunction of any bodily organ or part.

48. **Emergency Services**: Covered inpatient and outpatient services, inclusive of dialysis services, that are furnished by a provider that is qualified to furnish these services under Medicaid and needed to evaluate or stabilize an Emergency Medical Condition. This in accordance with 42 C.F.R. § 438.114.

49. **Emergency Transportation**: Ambulance services for emergencies.

50. **Enrollment**: Action taken by the Division to add a Member's name to the Contractor's monthly Member Listing report following the receipt and approval by the Division of an Enrollment application from an eligible Member who selects a Contractor or upon Passive Auto Enrollment of a Member to a Contractor.

51. **Expedited Resolution**: An expedited review by the Contractor of a Contractor's Adverse Benefit Determination within three (3) calendar days after the Contractor receives the request, which may extended by up to fourteen (14) days.

52. **Expedited Authorization Decisions**: Decisions required for authorization requests for which a Provider indicates, or the Contractor determines, that following the standard authorization decision time frame could seriously jeopardize the Member's life; health; or ability to attain, maintain, or regain maximum function.

53. **External Quality Review (EQR)**: The analysis and evaluation by an EQRO, or aggregated information in quality timeliness and access to the health care services that the Contractor or their contractors furnish to Medicaid beneficiaries.

54. **External Quality Review Organization (EQRO)**: An organization that meets the competence and independence requirements set forth in 42 C.F.R. § 438.354, and performs external quality review, other EQR-related activities as set forth in 42 C.F.R. § 438.358, or both.

55. **Federally Qualified Health Centers (FQHC)**: All organizations receiving grants under section 330 of the Public Health Service Act, certain tribal organizations, and FQHC Look-Alikes. FQHCs qualify for enhanced reimbursement from Medicare and Medicaid, as well as other benefits. FQHCs must serve an underserved area or population, offer a sliding fee scale, provide comprehensive services, have an ongoing quality assurance program, and have a governing board of directors.

56. **Fee-for-Service**: A method of making payment to health care Providers enrolled in the Medicaid program for the provision of health care services to Members based on the payment methods set forth in the State Plan and the applicable policies and procedures of the Division.

57. **Financial Relationship**: A direct or indirect ownership or investment interest (including an option or non-vested interest) in any entity. This direct or indirect interest may be in the form of equity, debt, or other means, and includes any indirect ownership or investment interest no matter how may levels removed from a direct interest, or a compensation arrangement with an entity.

58. **Fraud**: The intentional deception or misrepresentation made by a person or entity with the knowledge that the deception could result in some unauthorized benefit to the person or entity or some other person or entity. It includes any act that constitutes fraud under applicable Federal or State law.

59. **Health Care Services**: All Medicaid services provided by a Contractor under contract with the State Medicaid Agency in any setting, including but not limited to medical care, behavioral health care, and supports.

60. **Health Disparity**: A particular type of health difference that is closely linked with social or economic disadvantage.

61. **Health Equity**: When all people have the opportunity to attain their full health potential and no one is disadvantaged from achieving this potential because of their social position or other socially determined circumstance.

62. **Health Literacy**: The degree to which an individual has the capacity to obtain, communicate, process, and understand basic health information and services to make appropriate health decisions.

63. **Health Risk Screening**: A questionnaire completed by a Member soon after enrollment to a Contractor. This screening is always conducted before the Comprehensive Health Assessment, and it is used as an early gage of the needed Care Management level as indicated by answers to questions about potential health risks and Social Determinants of Health.

64. **Home Health Services**: Services provided to a beneficiary at the beneficiary's place of residence deveined as any setting in which normal life activities take place, other than:
    a. A hospital;
    b. Nursing facility;
    c. Intermediate care facility for individuals with intellectual disabilities, except when the facility is not required to provide the home health service; or,
    d. Any setting in which payment is or could be made under Medicaid for inpatient services that include room and board.

    Home Health Services must be provided in accordance with the beneficiary's physician's orders as part of a written plan of care, which must be reviewed every sixty (60) days. The beneficiary's attending physician must document that a face-to-face encounter occurred no more than ninety (90) days before of thirty (30) days after the start of home health services. The face-to-face encounter must be related to the primary reason the beneficiary requires the home health service.

    The home health agency providing home health services must be certified to participate as a home health agency under Title XVIII (Medicare) of the Social Security Act and comply with all applicable state and federal laws and requirements.

65. **Immediate Family Member**: With respect to the Member, may include the following: i) the husband or wife of the Member; ii) the biological or adoptive parent, Child, or sibling of the Member; iii) the stepparent, stepchild, stepbrother, or stepsister of the Member; iv) the father, mother, daughter, son, brother, or sister–in–law of the Member; v) the grandparent or grandchild of the Member; and vi) the spouse of a grandparent or grandchild of the Member.

66. **Indian**: Any individual defined at 25 U.S.C. §§ 1603(13), 1603(28), 1679(a), or who has been determined eligible as Indian, under 42 C.F.R. § 136.12. Also referred to as a Native American or First Nation person.

67. **Indian Health Care Provider**: A health care program operated by the Indian Health Service (IHS) or by an Indian Tribe, Tribal Organization, or Urban Indian Organization (otherwise known as an I/T/U) as those terms are defined in section 4 of the Indian Health Care Improvement Act (25 U.S.C. § 1603).

68. **Insolvency**: The inability of the Contractor to pay its obligations when they are due, or when its admitted assets do not exceed its liabilities plus the greater of: (i) any capital and surplus required by law for its organization; or (ii) the total par or stated value of its authorized and issued capital stock. Liabilities include but not be limited to reserves required by the Department of Insurance pursuant to Miss. Code Ann. § 83-41-329 (1972 as amended).

69. **Marketing**: Any communication from the Contractor to a Medicaid beneficiary who is not enrolled in that entity, that can reasonably be interpreted as intended to influence the beneficiary to enroll in that particular Contractor or either to not enroll in or to disenroll from another Contractor. Marketing does not include communication to a Medicaid beneficiary from the issuer of a qualified health plan, as defined in 45 C.F.R. § 155.20, about the qualified health plan.

70. **Material Adjustment**: An adjustment that, using reasonable actuarial judgment, has a significant impact on the development of the capitation payment such that its omission or misstatement could affect a determination of whether the development of the capitation rate is consistent with generally accepted actuarial principles and practices.

71. **Medical Loss Ratio (MLR)**: The proportion of premium revenues spent on clinical services and quality improvement by the Contractor as calculated in accordance with the requirements of 42 C.F.R. § 438.8.

72. **Medical Loss Ratio Reporting (MLR) Year**: A twelve (12) month period consistent with the Rating Period (e.g., July 1 through June 30) during which benefits and services are provided to Members through contract with the Division.

73. **Medical Record**: A single complete record that documents the entire treatment plan developed for, and medical services received by, the Member including inpatient, outpatient, referral services, and emergency medical services, whether provided by Network Providers or Out-of-Network Providers.

74. **Medically Necessary Services**: As defined by the Social Security Act, Section 1905 (42 U.S.C. § 1396d(a)), the State Plan, the CHIP State Health Plan, and the Administrative Code, Medically Necessary Services are defined as services, supplies, and equipment provided by an appropriately licensed practitioner and documented in

the Member's record in a reasonable manner, including the relationship of the diagnosis to the treatment. Medically Necessary Services are the most appropriate services that help achieve age-appropriate growth and development and will allow a Member to attain, maintain, or regain capacity. Medically Necessary Services are made in accordance with standards of good medical practice consistent with the Member's condition and not primarily for the comfort or conveniences of the Member, family, or Provider. Medically Necessary Services are the most appropriate services, supplies, equipment, or levels of care that can be safely and efficiently provided to the Member and are furnished in a setting appropriate to the Members' need and condition. When applied to the care of an inpatient, Medically Necessary Services further mean that the Member's medical symptoms or conditions require that the services cannot be safely provided to the Member as an outpatient. Medically Necessary Services may also be services for Members that are necessary to correct or ameliorate disorders and physical and behavioral/mental illnesses and conditions, whether such services are covered or exceed the benefit limits in the Medicaid State Plan and Title 23 of Mississippi Administrative Code. Medically Necessary Services are not experimental or investigational or for research or education.

75. **Member**: For MississippiCAN, an individual who meets all eligibility requirements for Mississippi Medicaid and enrolls with a Contractor under the MississippiCAN Program and receives health benefits coverage through MississippiCAN. For CHIP, an individual who meets all of the eligibility requirements for CHIP enrolls in a Contractor under CHIP and receives health benefits coverage through CHIP. The term "Member" will be used to refer to individuals in either population throughout this Contract. If a provision of the Contract applies to only one type of Member (be that MississippiCAN or CHIP), that delineation will be clearly stated in the Contract.

76. **Member Encounter Data**: The information relating to the receipt of any item(s) or service(s) by a Member under this Contract and is subject to the requirements of 42 C.F.R. §§ 438.242 and 438.818.

77. **Member Encounter Data Record**: A single electronic record of Claims for any item(s) or service(s) adjudicated by the Contractor, or by its Subcontractors, to Providers that have provided services to Members that is subject to the requirements of 42 C.F.R. §§ 438.242 and 438.818. An Encounter Record captures and reports information about each specific service provided each time a Member visits a Provider, regardless of the contractual relationship between the Contractor and Provider or Subcontractor and Provider.

78. **Member Encounter Record Denied**: Claims/lines are deemed as able to be processed and are given a final disposition of "no payment" within the claims adjudication processing system.

79. **Member Encounter Record Rejected**: Claims/lines are deemed as unable to be processed at any stage in the claims intake system.

80. **Member Grievance**: An expression of dissatisfaction, regardless of whether identified as a "Grievance," received by any employee of the Contractor orally or in writing about any matter or aspect of the Contractor or its operation, other than a Adverse Benefit Determination. Member Grievances may include but are not limited to the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the enrollee's rights regardless of whether remedial action is requested. Grievance includes but is not limited to an enrollee's right to dispute an extension of time proposed by the MCO, PIHP, or PAHP to make an authorization decision.

81. **Member Grievance and Appeal System**: The processes the Contractor implements to handle Appeals of an Adverse Benefit Determination and Grievances, as well as the processes to collect and track information about them. This includes grievances and appeals filed by a Provider on behalf of a Member or a Member's representative.

82. **Member Months**: The number of months a Member or group of Members is covered by Contractor during the Medical Loss Ratio Reporting (MLR) Year.

83. **Mississippi Coordinated Access Network (MississippiCAN) Program**: Mississippi Medicaid's coordinated care program for eligible Members that enroll with a Contractor, which are reimbursed with actuarially sound prepaid Capitation Payment rates.

84. **Network Provider**: Any provider, group of providers, or entity that is credentialed by the CVO and has a valid network provider agreement with the Contractor, or a Subcontractor, and receives Medicaid funding directly or indirectly to order, refer or render covered services as a result of the state's contract with the Contractor. A network provider is not a Subcontractor by virtue of the network provider agreement.

85. **Never Events**: Adverse events that are serious, largely preventable, and of concern to both the public and health care Providers for the purpose of public accountability as defined by the National Coverage Determinations (NCD) or the Division. The Never Events as defined in the NCD or the Division include ambulatory surgical centers (ASC) and practitioners as listed in the Mississippi State Plan.

86. **Non-claims Costs**: Those expenses for administrative services that are not: Incurred claims (as defined in paragraph (e)(2) of 42 C.F.R. § 438.8); expenditures on activities that improve health care quality (as defined in paragraph (e)(3) of 42 C.F.R. § 438.8); or licensing and regulatory fees, or Federal and State taxes (as defined in paragraph (f)(2) of 42 C.F.R. § 438.8).

87. **Non-Emergency Transportation (NET)**: Transportation for MississippiCAN Members to receive medically necessary services on a non-emergency basis.

88. **Non-Emergency Admission Reviews**: Non-emergency inpatient admissions are admissions for planned or elective admissions and the Member has not been hospitalized.

89. **Open Panel**: Providers who are accepting new patients for the Contractor as part of the MississippiCAN Program and/or CHIP.

90. **Overpayment**: Any payment made to a network provider by the Contractor to which the network provider is not entitled to under Title XIX or Title XXI of the Act or any payment to the Contractor by the Division to which the Contractor is not entitled under Title XIX or Title XXI of the Act.

91. **Out-of-Network Provider**: A health care Provider who has not been credentialed, does not hold current credentialed status, and/or does not have a signed Provider agreement with the Contractor.

92. **Out-of-Pocket Maximum**: The aggregate amount of Cost Sharing (e.g., deductibles, co-insurance, and co-payments) incurred by all enrolled Children in a single family in a Benefit Period. Once the Out-of-Pocket Maximum has been met, covered expenses are paid at one hundred percent (100%) of the Allowable Charge for the remainder of the Benefit Period.

93. **Outcomes**: Changes in member health, functional status, satisfaction or goal achievement that result from health care or supportive services.

94. **Panel**: Listing and number of Members that Network Providers have agreed to provide services to in accordance with this Contract.

95. **Partial Credibility**: A standard for which the experience of a Contractor is determined to be sufficient for the calculation of an MLR but with a non-negligible chance that the difference between the actual and target medical loss ratios is statistically significant. A Contractor that is assigned partial credibility (or is partially credible) will receive a credibility adjustment to its MLR.

96. **Patient-Centered Medical Home**: A health care delivery model whereby the Member receives treatment coordinated through their primary care provider, who acts as the Patient-Centered Medical Home, to ensure that the Member receives the necessary care when and where they need it, in a manner that the Member understands. Care is facilitated through partnerships between the Member, all of the Member's health care providers, the Member's family, the Contractor (including the

Member's Care Manager), and any other organizations (including community-based organizations) that can facilitate comprehensive care for the Member.

97. **Performance Improvement Project (PIP)**: A process or project to assess and improve processes, thereby improving outcomes of health care.

98. **Performance Measure**: The specific representation of a process or outcome that is relevant to the assessment of performance; it is quantifiable and can be documented.

99. **Pharmacy Benefits Administrator (PBA)**: An entity that manages the pharmacy benefit on behalf of the Division. This includes, but is not limited to, prescription drug claims processing, drug prior authorization, and pharmacy provider management.

100. **Physician-Administered Drugs and Implantable Drug System Devices**: 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.

101. **Post-Stabilization Care Services**: Post-Stabilization Care Services are covered services related to an Emergency Medical Condition that are provided after a Member is stabilized in order to maintain the stabilized condition or to improve or resolve the Member's condition.

102. **Potential Enrollee**: For MississippiCAN, a Medicaid beneficiary who is subject to mandatory enrollment in MississippiCAN or may voluntarily elect to enroll in a Contractor but is not yet Member of a specific Contractor. For CHIP, an eligible child who may enroll in a Contractor, but is not yet a Member of a specific Contractor.

103. **Premium Revenue**: Includes the following for the MLR Reporting Year:

    a. Capitation Payments, developed in accordance with 42 C.F.R. § 438.4, to the Contractor, for all Members under a risk contract approved under 42 C.F.R. § 438.3(a), excluding payments made under to 42 C.F.R. § 438.6(d).

    b. State-developed one-time payments, for specific life events of Members.

    c. Other payments to the Contractor approved under 42 C.F.R. § 438.6(b)(3).

    d. Unpaid cost-sharing amounts that the Contractor could have collected from Members under the contract, except those amounts the Contractor can show it made a reasonable, but unsuccessful, effort to collect.

e. All changes to unearned premium reserves.

f. Net payments or receipts related to risk sharing mechanisms developed in accordance with 42 C.F.R. §§ 438.5 or 438.6.

g. Payments to the Contractor for expenditures under State directed payments described in 42 C.F.R. § 438.6(c).

104. **Prepayment Review**: A review of documentation supporting services for Medicaid that is conducted prior to the provider receiving reimbursement.

105. **Primary Care Provider (PCP)**: Any physician or health care practitioner or group operating within the scope of their licensure who is responsible for supervising, prescribing, and providing primary care and primary case management services in MississippiCAN and/or CHIP whose practice is limited to the general practice of medicine or who is an Internist; Preventative Medicine specialist; Pediatrician; Obstetrician; Gynecologist; Family Practitioner; General Practitioner; specialist who performs primary care functions upon request; Physician Assistant; Certified Nurse Practitioners whose specialty is pediatrics, adult, family, certified nurse midwife, obstetrics/gynecology; or another provider approved by the Division. For purposes of enhanced PCP payments authorized by Mississippi Code § 43-13-117 (A) (6), PCP is defined in State Plan Attachment 4.19-B.

106. **Prior Authorization (PA)**: A determination to authorize a Provider's request, pursuant to services covered in MississippiCAN or CHIP (as applicable), to provide a service or course of treatment of a specific duration and scope to a Member prior to the initiation or continuation of the service.

107. **Provider**: Any individual or entity that is engaged in the delivery of services, or ordering or referring for those services, that is legally authorized to do so by the State in which the individual or entity delivers the services.

108. **Provider Grievance**: An expression of dissatisfaction, regardless of whether identified as a "Grievance," received by any employee of the Contractor orally or in writing about any matter or aspect of the Contractor or its operation, other than a Adverse Provider Determination

109. **Provider Grievance and Appeal System:** The processes the Contractor implements to handle Appeals of an Adverse Provider Determinations and Grievances, as well as the processes to collect and track information about them.

110. **Provider Network**: The Panel of health service Providers with which the Contractor contracts for the provision of covered services to Members and Out-of-Network Providers administering services to Members.

111. **Provider-Preventable Conditions**: A condition that meets the definition of a "health care-acquired condition" or an "other Provider-preventable condition" as defined by 42 C.F.R. § 447.26.

112. **Quality**: As it pertains to external quality review, quality means the degree to which a Contractor entity increases the likelihood of desired outcomes of its enrollees through (1) its structural and operational characteristics; (2) the provision of services that are consistent with current professional, evidence-based-knowledge; and (3) interventions for performance improvement.

113. **Quality Assurance**: Continuous measurement and oversight of quality programs with the aim of identifying successful strategies and areas for improvement.

114. **Quality Improvement**: The framework used to systematically improve the ways care is delivered to patients. Processes used have characteristics that can be measured, analyzed, improved, and controlled. Entails continuous efforts to achieve stable and predictable process results, reduce process variation, and improve the outcomes of these processes both for patients and the health care organization and system. Achieving sustained quality improvement requires commitment from the entire organization, particularly from top-level management.

115. **Rate Cell**: A set of mutually exclusive categories of Members that is defined by one or more characteristics for the purpose of determining the capitation rate and making a Capitation Payment; such characteristics may include age, gender, eligibility category, and region or geographic area. Each Member should be categorized in one of the rate cells for each unique set of mutually exclusive benefits under this Contract.

116. **Rating Period**: A period of twelve (12) months selected by the State for which the actuarially sound capitation rates are developed and documented in the rate certification submitted to CMS as required by 42 C.F.R. § 438.7(a). The Rating Period shall be July 1 to June 30 of the next calendar year, consistent with the State Fiscal Year.

117. **Redetermination Date**: The date when Medicaid or CHIP eligibility requirements are reviewed to ensure the Member is eligible to continue receiving benefits.

118. **Reinsurance**: Private insurance purchased by the Contractor to protect against individual high-cost cases and/or aggregate high cost. Insurance purchased by the

Contractor from insurance companies to protect against part of the costs of providing covered services to Members.

119. **Reserve Account**: An account established pursuant to Section 11.1.6, Reserve Account, of this Contract into which a portion of the payments made by the Division are deposited and held as security for any refund or liquidated damages due the Division.

120. **Retroactive Eligibility Review**: A review that is conducted after services are provided to a Member and the Member is retroactively determined to be eligible for Medicaid. The Division provides retroactive Medicaid eligibility for a Member who was not eligible for Medicaid benefits at the time of hospitalization. In the case of newborns, the Division will only retroactively enroll newborns in the categories of eligibility containing children under the age of one (1).

121. **Retrospective Authorization Review**: An authorization review that is conducted for anything other than inpatient hospital services when prior authorization was not obtained for the Member services due to demonstrable circumstances outside of the Provider's control.

122. **Rework**: Work performed by the Division and/or its Agent to identify deficiencies or errors associated with a deliverable, including but not limited to any root cause analysis and/or effort to identify the task(s) to be re-performed, as well as any other work performed by the Division and/or its Agent to correct any deficiencies or errors associated with a deliverable. The Division reserves the right to offset Contractor payments in the amount commensurate with the costs incurred by the Division for any rework.

123. **Risk Adjustment**: A methodology to account for the health status of Members via relative risk factors when predicting or explaining costs of services covered under this Contract for defined populations or for evaluating retrospectively the experience of Contractor. Must be developed in a budget neutral manner consistent with generally accepted actuarial principles and practices.

124. **Rural or Rural Area**: The Mississippi Department of Health (MSDH) defines a rural area as: 1) a Mississippi county that has a population less than 50,000 individuals; 2) an area that is less than 500 individuals per square mile; or 3) a municipality of less than 15,000 individuals. The Division also references Federal designations of both urban and rural areas. Rural may be defined in different ways for different instances. If the Contractor needs clarity, please contact the Division.

125. **Rural Health Clinics**: The Rural Health Clinics (RHC) program is intended to increase primary care services for Medicaid and Medicare members in rural

communities. RHCs can be public, private, or non-profit. RHCs receive enhanced reimbursement rates for providing Medicaid and Medicare services in rural areas. RHCs must be located in rural, underserved areas and must use midlevel practitioners.

126. **Service Authorization**: A request by a Provider for the provision of services for a Member.

127. **Service Limits**: the maximum quality of services per beneficiary that are eligible for reimbursement by the Division within a state fiscal year beginning on July 1 and ending June 30. These limits may also be referred to interchangeably as "Benefit Limits".

128. **State Plan**: The Mississippi Medicaid State Plan is a detailed agreement between the State of Mississippi and the Federal Government that describes the nature and scope of Mississippi's Medicaid Program. The State Plan is based on the federal requirements and regulations found in Title XIX of the Social Security Act.

129. **Special Health Care Needs**: The health care and related needs of children who have chronic physical, developmental, behavioral, or emotional conditions. Such needs are of a type or amount beyond that required by children generally.

130. **State Fair Hearing**: A hearing conducted by the Division or its Agent in accordance with 42 C.F.R. § 431 Subpart E for applicants, Members, or beneficiaries.

131. **State Issue**: A verbal or written request, point of discussion, or expression of dissatisfaction received from a Medicaid Member, Member's representative or Medicaid Provider that may include benefits, services, reimbursement, enrollment, utilization management, or other concerns related to service delivery. The Division forwards this concern to the Contractor for response and resolution to ensure that the Contractor is in compliance with the goals of MississippiCAN and/or CHIP.

132. **State Medicaid Fraud Control Unit (MFCU)**: A unit of the Mississippi Attorney General's office with the mission of investigating and prosecuting criminal cases of Fraud in the Mississippi Medicaid program.

133. **Subcontract**: An agreement between the Contractor and a third party, including but not limited to the Contractor's parent company or any subsidiary corporation owned by the Contractor's parent company, or between the third party and a fourth party, or between any subsequent parties, to perform part or all of the selected Contractor's responsibilities under the Mississippi Division of Medicaid Coordinated Care

Contract. Subcontracts must be approved in writing by the Division prior to the start date of the agreement.

134. **Subcontractor**: Any party that has entered into a subcontract to perform a specific part of the obligations specified under the Mississippi Division of Medicaid Coordinated Care Contract. A Network Provider is not a Subcontractor by virtue of the Network Provider Agreement with the Contractor.

135. **Substance Use Disorder**: Also known as drug/alcohol use disorder, a condition in which the use of one or more substances leads to a clinically significant impairment or distress.

136. **Substance Use Disorder Benefits**: Benefits with respect to items or services for substance use disorders, as defined under the terms of the plan or health insurance coverage and in accordance with applicable Federal and State law. Any disorder defined by the plan as being or as not being a substance use disorder must be defined to be consistent with generally recognized independent standards of current medical practice (for example, the most current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM), the most current version of the International Classification of Diseases (ICD), or State guidelines).

137. **Third Party Liability/Resource**: Any resource available to a Member for the payment of medical expenses associated with the provision of covered services, other than those that are exempt under the Act, including but not limited to insurers and workers' compensation plan(s).

138. **Through Date**: The last date of service for a single service event. For an inpatient hospital admission, the Through Date would be the date of discharge.

139. **Transitional Care Management**: A type of Care Management program to support Members' transition of care when discharged from an institutional clinic or inpatient setting.

140. **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 for MississippiCAN and CHIP programs. 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.

141. **Unpaid Claim Reserves**: Reserves and liabilities established to account for claims that were incurred during the MLR Reporting Year but had not been paid within three (3) months of the end of the MLR Reporting Year.

142. **Urban or Urban Area**: Any area not designated as Rural.

143. **Urgent Care**: Urgent care services are utilized because the Member's primary care physician is not available. An urgent condition is not life threatening but may need prompt attention. Urgent care services are for an illness, injury, or condition serious enough that a reasonable person would seek care right away, but not so severe it requires emergency room care. Urgent care centers can typically treat conditions including but not limited to sprains, strains, and minor broken bones.

144. **Urgent care and emergency care reviews**: A review of the urgent care services or emergency care services that is conducted after services are provided to a Member.

145. **Validation**: The review of information, data, and procedures to determine the extent to which they are accurate, reliable, free from bias, and in accord with standards for data collection and analysis.

146. **Value-Based Purchasing (VBP)**: A form of payment that links payments to performance by health care providers. It attempts to reduce inappropriate care and to identify and reward the best-performing providers.

147. **Waste**: The overutilization, underutilization, or misuse of resources or services.

148. **Weekend and Holiday Admission Reviews**: Weekend admissions are those admissions where the Member was admitted on a weekend (Friday, Saturday, or Sunday). Holiday admissions are defined as those admissions where a Member is admitted on a state-observed holiday.

149. **Well-Baby and Well-Child Care Services**: Regular or preventive diagnostic and treatment services necessary to ensure the health of babies, children, and adolescents in the CHIP program as defined by the Division in the CHIP State Health Plan. For the purposes of Cost Sharing, the term has the meaning assigned at 42 C.F.R. § 457.520.

2.2 Acronyms

1. ABN – Adverse Beneficiary Notification
2. ACIP – Advisory Committee on Immunization Practices
3. CAHPS® – Consumer Assessment of Healthcare Providers and Systems
4. CAP – Corrective Action Plan

5.CCBHC – Certified Community Behavioral Health Clinic
6. CHIP – Children's Health Insurance Program
7. CCO – Coordinated Care Organization
8. CEO – Chief Executive Officer
9. CLIA – Clinical Laboratory Improvement Amendments
10. CMS – Centers for Medicare and Medicaid Services
11. COB – Coordination of Benefits
12. COE – Category of Eligibility
13. CPS – Mississippi Department of Child Protection Services
14. CVO – Credentialing Verification Organization
15. DOI – Mississippi Department of Insurance
16. DSM – Diagnostic and Statistical Manual of Mental Disorders
17. ECM – Electronic Claims Management
18. EDI – Electronic Data Interchange
19. EIN – Employer Identification Number
20. EHR – Electronic Health Record
21. EPA – United States Environmental Protection Agency
22. EPSDT – Early and Periodic Screening, Diagnosis and Treatment
23. EQR – External Quality Review
24. EQRO – External Quality Review Organization
25. FFP – Federal Financial Participation
26. FFS – Fee-for-Service
27. FQHC – Federally Qualified Health Center
28. GAAP – Generally Accepted Accounting Principles
29. GAO – General Accounting Office
30. HEDIS® – Healthcare Effectiveness Data and Information Set
31. HHS – United States Department of Health and Human Services
32. HIPAA – Health Insurance Portability and Accountability Act of 1996
33. HTC – Hemophilia Treatment Center
34. ICD – International Classification of Diseases
35. ICF/IID – Intermediate Care Facility for Individuals with Intellectual Disabilities
36. I/T/U – Indian Tribe, Tribal Organization, or Urban Indian Organization
37. LTSS – Long-Term Support Services
38. MCO – Managed Care Organization
39. MDFA – Mississippi Department of Finance and Administration
40. MDHS – Mississippi Department of Human Services
41. MEPA – Mississippi Employment Protection Act
42. MES – Medicaid Enterprise Systems
43. MFCU – Medicaid Fraud Control Unit
44. MHAP – Mississippi Hospital Access Program

45. MLR – Medical Loss Ratio
46. MMIS – Medicaid Management Information System
47. MississippiCAN or MSCAN – Mississippi Coordinated Access Network
48. MOMS – Mississippi Outcomes for Maternal Safety
49. MSDH – Mississippi State Department of Health
50. MSDOM VBP - Mississippi Division of Medicaid Value-Based Payment Incentive Program
51. MS MAPS – Mississippi Medicaid Access to Physician Services
52. NAIC – National Association of Insurance Commissioners
53. NCCI – The National Correct Coding Initiative
54. NET – Non-Emergency Transportation
55. NCQA – National Committee for Quality Assurance
56. NPI – National Provider Identifier
57. OIG – Office of Inspector General
58. PAHP – Prepaid Ambulatory Health Plan
59. PBA – Pharmacy Benefits Administrator
60. PCMH – Patient Centered Medical Home
61. PCP – Primary Care Provider
62. PDL – Preferred Drug List
63. PHRM/ISS – Perinatal High Risk Management/Infant Services System
64. PHI – Protected Health Information
65. PI – Program Integrity
66. PIHP – Prepaid Inpatient Health Plans
67. PII – Personal Identification Information
68. PIP – Performance Improvement Project
69. PMPM – Per Member Per Month
70. PPACA – Patient Protection and Affordable Care Act
71. PRTF – Psychiatric Residential Treatment Facility
72. QI – Quality Improvement
73. QIPP – Quality Incentive Payment Program
74. QM – Quality Management
75. RAC – Recovery Audit Contractor
76. RHC – Rural Health Clinic
77. SDP – State Directed Payment
78. TANF – Temporary Assistance for Needy Families
79. TIN – Tax Identification Number
80. TPL – Third Party Liability
81. TREAT – Transforming Reimbursement for Emergency Ambulance Transportation
82. TTY/TDD – Teletypewriter/Text Telephones/Telecommunications Device for the Deaf
83. UM – Utilization Management

84. UM/QIO – Utilization Management/Quality Improvement Organization
85. URAC – Utilization Review Accreditation Commission
86. VBP – Value-Based Purchasing
87. VP – Video Phones

3. Eligibility, Enrollment, and Disenrollment

The Division will be responsible for assessing eligibility and conducting enrollment for members of MississippiCAN and CHIP. Eligibility and Enrollment guidelines for each program are described in this section.

The Contractor will be required to serve eligible Medicaid beneficiaries across the entire state. The Contractor will receive a prepaid capitated monthly payment and will provide services through a full-risk arrangement. For more information about monthly payment and capitation rates, see Section 11, Financial Requirements.

3.1 Eligibility

3.1.1 MississippiCAN

Eligibility criteria for the MississippiCAN Program will be the same as the eligibility criteria for Mississippi Medicaid. MississippiCAN Members must also meet additional requirements for Enrollment as described below.

The Program operates on a statewide basis. The Program includes two (2) populations:

1. Voluntary Population: Members who have the option to disenroll and receive services through the Fee-for-Service delivery system, and
2. Mandatory Population: Members who may not disenroll depending on the Member's Category of Eligibility (COE) and age.

Enrollment is voluntary, except in the case of mandatory enrollment programs that meet the conditions set forth in 42 C.F.R. § 438.50(a).

The Division reserves the right to assign a Member to a specific health plan.

3.1.1.1 Voluntary Population: Populations Who Have the Option to Enroll in MississippiCAN

Table 3.1 specifies Medicaid populations that may voluntarily enroll in MississippiCAN. The Division will enroll eligible Members within these categories into MississippiCAN, and Members will have the option to disenroll within ninety (90) calendar days of initial Enrollment and thereafter during annual open enrollment periods. Members who disenroll will be served through the Medicaid fee-for-service system.

Table 3.1. Voluntary Population: Populations Who Have the Option to Enroll

Populations Who Have the Option to Enroll	Age Categories*
SSI	0-19
Disabled Child Living at Home	0-19
DHS-Foster Care Children	0-19
DHS-Foster Care Children (Adoption Assistance)	0-19
American Indians	0-65
**The hyphen denotes "up to" the age listed. For instance, for SSI, the ability to optionally enroll ends on a Member's 19th birthday.*	

3.1.1.2 Mandatory Population: Populations Who May Not Disenroll from MississippiCAN

Table 3.2 specifies Medicaid populations that the Division will enroll into MississippiCAN on a mandatory basis. These Members may voluntarily select or be automatically enrolled with a Contractor but may not opt out of MississippiCAN. Members may change Contractor selection once within the first ninety (90) calendar days of Enrollment and thereafter during open enrollment periods.

Table 3.2. Mandatory Population: Populations Who May Not Disenroll

Populations Who May not Disenroll	Age Categories*
SSI	19-65
Working Disabled	19-65
Breast and Cervical Cancer	19-65
Pregnant Women	8-65
Parent/Caretakers	19-65
Medical Assistance Children (Populations other than those listed in Table 1)	0-19
**The hyphen denotes "up to" the age listed, and the categories run from birthday to birthday. For instance, for SSI, enrollment in MississippiCAN becomes mandatory on a Member's 19th birthday and ends on a Member's 65th birthday.*	

3.1.2 Children's Health Insurance Program

CHIP eligibility criteria will be based on citizenship, residency, age, and income requirements. Members must also meet additional requirements for Enrollment as described below and in accordance with 42 C.F.R. § 457.305(a) and § 457.320(a), and the CHIP State Health Plan.

CHIP will operate on a statewide basis. The Division reserves the right to assign a Member to a specific health plan.

Table 3.3 specifies populations that must enroll in CHIP. The Division will enroll eligible Members within these categories into one of the Contractors participating in CHIP, and Members will have the option to disenroll or change Contractors within ninety (90) days of initial Enrollment. Members who disenroll and do not choose another Contractor under CHIP may enroll in the Division's Medicaid program if they meet Medicaid eligibility requirements or pursue private insurance.

Table 3.3 Populations Who Are Eligible for CHIP

Populations*	Income Level
Birth - Age One (1) Year	194% FPL to 209% FPL
Ages One (1) - Six (6) Years	133% FPL to 209% FPL
Age Six (6) - Nineteen (19) Years	133% FPL to 209% FPL
FPL = Federal Poverty Level **The hyphen denotes "up to" the age listed, and ages run from birthday to birthday. For instance, children in the Age 6 to Age 19 Population are eligible beginning on their 6th birthday and ending on their 19th birthday.*	

3.1.3 Coordination with the Division's Agent

The Contractor must develop and maintain written policies and procedures for coordinating Enrollment information with the Division or its contracted Agent. The Contractor must receive advance written approval from the Division prior to use of these policies and procedures.

3.1.4 Potential Enrollees

The Contractor must provide information to all potential CHIP enrollees in compliance with 42 C.F.R. § 457.1207, cross-referencing to 42 C.F.R. § 438.10, and to all potential MississippiCAN enrollees in compliance with 42 C.F.R. § 438.10.

3.2 Enrollment and Disenrollment

The Division or its Agent shall send written and electronic (if available) notification to the Member to inform the Member of the Member's Enrollment into MississippiCAN or CHIP and to select a Contractor and PCP. The Division and its Agent will be responsible for Choice Counseling for the Member.

Upon enrollment, a Member must either choose a Contractor in which to enroll or be passively auto enrolled to a Contractor by the Division.

Regardless of whether the Member chooses a Contractor or is passively auto enrolled, the Member may change Contractor membership within ninety (90) calendar days from the date of enrollment if desired. The Member will remain a Member of the Contractor in which the Member is enrolled on the 90th day after the date of enrollment until the next open enrollment period unless the Member becomes ineligible for the program or is otherwise disenrolled. Passive auto enrollment rules will include provisions to determine the following:

1. **Prior Enrollment**: The Division will determine whether the Member was enrolled with a Contractor within the previous sixty (60) calendar days and assign the Member to that Contractor.
2. **Family History**: The Division will determine whether an immediate family member is assigned to a Contractor and assign the Member to that Contractor.
3. **Prior Claims History**: The Division will review paid claims data within the past six (6) months and assign the Member to the Contractor that has a contract with a PCP with whom the Member has a history in the last six (6) months.
4. **Proximity**: If there is no previous assignment within sixty (60) calendar days and no immediate family members already enrolled, or if the Member does not have a prior history with a PCP, then assign the Member to Contractor with a PCP closest to Member's home address.
5. **Value-Based Purchasing**: If multiple Contractors meet the Proximity standard, then assignment will occur based on Value-Based Purchasing (VBP) performance measures as defined by the Division (See Section 8.8, Value-Based Purchasing, of this Contract for more information), unless assignment is needed during the Special Open Enrollment described below.
6. **Special Open Enrollment**: If passive auto assignment is needed during that the Special Open Enrollment period, assignment will be made using a random process.

The Division reserves the right to modify the Enrollment and Passive Auto Enrollment rules at its discretion.

3.2.3. Percentage of Enrollees per Contractor and Auto Enrollment

The Division may, at its discretion, set and make subsequent changes to a threshold for the percentage of Members who can be enrolled with a single Contractor. Additionally, see 3.2.5, Value-Based Purchasing and Enrollment, for more information concerning the effect of VBP

on Enrollment. Members will not be auto enrolled to a Contractor that exceeds this threshold unless a family member is enrolled in the Contractor or a historical Provider relationship exists with a Provider that does not participate in any other managed care plan. The Division will provide the Contractors with a minimum of fourteen (14) calendar days advance notice in writing when changing the threshold percentage, if applicable.

The Division will notify Members and the Contractor within five (5) business days of the selection or Auto Enrollment. The Division's notice to the Member will be made in writing and sent via surface mail. Notice to the Contractor will be made via the Member Listing Report.

3.2.4 Open Enrollment

3.2.4.1 Special Open Enrollment

A Special Open Enrollment period will occur when the Division finds that, during the Readiness Review assessment of ability and capacity that the Contractor can satisfactorily perform contractual requirements. At that time, the Contractor may succeed to the operational/performance period of the contract. After the Special Open Enrollment Period, the next Annual Open Enrollment Period will occur each year of the operational contract between October 1 and December 15.

Beneficiaries already enrolled with an incumbent contractor, should one exist, are allowed to continue their enrollment with that entity or change to another entity. Following Special Open enrollment, a time-limited auto-assignment methodology will be used to ensure that each selected entity reaches a minimum threshold of twenty (20) percent of the program. Once such threshold has been reached, the Division will revert to the passive auto enrollment methodology outlined in Section 3.2 of the Contract. The Division will provide all Members with information required by federal regulations. The effective date of this Special Open Enrollment will be clearly stated for Members during enrollment. The actual date will depend on the date at which the Division sets the Special Open Enrollment period.

3.2.4.2 Annual Open Enrollment

For every calendar year during the term of this contract thereafter, the Annual Open Enrollment period will be held from October 1 through December 15, with the effective dates for those Enrollment periods being January 1 through December 31 of the following calendar year for so long as the Member remains eligible during that time.

3.2.5 Value-Based Purchasing and Enrollment

The Division will use Value-Based Purchasing performance measures to set these thresholds as stated in the Mississippi Division of Medicaid Value-Based Purchasing Work Plan. Members

will not be passively auto enrolled to a Contractor that exceeds this threshold unless a family member is enrolled in the Contractor or a historical Provider relationship exists with a Provider that does not participate in any other Contractor. The Division will provide the Contractors with a minimum of fourteen (14) calendar days' advance notice in writing when changing the threshold percentage.

The Division will notify Members and the Contractor within five (5) business days of the selection or passive auto enrollment. The Division's notice to the Member will be made in writing and sent via U.S. Mail. Notice to the Contractor will be made via the Member Listing Report.

3.2.6 Choice of a Network Provider

Each Member must be able to choose the Member's network provider to the extent possible and appropriate. At enrollment, the Contractor shall offer each Member the opportunity to choose from at least two (2) network Primary Care Providers (PCPs). If the Member does not voluntarily choose a PCP, the Contractor may assign the Member a PCP. A Member who has received Prior Authorization from the Contractor for referral to a specialist or from the Division's vendor for inpatient care shall be allowed to choose from among all the available specialists and hospitals within the Contractor's network to the extent possible, reasonable, and appropriate.

The Contractor is responsible for assigning Members to Patient-Centered Medical Homes when required as described in Section 6.2.5, Patient-Centered Medical Homes (PCMH), of this Contract.

The Contractor must have written policies and procedures for assigning Members to PCPs/PCMHs. The Contractor must submit PCP/PCMH assignment policies and procedures to the Division for review and approval within ninety (90) days of contract award and must also submit any updates. Any changes or modifications to these policies and procedures must be submitted by the Contractor to the Division at least thirty (30) calendar days prior to implementation and must be approved by the Division.

These policies and procedures shall include the features listed below:

1. **Providers Qualifying as Primary Care Providers (PCP)**: The following types of specialty Providers may perform as Primary Care Providers:
    a. Pediatricians;
    b. Family and General Practitioners;
    c. Internists;

d. Preventative Medicine specialists;

e. Obstetricians/Gynecologists;

f. Nurse Practitioners (contracted nurse practitioners acting as PCPs must have a formal, written collaborative/consultative relationship with a licensed physician with admitting privileges at an inpatient hospital facility or have a written agreement with a physician who has admitting privileges at a hospital appropriate for the patient needing admission);

g. Physician Assistants;

h. Specialists who perform primary care functions upon request; or

i. Other Providers approved by the Division. (e.g., surgeons, clinics including but not limited to Federally Qualified Health Centers, Rural Health Clinics, Health Departments, and other similar community clinics).

j. If applicable, for Members who qualify under the rural resident exception, (under which the Division may limit a rural area resident to a single Contractor), the limitation on the Member's freedom to change between Primary Care Providers can only be as restrictive as the limitations on Member-requested Disenrollment in accordance with 42 C.F.R. §438.56(e).

2. **Default Assignment of PCP**: If the Member does not request an available PCP within thirty (30) calendar days of Enrollment with the Contractor, then the Contractor must assign the new Member to a network PCP within sixty (60) calendar days of Enrollment, taking into consideration such known factors as current Provider relationships, language needs (to the extent they are known), age and sex, enrollment of family members (e.g., siblings), and area of residence. The Contractor's policies and procedures must include a documented process for ensuring that the PCP is willing to accept assignment of a Member prior to assigning the Member to the PCP.

3. **Change of PCP**: The Contractor must allow Members to select or be assigned to a new PCP when requested by the Member, when the Contractor has terminated a PCP, or when a PCP change is ordered as a part of the resolution to a formal grievance proceeding.

The Contractor must notify PCPs via U.S. Mail, web portal, or by telephone of the Members assigned to them within five (5) business days of the date on which the Contractor receives the Member Listing Report from the Division. If the Contractor elects to notify PCPs via web portal, the Contractor must confirm that the PCP acknowledges receipt of the list of Members assigned to them. The Contractor will also send written notification to the Member of the PCP assignment.

3.2.7 Enrollment Period

Each Member shall be enrolled with a Contractor subject to meeting applicable Medicaid or CHIP eligibility requirements. Enrollment with the Contractor begins at 12:01 a.m. on the first calendar day of the first calendar month for which the Member's name appears on the Member Listing Report and is automatically renewed for twelve (12) months unless the Member becomes ineligible for the program and is disenrolled.

The Division shall provide Members with open enrollment periods in accordance with program enrollment requirements and the length of Member enrollment. The first ninety (90) calendar days following a Member's initial Enrollment will be an open Enrollment period during which the Member can change the Member's enrollment to another Contractor without cause.

3.2.7.1 Enrollment of MississippiCAN Populations with the Option to Disenroll

The Division will enroll newly eligible Medicaid beneficiaries into MississippiCAN. Beneficiaries who are in eligibility categories that may voluntarily participate in MississippiCAN will have the option to disenroll from MississippiCAN without cause or change Contractors without cause during the ninety (90) calendar day period following the date the Division sends the Member notice of Enrollment or the date of the Member's initial Enrollment, whichever is later; during the Annual Open Enrollment period; upon automatic reenrollment if the temporary loss of Medicaid eligibility has caused the Member to miss the annual Disenrollment opportunity; or when the Division imposes an intermediate sanction on the Contractor as specified in this Contract in Section 14, Remedies, of this Contract.

3.2.7.2 Enrollment of MississippiCAN Populations Who May Not Disenroll

Members who are mandated into MississippiCAN may change Contractors without cause during the ninety (90) calendar day period following the date the Division sends the Member notice of Enrollment or the date of the Member's initial Enrollment, whichever is later. After the Member's initial Enrollment, the Member may change Contractors without cause during the Annual Open Enrollment period.

The Division or its Agent will notify MississippiCAN and CHIP Members at least once every twelve (12) months, and at least sixty (60) calendar days prior to the date upon which the Enrollment period ends, that they have the opportunity to change Contractors or, for Members for whom enrollment in MississippiCAN is optional, the option to change their program selection and disenroll from MississippiCAN. Members who do not make a choice will be deemed to have chosen to remain with their current Contractor.

3.2.7.3 Enrollment of CHIP Populations

CHIP Members may change Contractors without cause during this ninety (90) day open Enrollment period. Following the ninety (90) day open Enrollment period, these Members will be locked into that Contractor until the next open Enrollment period that will occur at least once every twelve (12) months.

The Division or its Agent will notify Members at least once every twelve (12) months and at least sixty (60) calendar days prior to the date upon which the Enrollment period ends that they have the opportunity to switch Contractors. Members who do not make a choice will be deemed to have chosen to remain with their current Contractor.

3.2.8 Member Information Packet

The Contractor must provide each Member an information packet indicating the Member's first effective date of Enrollment. The Contractor must ensure the information is provided no later than fourteen (14) calendar days after the Contractor receives notice of the Member's enrollment. The Contractor must utilize at least standard mail, in envelopes marked with "Return Services Requested" as the medium for providing the Member identification cards, in addition to electronic notification, if available. The Division must receive a copy of this packet on an annual basis for review and approval, or at any point when changes are made to the packet. At a minimum, the member packet must include:

1. An introductory letter;
2. A MississippiCAN or CHIP identification (as appropriate for the Member);
3. Information about how to obtain a copy of a provider Directory in compliance with 42 C.F.R. §438.10(f)(6)(h) at a minimum; and
4. Information about how to obtain a copy of the Member Handbook. If a Member requests a hard copy of the Member Handbook, the Contractor shall provide a hard copy. Otherwise, the Contractor shall make the Member Handbook available online.

If an individual is re-enrolled within sixty (60) calendar days of Disenrollment, the Contractor is only required to send the Member a new identification card. However, the complete Member Information Packet must be supplied upon Member request.

3.2.9 Health Risk Screening, Comprehensive Health Assessment, and Stratification

To effectively address the specific health needs of enrolled Members, the Contractor must employ a comprehensive risk assessment and stratification methodology. Details for the Health Risk Screening, Comprehensive Health Assessment, and assignment of Risk Levels are in Section 7, Care Management, of this Contract.

3.2.10 Enrollment of Children in Foster Care

If the Contractor is responsible for the provision of services to children in foster care, the Contractor shall comply with policies for the relevant federal and state agencies, such as DHS, CPS, or the Division, related to this population as well as associated state and federal requirements.

3.2.11 Enrollment Verification

The Division, or its Agent, shall provide the Contractor a listing of all MississippiCAN and CHIP Members who have selected or been assigned to the Contractor monthly.

The Contractor must ensure that Out-of-Network Providers can verify Member Enrollment in the Contractor's plan prior to treating a patient for non-Emergency Services. Within five (5) business days of the date on which the Contractor receives the Member Listing Report from the Division, the Contractor must provide Network Providers and Out-of-Network Providers the ability to verify Enrollment by telephone or by another timely mechanism.

3.2.12 Enrollment Discrimination

The Contractor must accept individuals eligible for enrollment in the order in which they apply without restriction (unless authorized by CMS), up to the limits set under the Contract.

Contractor must not discriminate against individuals eligible to enroll on the basis of health status or need for health care services.

The Contractor must not discriminate against individuals eligible to enroll on the basis of race, color, religion, sex, sexual orientation, gender identity, disability, national origin, limited English proficiency, marital status, political affiliation, or level of income, and must not use any policy or practice that has the effect of discrimination on the basis of race, color, religion, national origin, sex, sexual orientation, gender identity, disability, limited English proficiency, marital status, political affiliation, or level of income.

The Contractor must not disenroll a Member because of an adverse change in the Member's health status, or because of the Member's utilization of medical services, diminished mental capacity, or uncooperative or disruptive behavior resulting from Member's special needs (except when Member's continued Enrollment in the Contractor seriously impairs the Contractor's ability to furnish services to either this particular Member or other Members).

3.3 Disenrollment

3.3.1 Disenrollment from MississippiCAN

A Member must be disenrolled from the Contractor if the Member:

1. No longer resides in the State of Mississippi;

2. Is deceased;
3. No longer qualifies for medical assistance under one of the Medicaid eligibility categories in the eligible population;
4. Becomes a nursing home resident. For the purposes of determining eligibility for MississippiCAN, PRTFs shall not be considered a long-term care facility;
5. Becomes enrolled in a waiver program;
6. Becomes eligible for Medicare coverage.

3.3.2 Disenrollment from CHIP

At the time of eligibility redetermination, the Member will be disenrolled from CHIP and the Contractor if the Member:

1. Becomes eligible for Medicaid coverage;
2. Becomes institutionalized in a public institution or enrolled in a waiver program;
3. Becomes eligible for Medicare coverage; or

At any time, the Member must be disenrolled from CHIP and the Contractor if the Member:

1. No longer resides in the State of Mississippi;
2. Is determined to have Creditable Coverage by the Division;
3. Is deceased; or
4. Becomes a Custodial Nursing Home resident.

3.3.2.1 CHIP Members Who May be Eligible for Transfer to MississippiCAN

3.3.2.1.1 Member Who No Longer Qualifies for CHIP

If a CHIP Member no longer qualifies for CHIP under the eligibility categories, the Contractor should notify the Division so that the Division may assess whether the CHIP Member is eligible for MississippiCAN. If the Member is eligible, the Division will transmit that information to the Contractor, with direction to move the Member from CHIP to the appropriate Category of Eligible under MississippiCAN. If the Member is not eligible under MississippiCAN, and the Division will transmit a termination of eligibility date to the Contractor, along with the code

indicating the reason for termination, via the eligibility/enrollment update. Coverage will continue until such time as the Contractor receives a termination code from the Division.

3.3.2.1.2 CHIP Members Who Become Pregnant

For CHIP Members who become pregnant, the Contractor must notify the Division of Members identified with a diagnosis related to pregnancy within seven (7) calendar days of identification through a report, in a format and manner to be specified by the Division. If the Member is determined to be eligible for Medicaid and/or MississippiCAN, the Division will transmit that information to the Contractor, with direction to move the Member from CHIP to the appropriate Category of Eligible under MississippiCAN. If the Member is not eligible, the Division will transmit a termination of eligibility date to the Contractor, along with the code indicating the reason for termination, via the eligibility/enrollment update. Coverage will continue until such time as the Contractor receives a termination code from the Division.

3.3.3 Disenrollment Provisions Applying to All Members

The Contractor may request Disenrollment of a Member at any time based upon one or more of the reasons listed in Sections 3.3.1 or 3.3.2 of this Contract. The Contractor must notify the Division within three (3) calendar days of receipt of the Member Listing Report of their request that a Member be disenrolled and provide written documentation of the reason for the Disenrollment request, citing a reason or reasons from Sections 3.3.1 and/or 3.3.2 of this Contract. The Division will make a final determination regarding Disenrollment. The effective date of any approved Disenrollment will be no later than the first (1st) day of the second (2nd) month following the month in which the Member or the Contractor files the request with the Division. If the Division fails to make a Disenrollment determination by the first (1st) day of the second (2nd) month following the month in which the enrollee requests disenrollment or the Contractor refers the request to the Division, the Disenrollment is considered approved.

The Contractor cannot not request disenrollment of a Member because of an adverse change in the Member's health status, or because of the Members' utilization of medical services, the Member's diminished mental capacity, or uncooperative or disruptive behavior by the Member resulting from the Member's special needs except when the Member's continued enrollment in the Contractor impairs the Contractor's ability to furnish services to either the particular Member or other Member(s).

Additionally, any Member may request Disenrollment from the Contractor for cause if:

1. The Contractor does not, because of moral or religious objections, cover the service the Member seeks;

2. Not all related services are available within the network;

3. Member's PCP or another Provider determines receiving the services separately would subject the Member to unnecessary risk;

4. The Member does not have access to quality care within the Network;

5. There is a lack of access to services covered under the Contractor; or

6. There is a lack of access to Providers experienced in treating the Member's health care needs.

Any Member may request Disenrollment without cause:

1. Within ninety (90) days after initial enrollment or during the ninety (90) days following notification of enrollment, whichever is later;

2. At least once every twelve (12) months during Open Enrollment;

3. Upon reenrollment if a temporary loss of enrollment has caused the Member to miss the annual disenrollment period; or

4. The Division imposes intermediate sanctions, as defined by 42 U.S.C. § 1396u-2, on the Contractor. In this event, the Contractor shall be responsible for Member notification of ability to disenroll without cause. The Contractor is required to provide proof of making said notice to the Division.

Member requests for Disenrollment must be directed to the Division either orally or in writing.

Rules and policies governing disenrollment are subject to change by the Division due to a Federal or State emergency, regulation, or maintenance of effort requirement.

3.3.3.1 Disenrollment of Nursing Home Residents

Members who become Nursing Home or ICF/IID Residents must be disenrolled from the Contractor. Once the Medicaid office has completed the Nursing Home or ICF/IID application process and the long-term care segment has been entered, the Member will automatically be closed out of MississippiCAN or CHIP Enrollment, with a closure date of one (1) calendar day prior to the admission date.

For Members who become Nursing Home or ICF/IID Residents before the fifteenth (15th) day of a month, the Contractor will be required to refund the monthly capitation payment for that Member to the Division. For Members who become Nursing Home or ICF/IID Residents during the month, the Contractor will be allowed to keep the monthly capitation payment for that Member.

For the purposes of determining eligibility for MississippiCAN and CHIP, PRTFs shall not be considered a long-term care facility.

3.3.3.2 Disenrollment of Medicare Recipients

Members who become Medicare Recipients must be disenrolled from the Contractor. Once the Division receives notice from the regulatory source and the Medicare segment has been entered, the Member will automatically be closed out of MississippiCAN or CHIP Enrollment, with a closure date at the end of the month of update.

The Contractor will be required to render services for the months of capitation payment from the Division for that Member.

3.4 Re-Enrollment and Retroactive Eligibility

The Division or its Agent will automatically re-assign a Member into the Contractor in which he or she was most recently assigned if the Member has a temporary loss of eligibility, defined as less than sixty (60) calendar days. The Division will only retroactively enroll newborns in the categories of eligibility containing children under one (1).

When Retroactive Eligibility and Retrospective Reviews requests are necessitated, the Contractor must not deny payment for medically necessary covered services for lack of prior authorization or lack of referral. The Contractor must not deny a claim on the basis of the provider's failure to file the claim within a specified time period after the date of service when the provider could not have reasonably known which Contractor the Member was in during the timely filing period.

3.5 Member Listing Report

The Division or its Agent will prepare a Member Listing Report, prior to the first (1st) day of each month, listing all Members enrolled with the Contractor for that month. Adjustments will be made to each Member Listing Report to reflect corrections and the Enrollment or Disenrollment of Members reported to the Division or its Agent on or about the twenty-fifth (25th) day of the preceding month. The Division or its Agent will prepare a daily roster listing all new Members and a monthly report listing all disenrolled or closed files. The Member Listing Report will be

transmitted to the Contractor by electronic media. The Member Listing Report shall serve as the basis for Capitation Payments to the Contractor for the ensuing month.

The Member Listing Report shall be provided to the Contractor in a time sufficient to allow the Contractor to fulfill its identification card issuance and PCP notification responsibilities, described in Sections 5.3, Member Identification Card, and 3.2.5, Choice of a Network Provider, of this Contract, respectively. Should the Member Listing Report be delayed in its delivery to the Contractor, the applicable time frames for identification card issuance and PCP notification shall be extended by one (1) business day for each day the Member Listing Report is delayed. The Division and the Contractor shall reconcile each Member Listing Report as expeditiously as is feasible but no later than the twentieth (20th) day of each month.

The Division or its Agent will prepare a Member Listing Report, following the Special Open Enrollment Period, listing all Members enrolled with the Contractor. For subsequent periods of this Contract, all other terms and conditions will remain unchanged.

3.6 Enrollment Reports

The Contractor shall submit to the Division information about all new Enrollments, Disenrollments, reinstatements, and circumstances affecting the Enrollment status of Members, as received by the Contractor, in a submission format approved by the Division. The Contractor must review each Member Listing Report upon receipt and must submit all corrections to the Division on or before the fifteenth (15th) day of the month for which the Member Listing Report is issued. Adjustments will be made to the next Member Listing Report to reflect corrections, and the Enrollment or Disenrollment of Members reported to the Division (and approved by the Division in the case of voluntary or involuntary Disenrollment for cause) on or before the fifteenth (15th) calendar day of each month.

3.7 Special Rules for American Indians

If applicable, for Indian managed care entities, the Contractor may restrict Enrollment of Indians in the same manner as Indian Health Programs may restrict the delivery of services to Indians.

Indians who are enrolled in a non-Indian Contractor and are eligible to receive services from a participating I/T/U provider, may elect that I/T/U as the Member's Primary Care Provider, if that I/T/U participates in the network as a Primary Care Provider and has capacity to provide the services. Indian Members shall be permitted to obtain services covered under this Contract from Out-of-Network Indian Health Care Providers from whom the Member is otherwise eligible to receive such services.

Refer to Section 6.2.10 for more information regarding Indian Health Services.

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4. Covered Services and Benefits

The Contractor must ensure that all covered services provided to Members are Medically Necessary. The Contractor must submit reports related to covered services and benefits in accordance with Section 16, Reporting Requirements, of this Contract, and the MississippiCAN and CHIP Reporting templates, which are incorporated into this Contract via reference. The Contractor must also supply any other reports requested by the Division in the requested time, manner, and format.

4.1 Covered Services for MississippiCAN Members

The Contractor must provide all Medically Necessary covered services allowed under MississippiCAN as enumerated in the Mississippi Division of Medicaid State Plan and Administrative Code. The Contractor must ensure that all covered services are sufficient in an amount, duration, and scope to reasonably achieve its purpose as set forth in 42 C.F.R. § 440.230 and that no incentive is provided, monetary or otherwise, to Providers for withholding from Members' Medically Necessary Services. The Contractor must make available accessible facilities, service locations, and personnel sufficient to provide covered services consistent with the requirements specified in this Contract.

The Contractor must comply with Medicaid National Correct Coding Initiative (NCCI) guidelines. The Contractor must have policies, approved by the Division, that address manually priced claims, items, and services.

The Contractor must have policies and procedures in place to deal with states of emergency and public health emergencies. The Division may lift service limits for Members during states of emergency and public health emergencies, and the Contractor must provide, at minimum, coverage for the same level of services being covered by the Division during the state of emergency or public health emergency. It is expected that the Contractor will exceed the minimum service requirement through the programs, initiatives, and other service items enumerated throughout this Contract.

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

4.1.1 MississippiCAN Emergency Services

The Contractor shall provide all inpatient and outpatient Emergency Services in accordance with 42 C.F.R. § 438.114. The Contractor shall cover and pay for emergency medical services, including but not limited to dialysis and dialysis access services, regardless of whether the Provider that furnishes the services has a contract with the Contractor. Emergency Services when performed by an out-of-network provider shall be reimbursed at an in-network Provider rate. The Contractor shall have policies that address emergency use of services in an inpatient and outpatient emergency setting.

The Contractor must not deny payment for treatment obtained under either of the following circumstances:

1. A Member had an Emergency Medical Condition, including cases in which the absence of immediate medical attention would not have had the outcomes of placing the health of the individual (or pregnant woman and unborn child) in serious jeopardy, or would not have resulted in serious impairment to bodily functions, or would not result in serious dysfunction of any bodily part.
2. The Contractor, or the Member's Primary Care Provider (PCP) or Patient-Centered Medical Home (PCMH), instructed the Member to seek Emergency Services.

The Contractor must not limit what constitutes an Emergency Medical Condition on the basis of lists of diagnoses or symptoms, inclusive of dialysis services. The Contractor shall also not refuse to cover Emergency Services based on the emergency room provider or hospital not notifying the Member's PCP, PCMH, or the Contractor of the Member's screening and treatment within ten (10) calendar days of presentation for Emergency Services.

Coverage of Emergency Services is not subject to Prior Authorization requirements, but the Contractor may include a requirement in its provider agreements that notice be given to the Contractor regarding the use of Out-of-Network Providers for Emergency Services.

Such notice requirements shall provide at least a forty-eight (48) hour time frame after the Emergency Services for notice to be given to the Contractor by the Member and/or the emergency provider. Utilization of and payments to Out-of-Network Providers may, at the Contractor's option, be limited to the treatment of Emergency Medical Conditions, including Medically Necessary services rendered to the Member until such time as the Member may be safely transported to a network provider service location.

A Member who has an Emergency Medical Condition may not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or to stabilize the

Member. The attending emergency physician, or the Provider actually treating the Member, is responsible for determining when the Member is sufficiently stabilized for transfer or discharge, and that determination is binding on the Contractor for coverage and payment.

4.1.2 MississippiCAN Post-Stabilization Care Services

The Contractor shall cover and pay for Post-Stabilization Care Services in accordance with the provisions of 42 C.F.R. § 422.113(c).

The Contractor is financially responsible for Post-Stabilization Care Services obtained within the Contractor's Provider Network or from an Out-of-network Provider that are not pre-approved by a Network Provider or other Contractor representative, but administered to maintain, improve, or resolve the Member's stabilized condition if:

1. The Contractor does not respond to a request for pre-approval within one hour;
2. The Contractor cannot be contacted; or
3. The Contractor representative and the treating physician cannot reach an agreement concerning the Member's care and a Contractor physician is not available for consultation. In this situation, the Contractor must give the treating physician the opportunity to consult with a Contractor physician and the treating physician may continue with care of the patient until a Contractor physician is reached or one of the criteria of 42 C.F.R. § 422.113 is met.

The Contractor must not charge Members upon the end of Post-Stabilization Care Services for which the Contractor has not provided service authorization. Post-Stabilization Care Services not approved by the Contractor end when:

1. A Contractor physician with privileges at the treating hospital assumes responsibility for the Member's care;
2. A Contractor physician assumes responsibility for the Member's care through transfer;
3. A Contractor representative and the treating physician reach an agreement concerning the Member's care;
4. The Member is discharged; or
5. The Member dies.

4.1.3 MississippiCAN EPSDT Services

The Contractor shall comply with Sections 1902(a)(43) and 1905(a)(4)(B) and 1905(r) of the Social Security Act and Federal regulations, including necessary health care, diagnostic services, treatment, and other measures described in section 1905(a) to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the State plan. The Contractor must also comply with 42 C.F.R. Part 441 Subpart B that requires EPSDT services to include outreach and informing, screening, tracking, and diagnostic and treatment services.

The Contractor must have written policies and procedures, approved by the Division, related to the provision of the full range of EPSDT services as defined in, and in accordance with, the Division's policies and procedures for EPSDT and the provisions of this Contract. Such services shall include, without limitation, periodic health screenings as recommended by American Academy of Pediatrics (AAP) Bright Futures and appropriate and up-to-date immunizations using the Advisory Committee on Immunization Practices (ACIP) Recommended Immunization Schedule. All EPSDT-eligible Members shall receive services, in accordance with the Periodicity Schedule established by the Division for EPSDT services, including periodic examinations for vision, dental, and hearing and all medically necessary services. The Contractor shall identify all EPSDT-eligible Members whose Medical Records do not indicate up-to-date immunizations and shall ensure that these Members receive age-appropriate immunizations. Should the Division adopt a centralized Dental administrator during the life of Contract, the Contractor will cooperate with the Division in every way necessary to ensure a successful transition.

The Division requires that the Contractor cooperate to the maximum extent possible with efforts to improve the health status of Mississippi citizens and to actively work to improve the percentage of Members receiving appropriate screenings.

EPSDT wellness (screening) services shall be administered in accordance with Mississippi Administrative Code, State Plan, and written communication from the Division to the Contractor. For CMS mandatory reporting purposes, including but not limited to CMS 416 reporting, EPSDT wellness (screening) services must be provided by enrolled Medicaid providers, including but not limited to the Mississippi State Department of Health, other public and private agencies, private physicians, Rural Health Clinics, comprehensive health clinics, public schools and/or public school districts certified by the Mississippi Department of Education, and similar agencies that provide various components of the EPSDT services and have signed an EPSDT-specific provider agreement with the Division. EPSDT providers who have not signed an EPSDT-specific agreement with the Division shall not submit claims with

preventive Medicine Current Procedural Terminology (CPT) codes. The Division will provide the Contractor with a list of qualified EPSDT providers monthly.

The Contractor must require that EPSDT providers, as defined by the Division, render age-appropriate assessment screening services, including components defined by the Division. If a suspected problem is detected by a screening examination, the Member must be evaluated as necessary for further diagnosis with referral, if indicated. This diagnosis is used to determine treatment needs.

The Contractor must establish a tracking system that provides information on compliance with EPSDT service provision requirements in the following areas:

1. Initial visit for newborns;
2. EPSDT screenings and reporting of all screening results; and
3. Diagnosis, treatment and/or referral for Member.

The Contractor must have an established process for reminders, follow-ups and outreach to Members that includes:

1. Written notification of upcoming or missed appointments within a set time period, taking into consideration language and literacy capabilities of Members;
2. Telephone protocols to remind Members of upcoming visits and follow-up on missed appointments within a set time period;
3. If requested, any necessary assistance with arranging for transportation to ensure that Members obtain necessary EPSDT screening services. This assistance must be offered at least three (3) days prior to each due date of a child's periodic examination;
4. Protocols for conducting outreach with non-compliant Members, including home visits, as appropriate;
5. A process for outreach and follow-up to EPSDT-eligible Members with special health care needs; and
6. For children in foster care only, a process for outreach and follow-up with County Department of Human Services Agencies to assure that they are notified of all EPSDT-eligible members who are under their supervision and who are due to receive EPSDT screens and follow-up treatment.
7. The Contractor may develop alternate processes for follow-up and outreach subject to prior written approval from the Division.

The Contractor should utilize its Care Management System for follow-up and outreach as often as possible.

4.1.4 MississippiCAN Behavioral Health/Substance Use Disorders

The Contractor shall provide Behavioral Health/Substance Use Disorder Services to Members in MississippiCAN in accordance with 42 C.F.R. § 438.3 and the Mental Health Parity and Addiction Equity Act (MHPAEA). The Contractor shall comply with all requirements related to Care Management, access, and availability with respect to Behavioral Health/Substance Use Disorder Services. All Behavioral Health/Substance Use Disorder Services covered by the Division for enrolled populations that are medically necessary must be covered. The Contractor's provision of Behavioral Health/Substance Use Disorder services shall fully comply with the requirements set forth in 42 C.F.R. §§ 438.900 through 438.930.

In addition to services provided to Members through MHPAEA and other State Plan services, the Contractor shall provide Behavioral Health/Substance Use Disorder Services to Members in MississippiCAN in accordance with 42 C.F.R. § 438.3 and as required in the MSCAN State Health Plan..

IMD services are presently not included in the Mississippi Medicaid State Plan, but as of July 1, 2019, are required coverage for the Contractor pursuant to Section 9.211.7, Payment for Psychiatric Hospital Services. In accordance with section 1903(m)(7) of the Act and 42 C.F.R. § 438.6(e), states may receive federal financial participation (FFP) for monthly capitation payments for beneficiaries ages 21 through 64 receiving mental health or substance use disorder treatment (SUD)treatment in an IMD for a short term stay of no more than 15 days during the period of the monthly capitation payment so long as criteria identified in the regulation are met. The IMD must be a hospital providing inpatient mental health or SUD treatment or a sub-acute facility providing mental health or SUD crisis residential services. The state must have determined that the IMD is a medically appropriate and cost-effective substitute for the covered setting for providing mental health or SUD treatment under the State Plan. The enrollee must not be required by the managed care plan to use or reside in the IMD and must have a choice of settings for the mental health or SUD treatment. The IMD services for treatment of mental health or SUD must be authorized and identified in the managed care contract between the state and the managed care plan and offered to enrollees at the option of the managed care plan. Coverage of the mental health or SUD treatment services in an IMD setting cannot be required by the Managed Care Organization, pre-paid Inpatient Health Plan, or pre-paid Ambulatory Health Plan.

All Contract requirements herein apply to the provision of Behavioral Health/Substance Use Disorder Services unless specified.

Division policy regarding Behavioral Health/Substance Use Disorder Services is referenced in the Mississippi Administrative Code, Title 23, Part 206, but other sections of the code may also reference Behavioral Health/Substance Use Disorder Services. The Contractor is expected to follow all Division policy regarding Behavioral Health/Substance Use Disorders.

4.1.5 MississippiCAN Non-Emergency Transportation

The Contractor shall provide Non-Emergency Transportation (NET) for MississippiCAN Members to access Medically Necessary Services, in compliance with minimum Federal requirements for the provision of transportation services and according to Division policies, which are outlined in Mississippi Administrative Code, Title 23, Part 201. Non-Emergency Transportation shall be provided to Members who require transportation to and from medically necessary Medicaid covered Non-Emergency Services.

See Exhibit E, Non-Emergency Transportation, of this Contract for additional requirements of the Contractor.

4.1.6 MississippiCAN Non-Covered Services

The Contractor shall refer Members to Providers enrolled in the Medicaid Fee-for-Service delivery system for all medically necessary services not covered by the Contractor under MississippiCAN. The Contractor shall have written policies and procedures for the referral of Members for non-covered services, which shall provide for the smooth transition to Out-of-Network Providers and assistance to Members in obtaining a new PCP, if appropriate. These procedures shall be applicable to the referral of Members to Out-of-Network Providers, as necessary, upon Disenrollment, regardless of the reasons for Disenrollment.

4.1.7 MississippiCAN Enhanced Services

The Contractor may provide enhanced services that exceed the benefits or services provided under the Mississippi Fee-for-Service delivery system, subject to advance written approval by the Division. Any enhanced services must fully comply with the provisions of 42 C.F.R. § 438.3(e). Enhanced services are generally considered to have a direct relationship to the maintenance or enhancement of a Member's health status. Examples of potentially approvable services include various seminars and educational programs promoting healthy living or illness prevention, nutritional support, access to community resources, housing support, social services, memberships in health clubs and/or facilities promoting physical fitness and expanded eyeglass or eye care benefits. These services must be generally available to all Members and approved by the Division. In the submission for approval, the Contractor must specify whether it is seeking to tie the service to specific Member performance. A request to tie a service to a specific Member

performance may be denied by the Division even if the service itself is approved. The Division may grant exceptions in areas where it believes that such tie-ins will produce significant health improvements for Members.

The Contractor may only include information in Member communications about enhanced services that will apply for a minimum of one full year or until the Member information is revised, whichever is later. Upon sixty (60) calendar days' advance notice to the Division, the Contractor may modify or eliminate any enhanced services. The Contractor must send written notice to Members and affected Providers at least thirty (30) calendar days prior to the effective date of the change in covered services and must simultaneously amend all written materials describing its covered benefits or Provider Network.

If the Contractor elects to provide enhanced services, it shall submit a statement quarterly as to the value of these services in a format to be specified by the Division.

The utilization and actual cost of enhanced services are not taken into account in developing the medical expense component of the capitation rates that represents the covered State Plan services.

4.1.8 MississippiCAN Services for Foster Care Children

The Contractor will coordinate closely with the Mississippi Department of Child Protection Services (CPS) and the Division through regular meetings of a task force. The Contractor shall comply with relevant Contract requirements that impact the provision of services. The Contractor shall also provide data and reports required by the Mississippi Department of Child Protection Services and the Division to demonstrate compliance. Any such reports should include only de-identified data unless the minors whose personally identifiable information and/or protected health information are in the custody of the Mississippi Department of Child Protection Services at the time the report is provided. The Contractor shall also provide Foster Care Children Care Management.

4.1.9 MississippiCAN Prescribed Drugs, Physician-Administered Drugs and Implantable Drug System Devices

The Division PBA

The Division will use a single PBA for the administration of pharmacy claims benefits for MississippiCAN Members.

The Division PBA will be responsible for claims management and payment, prior authorization, and pharmacy provider management for all Members. The Contractor is required to cooperate with the Division PBA fully in all aspects of pharmacy administration. The Division PBA will share all Member claims with the Contractor for the purposes of Care Management and pharmacy claim

payment amount(s) processed. The Division will provide the Contractor with additional information and requirements regarding its obligation to cooperate with the PBA throughout the life of this Contract.

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

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

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

The Contractor must use the most current version of the MS DOM Universal PDL, which is subject to periodic changes. The Contractor must use the Medicaid PDL developed by the Division or its Agent and may not develop and use its own PDL. The Contractor will be provided opportunities to offer feedback on the PDL to the Division. A pharmacy representative from Contractor shall attend the P&T committee meetings as a guest and will be offered the opportunity to contribute in an evaluative and educational capacity in post P&T committee meetings. The Executive Director of the Division has final authority on drugs with preferred and non-preferred status on the PDL. The Contractor shall follow the same PA criteria of that of FFS for drugs requiring PA, regardless of PDL status. The Contractor shall not promote any preferred drugs over other preferred drugs.

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

information must be made available on the MCOs website. The Contractor must make available a link to the Universal PDL on their website.

The Contractor may require Prior Authorization in accordance with Section 4.3 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 any drugs or other 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 shall operate a retrospective Drug Utilization Review (DUR) program that complies with the requirements described in Section 1927(g) of the Social Security Act and 42 C.F.R. Part 456, Subpart K. The Contractor shall maintain drug utilization review provisions as outlined in Section 1004 of the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act.

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

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

(1) Monitor opioid prescriptions (duplicate therapy, early refills, quantity limits, etc.).
(2) Automated retrospective claim reviews process to monitor opioid prescriptions exceeding State defined limitations.
(3) Monitor opioids and benzodiazepines being used concurrently.
(4) Monitor opioids and sedatives being used concurrently.
(5) Monitor opioids and antipsychotics being used concurrently.
(6) Maintain safety edits or perform automated retrospective claims reviews and/or provider education regarding beneficiaries with a diagnosis or history of opioid use disorder (OUD) or opioid poisoning diagnosis.
(7) Monitor MME total daily dose of opioid prescriptions dispensed.
(8) Monitor and manage appropriate use of naloxone to persons at risk of overdose.
(9) Manage or monitor the appropriate use of antipsychotic drugs in children.
(10) Manage or monitor the appropriate use of stimulant drugs in children.
(11) Manage or monitor the appropriate use of other psychotropic medication (antidepressants, mood stabilizers, antianxiety/sedative) in children.

The Contractor must conduct a prior authorization program for PADs that complies with the requirements of section 1927(d)(5) of the Act. Please refer to Mississippi Administrative Code, Title 23, Part 203. The Contractor shall report information specified by the Division to enable the collection of rebates by the Division, as described in Section 11, Reporting Requirements, of this Contract.

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

4.2 Covered Services for CHIP Members

The Contractor shall provide all Medically Necessary covered services allowed under CHIP in accordance with the CHIP State Health Plan and as enumerated in the Administrative Code. The Contractor shall ensure that all covered services are as accessible to Members (in terms of timeliness, amount, duration, and scope); that no incentive is provided, monetary or otherwise, to Providers for withholding from a Member's Medically Necessary Services. 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. § 457.950. The Contractor shall make available accessible facilities, service locations, and personnel sufficient to provide covered services consistent with the requirements specified in this Contract.

The Contractor shall have policies, approved by the Division, that address manually priced claims, items, and services.

Contractor must have policies and procedures in place to deal with states of emergency and public health emergencies. The Division may lift service limits for Members during states of emergency and public health emergencies, and Contractor must provide, at minimum, coverage for the same level of services being covered by the Division during the state of emergency or public health emergency. It is expected that the Contractor will exceed the minimum service requirement through the programs, initiatives, and other service items enumerated throughout 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 Act.

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

4.2.1 CHIP Emergency Services

The Contractor will provide all inpatient and outpatient Emergency Services in accordance with 42 C.F.R. §438.114. The Contractor shall cover and pay for Emergency Services including but not limited to dialysis and dialysis access services, regardless of whether the Provider that furnishes the services has a contract with the Contractor. Emergency Services when performed by an out-of-network provider shall be reimbursed at an in-network Provider rate. The Contractor shall have policies that address emergency use of services in an inpatient and outpatient emergency setting.

The Contractor shall not deny payment for treatment obtained under either of the following circumstances:

1. A Member had an Emergency Medical Condition, including cases in which the

absence of immediate medical attention would have the outcome of placing the health of the individual (or pregnant woman and unborn child) in serious jeopardy, or would result in serious impairment to bodily functions, or would result in serious dysfunction of any bodily part.

2. The Contractor, or the Member's Primary Care Provider (PCP) or Patient-Centered Medical Home (PCMH), instructed the Member to seek Emergency Services.

The Contractor shall not limit what constitutes an Emergency Medical Condition based on lists of diagnoses or symptoms, inclusive of dialysis services. The Contractor shall also not refuse to cover Emergency Services based on the emergency room Provider or hospital not notifying the Member's PCP, PCMH, or Contractor of the Member's screening and treatment within ten (10) calendar days of presentation for Emergency Services.

Coverage of Emergency Services are not subject to Prior Authorization requirements, but the Contractor may include a requirement in its Provider agreements that notice be given to the Contractor regarding the use of Out-of-Network Providers for Emergency Services.

Such notice requirements shall provide at least a forty-eight (48) hour time frame after the Emergency Services for notice to be given to the Contractor by the Member and/or the emergency Provider. Utilization of and payments to Out-of-network Providers may, at the Contractor's option, be limited to the treatment of Emergency Medical Conditions, including Medically Necessary services rendered to the Member until such time as he or she may be safely transported to a network Provider service location.

A Member who has an Emergency Medical Condition may not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition to stabilize the patient. The attending emergency physician, or the Provider actually treating the Member, is responsible for determining when the Member is sufficiently stabilized for transfer or discharge, and that determination is binding on the Contractor for coverage and payment.

4.2.2 CHIP Post-Stabilization Care Services

The Contractor shall cover and pay for Post-Stabilization Care Services in accordance with the provisions of 42 C.F.R. § 422.113(c).

The Contractor is financially responsible for Post-Stabilization Care Services obtained within the Contractor's Provider Network or from an Out-of-network Provider that are not pre-approved by a Network Provider or other Contractor representative, but administered to maintain, improve, or resolve the Member's stabilized condition if:

1. The Contractor does not respond to a request for pre-approval within one (1) hour;

2. The Contractor cannot be contacted; or

3. The Contractor representative and the treating physician cannot reach an agreement concerning the Member's care and a physician from the Contractor's Provider Network is not available for consultation. In this situation, the Contractor must give the treating physician the opportunity to consult with a physician from the Contractor's Provider Network and the treating physician may continue with care of the Member until a Contractor physician is reached or one of the criteria of 42 C.F.R. § 422.113 is met.

The Contractor must not charge Members upon the end of Post-Stabilization Care Services that the Contractor has not pre-approved. Post-Stabilization Care Services not approved by the Contractor end when:

1. A physician from the Contractor's Provider Network with privileges at the treating hospital assumes responsibility for the Member's care;

2. A physician from the Contractor's Provider Network assumes responsibility for the Member's care through transfer;

3. A Contractor representative and the treating physician reach an agreement concerning the Member's care;

4. The Member is discharged; or

5. The Member dies.

4.2.3 CHIP Well-Baby and Well-Child Services and Immunization Services

The Contractor shall provide Well-Baby and Well-Child Care services, including but not limited to vision screening, laboratory tests, and hearing screenings, according to the recommendations of the U.S. Preventive Services Task Force. Vision and hearing screenings shall be included as part of periodic Well-Child assessments.

The Contractor must have written policies and procedures related to the provision of the full range of Well-Baby Care, Well-Child Care, and childhood and adolescent immunizations services as defined in, and in accordance with, the CHIP State Health Plan, 42 C.F.R. § 457.495, and the provisions of this Contract. Services shall include, without limitation, periodic health screenings and appropriate and up-to-date immunizations using the immunization schedule for all Members recommended by the Advisory Committee on Immunization Practices (ACIP).

The Contractor shall make all reasonable efforts to identify all Members whose Medical Records do not indicate up-to-date immunizations and shall ensure that these Members receive necessary immunizations. Immunizations are purchased by the Division and distributed through

the Mississippi State Department of Health. The Contractor shall reimburse Providers for the administration of the immunizations.

The Division requires that the Contractor cooperate to the maximum extent possible with efforts to improve the health status of Mississippi citizens and to actively work to improve the percentage of Members receiving appropriate screenings.

The Contractor must establish a tracking system that provides information on compliance with Well-Baby and Well-Child Care services, immunization services provision requirements, and all other items in the CMS Child Core Set and HEDIS Measurement Set relevant to children and adolescents younger than the age of 19.

The Contractor must have an established process for reminders, follow-ups, and outreach to Members that includes:

1. Written notification of upcoming or missed appointments within a set time period, taking into consideration language and literacy capabilities of Members;
2. Telephone protocols to remind Members of upcoming visits and follow-up on missed appointments within a set time period;
3. Protocols for conducting outreach with non-compliant Members, including home visits, as appropriate; and
4. A process for outreach and follow-up to Members with special health care needs.

The Contractor may develop alternate processes for follow-up and outreach subject to prior written approval from the Division. The Contractor should utilize its Care Management System for follow-up and outreach as often as possible.

4.2.4 CHIP Behavioral Health/Substance Use Disorder

The Contractor shall provide Behavioral Health/Substance Use Disorder Services to Members in CHIP in accordance with 42 C.F.R. §438.3 and §457.1201 and the Mental Health Parity and Addiction Equity Act (MHPAEA). The Contractor shall comply with all requirements related to Care Management, access, and availability with respect to Behavioral Health/Substance Use Disorder Services. All Behavioral Health/Substance Use Disorder Services covered by the Division for enrolled populations that are medically necessary must be covered. The Contractor's provision of Behavioral Health/Substance Use Disorder services shall fully comply with the requirements set forth in 42 C.F.R. §§438.900 through 438.930.

In addition to services provided to Members through MHPAEA and other State Plan services, the Contractor shall provide Behavioral Health/Substance Use Disorder Services to Members in CHIP in accordance with 42 C.F.R. § 438.3 and as required in the CHIP State Health Plan.

All Contract requirements herein shall apply to the provision of Behavioral Health/Substance Use Disorder Services unless specified.

4.2.6 CHIP Dental Services

The Contractor is required to deliver CHIP Dental Services as required in the CHIP State Health Plan. Should the Division adopt a centralized Dental administrator during the life of Contract, the Contractor will cooperate with the Division in every way necessary to ensure a successful transition.

4.2.7 CHIP Vision Services

The Contractor is required to deliver CHIP Vision Services as required in the CHIP State Health Plan.

4.2.8 CHIP Non-Covered Services

The Contractor shall refer Members to Providers enrolled in Medicaid Fee-for-Service. The Contractor shall have written policies and procedures for the referral of Members for non-covered services, which shall provide for the smooth transition to Out-of-Network Providers and assistance to Members in obtaining a new PCP, if appropriate. These procedures shall be applicable to the referral of Members to Out-of-Network Providers, as necessary, upon Disenrollment, regardless of the reasons for Disenrollment.

4.2.9 CHIP Enhanced Services

The Contractor may provide enhanced services that exceed the benefits or services provided under the CHIP delivery system, subject to advance written approval by the Division. Any enhanced services must fully comply with the provisions of 42 C.F.R. § 438.3(e). Enhanced services are generally considered to have a direct relationship to the maintenance or enhancement of a Member's health status. Examples of potentially approvable services include various seminars and educational programs promoting healthy living or illness prevention, nutritional support, access to community resources, housing support, social services, memberships in health clubs and/or facilities promoting physical fitness and expanded eyeglass or eye care benefits.

These services must be generally available to all Members and approved by the Division. In the submission for approval, the Contractor must specify whether it is seeking to tie the service to specific Member performance. A request to tie a service to a specific Member performance may be denied by the Division even if the service itself is approved. The Division may grant exceptions in areas where it believes that such tie-ins will produce significant health improvements for Members.

The Contractor may only include information in Member communications about enhanced services that will apply for a minimum of one full year or until the Member information is revised, whichever is later. Upon sixty (60) calendar days' advance notice to the Division, the Contractor may modify or eliminate any expanded services. The Contractor must send written notice to Members and affected Providers at least thirty (30) calendar days prior to the effective date of the change in covered services and must simultaneously amend all written materials describing its covered benefits or Provider Network.

If the Contractor elects to provide enhanced services, it shall submit a statement annually as to the value of these services in a format to be specified by the Division.

The utilization and actual cost of enhanced services are not taken into account in developing the medical expense component of the capitation rates that represents the covered State Plan services.

4.2.10 CHIP Immunization Schedules

The Contractor shall cooperate with the MSDH in matching CHIP Enrollment data with immunization records.

The Contractor shall develop and implement procedures to contact Members and their parents/guardians who have not complied with the recommended schedule by the ACIP and to arrange appointments for such Members to receive required immunizations.

4.2.11 CHIP Member Financial Liability

The Contractor shall educate network Providers to collect Co-Payments from Members in accordance with Table 4.5.

Table 4.5. Allowable Cost Sharing by FPL

Requirement	≤150% FPL	151% to 175% FPL	176% to 209% FPL
Per Physician Visit	None	$5.00	$5.00
Per Emergency Room Visit	None	$15.00	$15.00

Out-of-Pocket Maximum	N/A	$800.00	$950.00

The Contractor shall track the amount of co-payments collected in a given calendar year. When a Member meets his or her Out-of-Pocket Maximum, the Contractor shall send a letter to the Member indicating that no further co-payments should be paid for the remainder of the State Fiscal Year. The Contractor shall include instructions in the letter to present the letter when future health services are sought, or request the Provider to contact the Contractor regarding this issue. The Contractor must submit the template letter to the Division thirty (30) calendar days prior to use for the Division review. No Cost Sharing may be collected from these CHIP Members for the balance of the State Fiscal Year.

The Contractor shall comply with all Cost Sharing restrictions imposed on Members by Federal or State laws and regulations, including the following specific provisions:

1. The Contractor shall not apply Cost Sharing to the following services: preventive services, including immunizations, Well-Baby and Well-Child Care Services, routine preventive and diagnostic dental services, routine dental fillings, routine eye examinations, eyeglasses, and hearing aids in accordance with 42 C.F.R. § 457.520.

2. The Contractor shall not apply Cost Sharing to the costs of Emergency Services that are provided at a facility that does not participate in the Contractor's Provider Network beyond the Cost Sharing amounts specified in Table 2, in accordance with 42 C.F.R.§ 457.515(f).

3. Federal law prohibits charging premiums, deductibles, coinsurance, co-payments, or any other Cost Sharing to Native Americans or Alaskan Natives. The Contractor shall be responsible for educating network Providers regarding the waiver of Cost Sharing requirements for this population.

4. Members shall not be liable for payments to Providers for Covered Services provided other than the co-payments referenced within this Contract.

5. Providers may not bill a Member for Covered Services in the event the Contractor becomes insolvent.

In addition, a Member who has an Emergency Medical Condition may not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or to stabilize the Member. The attending emergency physician, or the treating Provider, is responsible for determining when the Member is sufficiently stabilized for transfer or discharge, and that determination is binding on the Contractor for coverage and payment.

Co-payments are subject to change by the Division and may only be charged as approved by the Division.

4.2.12 CHIP Prescribed Drugs, Physician-Administered Drugs and Implantable Drug Systems Devices

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 4.3 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 any drugs or 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 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.

4.3 Prior Authorization Requirements for All Members

4.3.1 General Requirements

The Contractor must have written policies and procedures, approved by the Division, for the Prior Authorization (PA) of services, which must comply with Federal and State laws and regulations, this Contract, the Mississippi Administrative Code, the Mississippi Division of Medicaid State Plan, the Mississippi CHIP State Health Plan, formal memorandums, and policies promulgated by the Division.

4.3.1.1 Criteria

In performing medical necessity determinations, the Contractor shall use a standard, evidence-based clinical decision support solution (such as InterQual or Milliman Care Guidelines) as approved by the Division. When such support solution criteria is not available for medical necessity determination, then the Contractor shall use a nationally recognized standard for the clinical criteria in reviewing each authorization, prior authorization and prepayment review request, as approved by the Division. The criteria shall provide a clinically sound basis for professional determinations of the medical necessity for all services reviewed under the resulting Contract.

The Division must receive the Contractor's PA criteria for each service delivery area at least ninety (90) calendar days prior to implementation of the Contract for Division approval. Should the Contractor change criteria for a service delivery area during the life of the Contract, the Division must receive the Contractor's new PA criteria for advanced written approval at least ninety (90) calendar days prior to the implementation of the new criteria.

The Division will assist as needed with interpretation and clarification of the Division's policy and will notify the Contractor as changes are made that affect the program. Any instances of discrepancies in interpretation of the Contract, policies, or program requirements between the Contractor and the Division will be decided at the discretion of the Division. The Division reserves the right to review any of the Contractor's prior authorization policies and procedures, as well as any other documentation related to the Contractor's prior authorization policies and procedures, at any time.

The Contractor shall use a mechanism to ensure consistent application of review criteria for authorization decisions that includes consultation with the requesting Provider when appropriate. The Contractor shall determine the medical necessity for all services to eligible Members beneficiaries utilizing the Division's approved criteria and policies.

4.3.1.2 Continuing Authorizations

The Contractor shall have procedures for processing requests for initial and continuing authorization of services.

Continuing authorizations include Member authorizations obtained from the Division or previous Contractor for which dates of approval extend through the effective date of the new Contractor. When a Member changes to a different payer, such as FFS or another Contractor, then the Provider shall contact the current Contractor, submit an authorization request for services, and provide a copy of the authorization approval from FFS or the previous Contractor. The current Contractor shall accept the authorization for the dates of service listed on the approval notification from the previous Contractor for this transition period.

4.3.1.3 Transition of Care

Upon receipt of notification that a Member is transferring from a former Contractor to a new Contractor, the former Contractor shall be responsible for contacting the new Contractor, the Member, and the Member's Providers to transition existing care. A PA shall be accepted by the new Contractor for thirty (30) days or until the recipient or Provider is contacted by the new Contractor regarding the PA. If the recipient and Provider are not contacted by the new Contractor, the existing PA shall be accepted until expired.

4.3.1.4 Two Levels of Review

The Contractor shall conduct authorization, prior authorization, and prepayment review processes that include two (2) levels of review. The first level of review is conducted by a qualified health professional licensed in the State of Mississippi with clinical knowledge and experience in utilization review. Requests not approved at the first level of review for not meeting criteria shall be referred for a second level review by an appropriate health care professional (physician, dentist, orthodontist, etc.).

4.3.1.5 No Collusion

The Contractor may not structure compensation to individuals or utilization management entities to provide inappropriate incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any Member.

4.3.1.6 Denials

The Contractor shall comply with 42 C.F.R. § 438.210 (b)(3), which requires that any decision to deny a Service Authorization request or to authorize a service in an amount, duration, or scope that is less than requested, be made by an individual who has appropriate expertise in addressing the Member's medical, behavioral health, and/or long-term services and supports needs. Nurses, physicians, and other licensed health professionals conducting reviews of medical services, and other clinical reviewers conducting specialized reviews in their area of specialty shall be currently licensed or certified by the Mississippi state licensing agency or hold a multi-state license with Mississippi privilege.

Decisions to deny a Service Authorization request or to authorize a service in an amount, duration, or scope that is less than requested must be made by a physician pursuant to Miss. Code Ann. § 41-83-31.

The Contractor shall have in place procedures for appeals of determinations not to certify an admission, procedure, service, or extension of stay. The right to appeal shall be available to the patient or member, and to the attending physician on behalf of the patient. Prior to upholding the original decision not to certify for clinical reasons, the private review agent shall conduct a review of such documentation by a physician who did not make the original determination not to certify. An attending physician who has been unsuccessful in their attempt to reverse a determination not to certify should be provided, upon request, the clinical basis for the determination.

The Contractor may request copies of medical records retrospectively for multiple purposes, including auditing the services provided, quality assurance, evaluation of compliance with the terms of the health benefit plan, or utilization review provisions.

4.3.1.7 Retroactive Reviews

The Contractor shall have the capability and established procedures to receive Retrospective Review requests within sixty (60) days of the service date and conduct prepayment reviews. The Contractor shall ensure determinations for Retrospective Reviews are completed within thirty (30) business days of receipt. Health care Providers may be reimbursed by the Contractor for reasonable direct costs of duplicating requested records for retrospective review.

4.3.1.8 Mental Health Parity

The Contractor shall require that prior authorization requirements comply with the requirements for parity in mental health and substance use disorder benefits in 42 C.F.R. Part 438, Subpart K.

4.3.1.9 Web-based Prior Authorization System

The Contractor shall establish, during the Implementation Period, a secure Web-based, electronic review request system accessible to Providers and Division staff, through which Providers may submit requests and view determinations for any and all services. The Contractor shall also have the capability to accept supporting documentation for Prior Authorization requests via facsimile transmission, via secure electronic upload through the Web-based system, or via a secure email platform.

The Web-based, electronic review request system for Prior Authorization and prepayment review must allow for data input by the submitting providers. The Contractor's system shall have the capability for an automated criteria/rules-based certification system. The Contractor shall manually review each Prior Authorization and prepayment review request received that is not certified by the Contractor's rules-based system, along with any required supporting documentation to support the need for services.

The Contractor shall have the capability and established procedures for verbal consultation by the physician reviewer with the attending physician to obtain additional information when the documentation submitted does not clearly support medical necessity.

The Contractor shall ensure that all cases (including reductions) not meeting medical necessity criteria are reviewed by medical directors duly licensed in Mississippi and in compliance with Miss. Code Ann. § 41-83-31. At any point after an initial denial, a physician who has had a denial may request a review by a reviewer of the same specialty for the case in question.

The Contractor shall have the ability to communicate through a statewide and a regional Health Information Exchange (HIE) at no additional cost to the Division.

The Contractor's Web-based, electronic review request system shall include the ability for authorized users to access the Web-based, electronic review request system via a secured logon. The Contractor shall establish a protocol to assign user logons and passwords upon receipt of necessary documentation, to verify that the user is authorized to view Member information.

The Contractor shall include in the Web-based, electronic review request system the ability for users to view and securely download all data, analytics, or reports that are specific to the user defined by the user's profile and security access.

The Contractor's Web-based, electronic review request system shall have the ability to receive Prior Authorization requests from Providers for the services where electronic submission is required. The Contractor shall have the capability to assign a unique tracking number to each review record. The Contractor's Web-based, electronic review request system shall have the ability to send and receive HIPAA-compliant Personally Identifiable Information (PII) and Protected Health Information (PHI) transactions for Prior Authorization requests requiring attachments.

The Contractor shall create a "smart" electronic authorization request form, customized for each service that requires certification. The form must be standardized for all Contractors and must be prior approved by the Division. The Contractor shall design this form so that it reduces the chances of technical denials due to incorrect or missing information.

The Contractor shall provide training in the use of the Web-based system and the equipment required for Division online access to the Web-based system. Division staff shall be given access to the Contractor's electronic system for the purpose of monitoring Prior Authorizations (at no additional cost to the Division).

4.3.1.10 Notifications

The Contractor shall have the capability and established procedures for verbal and written notification to the requesting provider of a pended review and for informing the provider of the information needed along with a time frame for submission.

The Contractor shall have the capability and established procedures for verbal and written notification to the requesting provider of a suspended review. Notification to providers of suspended reviews shall not exceed the following:

Table 4.1. Notification of Suspended Reviews for All Services

Review Type	Contractor Action	Time Standard
Emergency Admission Reviews	Verbal Notification to Provider	Within four (4) hours past due date for requested information
Non-Emergency Admission Reviews Weekend and Holiday Admission Reviews Continued Stay Reviews	Written Notification to Provider	Within one (1) business day past due date for requested information
Retrospective Authorization Reviews	Written Notification to Provider	Within three (3) business days past due date for requested information

The Contractor shall establish and maintain a procedure for the attending physician to contact the Contractor's Medical Director to discuss any services that have been denied, modified, or considered for denial.

The Contractor shall notify providers and Members or legal guardians/representatives of review determinations for all services requests.

1. The Contractor shall notify the requesting provider of the approval by telephone, fax, or secure e-mail.

2. The Contractor shall notify the requesting provider of the denial orally.

3. Written or electronic notice of the denial will be issued to the attending physician, facility, and Member or, if a child, the legal guardian/ representative, and shall include the reason(s) for the determination and the way to initiate an Appeal of the determination if the member or their representative so chooses. Reasons for a determination not to certify shall include, among other things, the lack of adequate information to certify after a reasonable attempt has been made to contact the attending physician. Time frames for notification to Providers and Members of review outcomes for Prior Authorization and prepayment review of all services shall not exceed the following standards:

Table 4.2: Notification of Review Outcomes for All Services

Review Type	Contractor Action	Time Standard
Emergency Admission Reviews	Verbal Approval to Provider	Within 24 hours from review determination
Non-Emergency Admission Reviews Weekend and Holiday Admission Reviews Continued Stay Reviews	Written Approval to Provider	Within one (1) business day from review determination
	Verbal Denial to Provider	Within 24 hours from review determination
	Written Denial to Provider	Within one (1) business day from review determination
	Written Denial to Member/ Parent/Representative	Within one (1) business day from review determination
Retrospective Authorization Reviews	Written Approval to Provider	Within three (3) business days from review determination
	Written Denial to Provider	Within three (3) business days from review determination
	Written Denial to Member/ Parent/Representative	Within three (3) business days from review determination

4.3.2 Timeframes for Inpatient Hospital Services

The Contractor shall determine the medical necessity for emergency and non-emergency inpatient hospital admission prior authorizations, continued stays, Retroactive Eligibility Reviews and Retrospective Reviews for inpatient medical/surgical/behavioral health services to eligible Mississippi Medicaid beneficiaries utilizing the Division's approved criteria and policies.

4.3.2.1. Emergency Admission Reviews

The Contractor shall have the capability and established procedures to receive Emergency Admission Reviews post-admission for admissions that are not planned or elective and conduct prior authorizations when the Member has not been discharged. The Contractor shall ensure determinations for Emergency Admission Reviews are completed within twenty-four (24) hours (one workday) of receipt ninety-eight percent (98%) of the time.

4.3.2.2 Non-Emergency Admission Reviews

The Contractor shall have the capability and established procedures to receive Non-Emergency Admission Reviews requests and conduct prior authorizations prior to the planned date of admission. The Contractor shall ensure determinations for Non-Emergency Admission Reviews are completed within twenty-four (24) hours (one workday) of receipt ninety-eight percent (98%) of the time.

4.3.2.3 Weekend and Holiday Admission Reviews

The Contractor shall have the capability and established procedures to receive Weekend and Holiday Admission Reviews requests and conduct prior authorizations post-admission when the Member has not been discharged. The Contractor shall ensure determinations for Weekend and Holiday Admission Reviews are completed within twenty-four (24) hours (one workday) of receipt ninety-eight percent (98%) of the time.

4.3.2.4 Continued Stay Reviews

The Contractor shall have the capability and established procedures to receive Continued Stay Reviews requests for additional inpatient days of care for admissions previously authorized and conduct prior authorizations on or before the next review point (i.e., the last certified day). The Contractor shall ensure determinations for Continued Stay Reviews are completed within twenty-four (24) hours (one workday) of receipt ninety-eight percent (98%) of the time when Members remain hospitalized and within twenty-four (24) hours (one workday) ninety-eight percent (98%) of the time when Members have been discharged.

4.3.2.5 Retroactive Eligibility Reviews

The Contractor shall have the capability and established procedures to receive Retroactive Eligibility Review requests. The Contractor shall ensure determinations for Retroactive Eligibility Reviews are completed within twenty (20) business days of receipt ninety-eight percent (98%) of the time.

4.3.2.6 Retrospective Authorization Hospital Reviews

The Contractor shall have the capability and established procedures to receive Retrospective review requests for all covered services within sixty (60) days of the service date and conduct prepayment reviews. The Contractor shall ensure determinations for Retrospective Authorization Reviews are completed within twenty (20) business days of receipt ninety-eight percent (98%) of the time.

4.3.2.7 Organ Transplant Services

The Contractor shall develop, implement, and maintain a utilization management program that includes Prior Authorization and Retrospective Review of application requests for organ transplant services.

The Contractor shall determine the medical necessity of transplant applications and requests for extension of benefits for eligible Mississippi Medicaid beneficiaries utilizing the Contractor's criteria and policies that have been approved by the Division. The Contractor shall ensure determinations of transplant applications and requests for extensions of benefits are completed ninety-eight percent (98%) of the time within three (3) business days of receipt. The Contractor shall ensure determinations for Retrospective Reviews are completed within twenty (20) business days of receipt ninety-eight percent (98%) of the time.

The Contractor shall establish and maintain a procedure for the attending physician to contact the Contractor's Medical Director to discuss transplant cases that have been denied, modified, or considered for denial.

The Contractor shall issue notifications of approvals and denials to the requesting provider, facility, Division and Member or, if a child, the legal guardian/representative.

4.3.3 Timeframes for All Services Other Than Inpatient Hospital Services

The Contractor must notify the requesting Provider and the Member in writing of any decision by the Contractor to deny an authorization request or to authorize a service in an amount, duration, or scope that is less than requested by the treating Provider and/or Member. The notice must meet the requirements specified in 42 C.F.R. § 438.404.

The Contractor must make standard authorization decisions and provide notice within three (3) calendar days and/or two (2) business days per Minimum Standards for Utilization Review Agents issued by the Mississippi State Department of Health (MSDH) following receipt of the request for services. If the Contractor requires additional medical information in order to make a decision, the Contractor will notify the requesting provider of additional medical information needed and the Contractor must allow three (3) calendar days and/or two (2) business days for the requesting provider to submit the medical information. If the Contractor does not receive the additional medical information, the Contractor shall make a second attempt to notify the requestor of the additional medical information needed and the Contractor must allow one (1) business day or three (3) calendar days for the requestor to submit medical information to the Contractor.

Once all information is received from the provider, if the Contractor cannot make a decision, the three (3) calendar day and/or two (2) business day period may be extended up to fourteen (14) additional calendar days upon request of the Member or the Provider to the Contractor, or if the Contractor requests an extension from the Division. The extension request to the Division applies only after the Contractor has received all necessary medical information to render a decision and the Contractor requires additional calendar days to decide. The extension request must justify to the Division a need for additional information and explain how the extension is in the Member's best interest. Any such request is subject to prior approval by the Division. The Contractor must provide to the Division the reason(s) justifying the additional calendar days needed to render a decision. The Division will evaluate the Contractor's extension request and notify the Contractor of its decision within of receiving the Contractor's request for extension.

The Contractor must expedite authorization for services when the Provider indicates or the Contractor determines that following the standard authorization decision time frame could seriously jeopardize the Member's life, health, or ability to attain, maintain, or regain maximum function. The Contractor must provide decision notice no later than twenty-four (24) hours after receipt of the expedited authorization request. This twenty-four (24) hour period may be extended up to fourteen (14) additional calendar days upon request of the Member, or the Provider, or if Contractor requests an extension from the Division. The extension request to the Division applies only after the Contractor has received all necessary medical information to render a decision and the Contractor requires additional calendar days to make a decision. The extension request must justify to the Division a need for additional information and explain how the extension is in the Member's best interest. Any such request is subject to Division approval. The Division will evaluate the Contractor's extension request and notify the Contractor of its decision within three (3) calendar days and/or two (2) business days of receiving the Contractor's request. The Contractor must justify to the Division a need for additional information and how the extension is in the Member's best interest. The extension request to the Division applies only after the Contractor has received all necessary medical information to render a decision and the Contractor requires additional calendar days to decide. The Contractor must provide to the Division the reason(s) justifying the additional calendar days needed to render a decision. The Division will evaluate the Contractor's extension request and notify the Contractor of its decision within three (3) calendar days and/or two (2) business days of receiving the Contractor's request for extension.

4.4 Additional Provisions Applying to All Members

4.4.1 Member Notification of Adverse Benefit Notifications

The Contractor shall provide Members written notice of an Adverse Benefit Determination consistent with 42 C.F.R. §§ 457.1230(d), 438.210(c), 438.404, and 438.10, and any other applicable Federal or State laws or regulations.

4.4.1.1 Required Explanations

The notice must explain the following:

1. The Adverse Benefit Determination the Contractor has made or intends to make;

2. The reasons for the Adverse Benefit Determination, including the right of the Member to be provided, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the Member's Adverse Benefit Determination. Such information includes medical necessity criteria, and any processes, strategies, or evidentiary standards used in setting coverage limits;

3. The Member's right to request an appeal of the Contractor's Adverse Benefit Determination, including information on exhausting the Contractor's one level of appeal described at 42 C.F.R. § 438.402(b) and the right to request a State Fair Hearing;

4. The procedures for exercising the rights specified in this subsection;

5. The circumstances under which an appeal process can be expedited and how to request an expedited appeal; and

6. For MississippiCAN Members only, the Member's right to have benefits continue pending resolution of the appeal, how to request that benefits be continued, and the circumstances under which the Member may be required to pay the costs of these services.

4.4.1.2 Timeframes

The notice(s) as described within this subsection must be mailed within the following timeframes:

1. For termination, suspension, or reduction of previously authorized covered services, within the timeframes specified in 42 C.F.R. §§ 431.211, 431.213, and 431.21;

2. For denial of payment, at the time of any action affecting the claim; and

3. For standard service authorization decisions that deny or limit services, within the timeframe specified in 42 C.F.R § 438.210(d)(1).

4.4.1.3 Exceptions from Advance Notice

Per 42 C.F.R. § 431.213, the Contractor may not give notice of an Adverse Benefit Determination later than date on which the Adverse Benefit Determination becomes effective when any of the following occur:

a. The Member has died;

b. The Member submits a signed written statement requesting service termination;

c. The Member submits a signed written statement including information that:

    1. Requires service termination or reduction of services, and

    2. The Member indicates that the Member understands that service termination or reduction will result;

d. The Member has been admitted to an institution in which he is ineligible for MississippiCAN and/or CHIP services (as applicable);

e. The Member's address is determined unknown based on returned mail with no forwarding address;

f. The Member is accepted for Medicaid or CHIP services (as applicable) by another local jurisdiction, state, territory, or commonwealth;

g. A change in the level of medical care is prescribed by the Member's physician;

h. The notice involves an adverse determination with regard to preadmission screening requirements; and

i. If applicable, the effective date of the Adverse Benefit Determination will occur in less than 10 days in accordance with 42 C.F.R. § 483.15(b)(4)(ii) and (b)(8) and 483.12(a)(5)(ii).

4.4.2 Telehealth

The Contractor will facilitate the administration of telehealth services as dictated by the Mississippi Administrative Code, Mississippi Division of Medicaid State Plan, and communications issued by the Division. The Contractor is responsible for ensuring constant compliance with the Division's policies and ensuring that Members have access to telehealth services as needed. The Contractor is also expected to develop its own innovative telehealth

plans and policies for Members and present them to the Division for approval within sixty (60) days of award of this Contract.

4.4.3 Advance Directives

The Contractor shall develop, document, and maintain written advance directive policies that comply with 42 C.F.R. § 422.128 and with the State's Uniform Health Care Decisions Act (Miss. Code Ann. § 41-41-201, *et seq*.). The Contractor is responsible for educating and training staff, individuals, and the community on policies and procedures as it relates to advance directives. Additionally, the Contractor shall provide adult and emancipated minor Members with written information on its advance directives policies. The Contractor shall inform the Members as to the implementation of those rights according to State law.

Any written information provided by the Contractor must reflect changes in State law as soon as possible, but no later than ninety (90) calendar days after the effective date of the change. The Contractor must also inform Members that Complaints and Grievances concerning non-compliance with the advance directive requirements may be filed with the State Survey and Certification Division of the State Department of Health. The Contractor shall have policies that include written information concerning the individual's rights to make decisions concerning medical care, to refuse or accept medical or surgical treatment, and to formulate advance directives, and provision for individual and community education about advance directives.

The Contractor is prohibited from conditioning the provision of care or otherwise discriminating against an individual based on whether the individual has executed an advance directive.

The Contractor must maintain written policies and procedures on advance directives for adults receiving medical care by or through the PAHP if the Contractor's Provider Network includes home health agencies, home health care providers, personal care providers, or hospice providers.

4.4.4 Pharmacy

4.4.4.1 Covered Outpatient Drugs

The Division will use a single Pharmacy Benefits Administrator (PBA) for the administration of Covered Outpatient Drugs benefits for MississippiCAN and CHIP Members. The PBA will be responsible for claims management and payment, prior authorization, and the pharmacy network for all Members. The Contractor is expected to cooperate with the PBA fully in all aspects of pharmacy administration. The PBA will share all Member claims with the Contractor for the purposes of Care Management and payment.

The Contractor must cover benefits for MississippiCAN and CHIP Members as dictated by each program's respective State Plan.

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.

4.4.4.2 PBA Payment

The PBA will submit a weekly invoice to the Contractor that the Contractor will pay with funds provided by the Division. The Contractor must make payments as directed by the Division to the PBA. The Contractor will establish a dedicated bank account for the purpose of receiving the funds and managing the payment of PBA invoices.

4.4.4.3 Care Management

The Contractor must utilize Member pharmacy claims data in all aspects of Care Management for all Members. Details regarding Care Management requirements are outlined in Section 7.

4.4.4.4 Delivery of Services

The Contractor must deliver pharmacy services and make services available as required by and in a manner approved by the Division.

4.4.5 Physician-Administered Drugs and Implantable Drug Systems

Physician-Administered Drugs and Implantable Drug Systems are covered under Physician Services and are therefore not subject to policies stated in Section 4.4.4, Pharmacy, of this Contract. The Contractor is responsible for providing Physician-Administered Drugs and Implantable Drug System Devices to Members enrolled in MississippiCAN as defined in the Mississippi Administrative Code, Title 23, Part 203 and to Members enrolled in CHIP as noted in 6.2.3(5) of the CHIP State Health Plan.

The Contractor shall ensure that 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 CMS. No payment may be made for services, procedures, devices, supplies or drugs which are still in clinical trials and/or investigative or experimental, cosmetic, or unproven in nature. The Contractor may consider exceptions to the criteria if there is sufficient documentation of stable therapy as reflected in ninety (90) calendar days of paid Medicaid claims.

4.4.6 Items Not Covered by the Contractor for Moral or Religious Reasons

If the Contractor elects not to reimburse for or provide coverage of a counseling or referral service because of an objection on moral or religious grounds, the Contractor must furnish information about the services it does not cover in accordance with 42 C.F.R. § 438.102(b):

1. To the Division with its application for a Medicaid contract or whenever the Contractor adopts the policy, if the policy is adopted during the term of the Contract;

2. Information must be consistent with the provisions of 42 C.F.R. § 438.10;

3. Information must be provided to potential Members before and during Enrollment; and

4. Information must be provided to Members at least thirty (30) calendar days prior to the effective date of the policy for any particular service.

In notices to Members regarding the Contractor's objections to coverage of a service or services under moral or religious grounds, the Contractor must also state the Member's right to Disenroll from the Contractor when the subject services needed are not covered by the Contractor and the methods by which the Member may Disenroll from the Contractor for this purpose, if so desired.

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5. Member Services

The Contractor must submit reports related to Member Services in accordance with Section 16, Reporting Requirements, of this Contract, and the MississippiCAN and CHIP Reporting Requirements Exhibit(incorporated as Exhibit H to this Contract). All services named must be available to MississippiCAN and CHIP Members unless otherwise noted in this section. The Contractor must also deliver all services stated in the State Plan, CHIP State Health Plan, Administrative Code, and state and federal regulations, as applicable.

5.1 Member Services Call Center

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. 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.

As part of its Member Services Call Center services, the Contractor must also maintain a 24-hour Behavioral Health/Substance Use Disorder line and a 24-Hour Nurse Advice line, further details of which are included in this section.

5.1.1 Automatic Call Distribution

The Contractor shall operate an automatic call distribution (ACD) system. Callers shall be advised that calls are monitored and recorded for quality assurance purposes. The ACD and reporting system shall be able to record and aggregate the information so that the Contractor is able to produce reports as required in the MississippiCAN and CHIP Reporting Requirements, as well as any other reports requested by the Division.

The average hold time for a Member before speaking with a live representative must not exceed two (2) minutes.

5.1.2 Required Services

5.1.2.1 Language Assistance

Upon answer of the line, the ACD must ask the member if the Member requires assistance in a language other than English. Oral communication between the Contractor and a beneficiary shall be in a language the beneficiary understands. The Contractor shall employ English-speaking Call

Center staff. If the beneficiary's language is one other than English, the Contractor shall offer and, if accepted by the beneficiary, supply interpretive services.

5.1.2.2 Behavioral Health

After a Member is asked about the need for Language Assistance, the ACD must ask the Member if the Member is experiencing a Mental or Behavioral Health event, giving the Member the option to be routed directly to the Behavioral Health/Substance Use Disorder line.

5.1.2.3 Other Services

After Language Assistance and Mental and Behavioral Health Emergencies, the Member Line will offer assistance in the following areas:

1. 24-hour Behavioral Health/Substance Use Disorder;

2. 24-hour Nurse Advice;

3. Member Services, included but not limited to explaining the operation of the Contractor, connecting Members with PCPs, assistance with making appointments and obtaining services, explaining Members rights (including covered benefits) and, and identifying and making appropriate referrals to assist Members in resolving emergency Member issues;

4. Care Management, including but not limited to connecting Members with their Care Manager or Care Management Team and appropriately identifying and/or assisting Members who need Care Management referrals or wish to self-refer for Care Management;

5. Member Grievances and Appeals, including but not limited to assistance with lodging Grievances and filing of Appeals;

6. Member Fraud and Abuse, including but not limited to assistance to Members in making fraud and abuse referrals; and

7. For MississippCAN only, Member Transportation

5.1.3 Hours of Operation

5.1.3.1 24-Hour Lines

5.1.3.1.1 Behavioral Health/Substance Use Disorder

The Contractor must operate a Behavioral Health/Substance Use Disorder line twenty-four (24) hours, seven (7) days per week giving Members access to clinical personnel who act within the scope of their licensure to practice a Behavioral Health/Substance Use Disorder-related profession.

5.1.3.1.1 Nurse Advice

The Contractor must operate a Nurse Advice Line twenty-four (24) hours, seven (7) days per week giving Members access to clinical personnel who act within the scope of their licensure of practice to advise and triage Members.

5.1.3.2. All Other Calls

All other calls must be answered by live operators at minimum Monday through Friday, 7:00 a.m. to 8:00 p.m. Central Time Zone, including State holidays except for New Year's Day, Memorial Day, Independence Day, Labor Day, Thanksgiving Day, and Christmas Day. Calls placed during hours that the Call Center is not open shall receive a voice message, in English, stating the hours of operation and giving the Member the option to transfer to either the Behavioral Health/Substance Use Disorder Line or Nurse Advice Line, and also advising the caller to dial "911," if there is an emergency.

5.1.4 Customer Care

The Contractor must develop appropriate, interactive scripts for call center staff to use during initial outbound welcome calls to new Members and to respond to Member calls. These scripts are subject to Division approval prior to use. The Contractor's call center staff must also use a Division-approved script to respond to Members who call to request assistance with PCP selection. The Contractor must develop special scripts for emergency and unusual situations, as requested by the Division.

All scripts must be clear and easily understood. The Contractor must review the scripts annually to determine any necessary revisions. Scripts must be written in such a manner as to adequately address limited English proficiency, diverse cultural and ethnic backgrounds, disabilities, and regardless of race, color, religion, sex, sexual orientation, gender identity, disability, national origin, limited English proficiency, marital status, political affiliation, or level of income. The Division reserves the right to request call center scripts at any time. All call center scripts must be submitted by Contractor to the Division for review and approval thirty (30) calendar days prior to use.

Under no circumstances will unlicensed Member services staff provide health-related advice to Members requesting clinical information. In such cases, these calls must be immediately

transferred to clinical personnel. The Contractor must ensure that all such inquiries are addressed by clinical personnel acting within the scope of their licensure to practice a health- related profession.

The Contractor's internal staff is required to ask the callers whether they are satisfied with the response given to their call. All calls must be documented, and if the caller is not satisfied, the Contractor must ensure that the call is referred to the appropriate individual within the Contractor for follow-up and/or resolution. This referral must take place within forty-eight (48) hours of the call.

5.1.5 Staff Training

The Contractor's Member services call center staff must receive trainings at least quarterly. Trainings must include education about Medicaid, MississippiCAN, and CHIP; appropriate instances for transferring a MississippiCAN or CHIP Member to a Care Manager, the Behavioral Health/Substance Abuse line, or the Nurse Advice line; redirecting pharmacy-related calls to the Division PBA call center; customer service, including but not limited to how to interact with Members in a culturally appropriate manner, keeping in mind health equity and possible implicit bias. Staff must receive updates about continued Medicaid changes and requirements, including "Late Breaking News" articles; Provider Bulletins; State Plan Amendments, CHIP State Health Plan Amendments, and Administrative Code Filings; Provider Billing Handbook; and MississippiCAN and CHIP updates. The Contractor will submit quarterly reports detailing the trainings conducted, topics covered, and the number and positions of staff completing the trainings.

5.1.6 Additional Call Center Sufficiency Standards

1. The ACD must answer all calls within one (1) ring;

2. The average monthly speed to answer after the initial automatic voice response is one hundred and twenty (120) seconds or less;

3. The average monthly abandonment rate is no more than four percent (4%);

4. Appropriate number of qualified staff are available on-site to ensure on a monthly basis the Call Center Sufficiency Standards are met;

    a. The Contractor shall submit to the Division a monthly deliverable report which includes the Call Center staffing to call ratio. The report shall include recommendations by the Contractor to the Division regarding appropriate staffing based on Call Center Sufficiency Standards.

b. The Division may require the Contractor to increase the number of available on-site staff at no charge to the Division based on noncompliance with Call Center Sufficiency Standards.

5. Qualified staff are available on-site to communicate with callers who speak English, and an interpreter telephone service, or other proposed method, is available for callers who speak other languages;

6. All reporting criteria as required by the Division is captured and met;

7. The Contractor shall randomly select, and record calls received at the call center and monitor no less than three percent (3%) of calls for compliance with customer care guidelines. The Contractor will report the findings of these audits to the Division via a quarterly Deliverable report. The Contractor will make recordings available to the Division upon request within five (5) business days. The Contractor shall maintain the recordings for at least six (6) months.

8. In the event of a power failure or outage, the Contractor shall have a back-up system capable of operating the telephone system for a minimum of eight (8) hours, at full capacity, with no interruption of data collection identified in this bid. The Contractor shall notify DOM immediately when its phone system is on an alternative power source or is inoperative. Contractor shall have a manual back-up procedure to continue to take requests if the computer system is down. The Contractor shall submit the plan to the Division sixty (60) days prior to Operations Start Date and the plan must be approved by the Division prior to the Contractor commencing operations.

9. The Contractor shall maintain a monthly service level of answering no less than 85 percent (85%) of all calls by representatives within the first 60 seconds of their delivery to the queuing system. Initial call resolution representatives will handle no less than 80 percent of the calls to completion during the initial contact with the representative. A call is considered resolved during the initial contact if it does not require a return call by a customer service representative.

5.2 Member Education

The Contractor must implement, monitor, and evaluate a program to promote health education for its new and continuing Members. The Contractor shall maintain an annual health education and prevention work plans for MississippiCAN and CHIP, based on the needs of its Members, and shall submit these work plans, with quarterly updates, to the Division for approval. The Division will work to review and approve work plan and quarterly updates within thirty (30) calendar days.

At a minimum, the health education and prevention work plan shall describe topics to be addressed, the method of communication with Members, the method of identifying those Members who will be contacted, and the time frames for distributing materials or outreach to Members. Any changes to the health education and prevention work plan, and all materials to be distributed to Members, must be approved by the Division prior to implementation or distribution. The comprehensive health education program shall support and complement the Contractor's Care Management programs.

The Contractor shall conduct, in collaboration with the Division, a minimum of ten (10) workshops targeting MississippiCAN members and ten (10) workshops targeting CHIP members. By January 1 of each year, the Contractor must propose to the Division dates, times, locations, topics, and content for workshops. Collaboration with other Contractors is both allowed and encouraged. At least half of the Contractor's proposed Member trainings should target Members with specific conditions that are identified by the Division. The Division will have final approval of all dates, times, locations, topics, and content.

5.3 Member Identification Card

The Contractor shall provide each Member an identification card that is recognizable and acceptable to the Contractor's network Providers. The Contractor may only issue one (1) identification card for all covered benefits. The Contractor's identification card will include, at a minimum:

1. The name of the Member,
2. The Mississippi Medicaid or CHIP (as applicable) identification number;
3. The name and address of the Contractor,
4. The name of the Member's PCP (if PCP name is available),
5. A telephone number to be used to access after-hours non-emergency care,
6. Instructions on what to do in an emergency,
7. Cost sharing and cumulative maximum out-of-pocked amounts (as applicable),
8. The Member Services Call Center phone number;
9. A Contractor identification number, if applicable; and

10. BIN/PCN of the Division PBA.

The Contractor must submit and receive approval of the identification card from the Division at least fifteen (15) calendar days prior to production of the cards.

The Contractor shall provide each Member an identification card within fourteen (14) calendar days after the Contractor receives notice of the Member's Enrollment. The Contractor must mail all Member identification cards, utilizing at least standard mail, in envelopes marked with the phrase "Return Services Requested."

In cases of returned Member identification cards, the Contractor must attempt to contact the Member to verify the Member's address. The Contractor shall be innovative and employ creative techniques to contact Members with returned Member identification cards and identify valid addresses for these Members. The Contractor must submit its policy for verification of addresses to the Division for approval within sixty (60) days of award of the Contract.

On a monthly basis, the Contractor shall provide the Division the date and the number of identification cards mailed to new Members each month, as well as the number returned, and methods used to deliver them.

5.4 Member Handbook

5.4.1 Member Handbook Generally

The Contractor must produce a handbook in compliance with applicable requirements from 42 C.F.R. § 457.1207 and 42 C.F.R. § 438.10 for each of the covered populations: MississippiCAN and CHIP. It is left to the Contractor's discretion as to whether it will produce separate physical handbooks for each population type or a combined physical handbook with separate sections for each population.

Within fourteen (14) days after the Contractor receives notice of the Member's Enrollment, the Contractor must provide the applicable Member Handbook to each Member along with a cover letter providing a summary of the contents of the Member Handbook. At least annually, the Contractor shall notify all Members of their right to request and obtain the information specified in the Member Handbook and in this Contract.

The Contractor shall submit a copy of the Member Handbook(s) to the Division for approval ninety (90) calendar days prior to distribution and as part of the Readiness Review process. With this submission, the Contractor must include the method(s) it will use to distribute the Member Handbook to Members. The Contractor must update the Member Handbook(s) at least annually, addressing changes in policies through submission of a cover letter to the Division identifying sections that have changed as well as an electronic redlined handbook showing before and after

language. The Contractor shall submit a copy of any changes to the Member Handbook(s) to the Division for approval no fewer than sixty (60) calendar days prior to distribution. Upon receipt of any changes to the initial handbook, the Division will work to review and approve any changes within sixty (60) calendar days. Any changes to content after printing shall be corrected through an addendum or subsequent printing mutually agreed upon between the Contractor and the Division.

The Contractor shall give each of its Members thirty (30) calendar days' written notice of any material change to MississippiCAN and/or CHIP before its intended effective date. If only one of the two populations are affected, then notifications are only required to the affected population. When there are changes to covered services, benefits, or the process that the Member should use to access benefits, (i.e., different than as explained in the Member Handbook), the Contractor shall ensure that affected Members are also notified of such changes at least thirty (30) calendar days prior to their implementation.

The Contractor must keep an updated copy of the applicable Member Handbook(s) in an accessible format on its website for each line of business covered by this Contract. If the Contractor has a combined Member Handbook, the same copy may appear on each website.

5.4.2 MississippiCAN Member Handbook Requirements

The Member Handbook must include at a minimum the following information:

1. Table of Contents.

2. Terms and conditions under which Member eligibility and coverage for Medicaid and MississippiCAN may be terminated.

3. A general description of covered services, including the appropriate utilization of services and eligibility determination process.

4. Description of populations who are eligible for MississippiCAN, including information about which populations have the option to disenroll and which may not disenroll, as well as a description of populations that are excluded from program participation.

5. Procedures to be followed if the Member wishes to change Contractors.

6. PCP roles and responsibilities in serving as a Patient-Centered Medical Home in directing care.

7. Information about choosing and changing PCPs.

8. Making appointments and accessing care, including but not limited to:

    a. Appointment-making procedures and appointment access standards;

    b. A description of how to access all services, including specialty care and authorization requirements;

    c. Any restrictions on the Member's freedom of choice among Network Providers;

    d. The extent to which, and how, Members may obtain benefits, including information about receiving care from Out-of-Network Providers and any referral requirements;

    e. Information about family planning services, including an explanation that there are no restrictions on the choice of Provider from whom the Member may receive family planning services and supplies and that each Member is free from coercion or mental pressure and free to choose the method of family planning to be used, in accordance with 42 C.F.R. § 441.20. The Contractor must comply with section 42 C.F.R 438.10(g)(2)(vii), which specifies that members cannot be required to obtain a referral prior to choosing a family planning provider; and

    f. The list of services, if any, not covered by the Contractor because of moral or religious objections and how to obtain information from the State about how to access those services not covered.

9. Member Services, including but not limited to:

    a. Instructions on how to contact the Member Services Call Center and a description of the functions of Member Services;

    b. A description of availability of and instructions on how to access clinical personnel who act within the scope of their licensure to practice medical and Behavioral Health/Substance Use Disorder-related profession twenty-four (24) hours, seven (7) days per week;

    c. A description of availability of and instructions on how to utilize the twenty- four (24) hours, seven (7) days per week nurse advice line;

    d. A description of EPSDT screenings and services and instructions advising Members about how to access such services;

e. A description of all available covered services, including inpatient services, behavioral health/substance use disorder, Patient-Centered Medical Home, Non-Emergency Transportation, dental, maternity, pharmacy (including but not limited to information about which generic and name brand medications are covered and information about what tier each medication is on), and preventive services, services available to children in foster care, if applicable, and an explanation of any service limitations, referral, and Prior Authorization requirements. This description should include that the Member may receive a minimum of a three (3)-day emergency supply for prior authorized drugs until authorization is completed;

f. A description of family planning services and how Members may obtain benefits from Out-of-Network Providers;

g. Information about the features of Care Management, how Members are assigned to a Care Management acuity category, the responsibilities of the Contractor for coordination of Member care, and the Member's role in the Care Management process;

h. Information about the Contractor's Transition of Care System;

i. Procedures for notifying Members of the termination or change in any benefits, services, or locations;

j. A description of the enhanced services the Contractor offers, if applicable;

k. A description of the Contractor's confidentiality policies;

l. An explanation of any service limitations or exclusions from coverage, including limitations that may apply to services obtained from Out-of-Network Providers;

m. A notice stating that the Member shall be liable only for those services subject to Prior Authorization and not authorized by the Contractor and non-covered services;

n. Circumstances under which an eligible Member may disenroll or be involuntarily disenrolled from the Contractor and/or MississippiCAN, including information as required by 42 C.F.R. § 438.10(f).

10. Instructions on reporting suspected cases of Fraud and Abuse to the Fraud and Abuse Hotline.

11. Member Grievances and Appeals:

    a. A description of the Grievance and Appeals procedures including but not limited to:

        i. The definition of a Grievance and Appeal and who may file each of these;

        ii. Information on filing Grievances and Appeal procedures as specified in 42 C.F.R. §§ 438.400 through 438.424, with reference to the applicable portions of the Division's Administrative Code and an explanation of the ability to appeal to the Division after the Contractor's appeals process is exhausted;

        iii. Time frames to register and receive a response regarding a Grievance or Appeal with the Contractor and/or the Division as described in this Contract;

        iv. The availability of assistance in the filing process, including making available reasonable assistance in completing forms and taking other procedural steps, which includes, but is not limited to, providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability;

        v. The toll-free numbers that the Member can use to file a Grievance, or an Appeal by telephone, including numbers to register Grievances regarding Providers and the contractor; and

        vi. A description of the continuation of benefits process required by 42 C.F.R. § 438.420 and information describing how the Member may request continuation of benefits, as well as information on how the Member may be required to pay the cost of services furnished while the Appeal is pending if the final decision is adverse to the Member. In accordance with 42 C.F.R. § 438.420, the Contractor must continue the enrollee's benefits when all the following occur:

            a) The enrollee files the request for an appeal timely in accordance with 42 C.F.R. § 438.402(c)(1)(ii) a(c)(2)(ii);

            b) The appeal involves the termination, suspension, or reduction of previously authorized services;

            c) The services were ordered by an authorized provider;

            d) The period covered by the original authorization has not expired; and

e) The enrollee timely files for continuation of benefits.

12. Emergency Medical Care:

a. How to appropriately use Emergency Services and facilities, including a description of the services offered by the Member Services Call Center;

b. Explanation of the definition of an emergency using the "prudent layperson" standard as used in this Contract and in accordance with 42 C.F.R. § 438.114, a description of what to do in an emergency, instructions for obtaining advice on getting care in an emergency, and the fact that Prior Authorization is not required for Emergency Services. Members are to be instructed to use the emergency medical services available or to activate Emergency Services by dialing 911;

c. A description of how to obtain Emergency Transportation and other medically necessary transportation;

d. Availability in the Provider Directory of locations of any emergency settings and other locations at which Providers and hospitals furnish Emergency Services and Post-Stabilization Care Services covered herein;

e. Information indicating that Emergency Services are available without Prior Authorization and Out-of-Network Emergency Services are available without any financial penalty to the Member;

f. Information indicating that Members have a right to use any hospital or other setting for emergency care; and

g. Definition of and information regarding coverage of Post-Stabilization Care Services in accordance with 42 C.F.R. § 422.113(c).

13. Member Identification Cards:

a. A description of the information printed on the Member Identification Card;

b. A description of when and how to use the Member Identification Card; and

c. A description of how to obtain a replacement Member Identification Card.

14. Interpretation and Translation Services:

a. Information on how to access verbal interpretation services, free of charge, for any non-English language spoken [42 C.F.R. § 438.10(d)];

b. A multilingual notice that describes translation services that are available and provides instructions explaining how Members can access those translation services [42 C.F.R. § 438.10(d)]; and

c. Information on how to access the handbook in an alternative format for special needs individuals including, for example, individuals with visual impairments [42 C.F.R. § 438.10(d)].

15. Member Rights:

a. A description of Member rights and protections as specified in 42 C.F.R. § 438.100 and Section 5.10, Member Rights and Responsibilities, of this Contract as provided during Open Enrollment;

b. Information explaining that each Member is entitled to a copy of his or her Medical Records and instructions on how to request those records from the Contractor. [42 C.F.R. § 438.100(b)(2)(vi)],

c. Information about the Contractor's privacy policies; and

d. Information about the Contractor's compliance with Section 1557 of the PPACA.

16. Member Responsibilities:

a. A description of procedures to follow if:

i. The Member's family size changes;

ii. The Member moves out of state or has other address changes; and

iii. The Member obtains or has health coverage under another policy or there are changes to that coverage.

b. Actions the Member can make towards improving his or her own health, Member responsibilities, and any other information deemed essential by the Contractor;

c. Information about the process that Members and Providers must follow when requesting inpatient Prior Authorization and how to notify the Contractor of an inpatient admissions;

d. Information about advance directives such as living wills or durable powers of attorney, in accordance with 42 C.F.R. § 422.128 and the State's Uniform Health Care Decisions Act (Miss. Code Ann. § 41-41-201, et. seq); and

e. Information regarding the Member's repayment of capitation premium payments if enrollment is discontinued due to failure to report truthful or accurate information when applying for Medicaid.

17. Contractor Responsibilities:

a. Additional information that is available upon request, including information about the structure and operation of the Contractor;

b. Additional information about physician incentive plans as set forth in 42 C.F.R. § 438.3(i); and

c. Notification to the Member that the Division should be notified if the Member has another health insurance policy or Creditable Coverage, and that the Contractor will coordinate the payment of claims between the two (2) insurance plans.

5.4.3 CHIP Member Handbook Requirements

The CHIP Member handbook must include at a minimum the following information:

1. Table of Contents.

2. Terms and conditions under which Member eligibility and coverage for CHIP may be terminated.

3. A general description of covered services, including the appropriate utilization of services and eligibility determination process.

4. Description of populations eligible for CHIP, as well as a description of populations that are excluded from program participation.

5. Procedures to be followed if the Member wishes to change Contractors.

6. PCP roles and responsibilities in serving as a Patient-Centered Medical Home in directing

care.

7. Information about choosing and changing PCPs.

8. Making appointments and accessing care, including but not limited to:

   a. Appointment-making procedures and appointment access standards;

   b. A description of how to access all services including specialty care and authorization requirements;

   c. Any restrictions on the Member's freedom of choice among Network Providers;

   d. The extent to which, and how, Members may obtain benefits, including information about receiving care from Out-of-network Providers and any referral requirements;

   e. Information about family planning services, including an explanation that there are no restrictions on the choice of Provider from whom the Member may receive family planning services and supplies and that each Member is free from coercion or mental pressure and free to choose the method of family planning to be used, in accordance with 42 C.F.R. § 441.20. The Contractor must comply with section 42 C.F.R 438.10(g)(2)(vii), which specifies that members cannot be required to obtain a referral prior to choosing a family planning provider; and

   f. The list of services, if any, not covered by the Contractor because of moral or religious objections and how to obtain information from the State about how to access those services not covered.

9. Member Services, including but not limited to:

   a. Instructions on how to contact the Member Services Call Center and a description of the functions of Member Services;

   b. A description of availability of and instructions on how to access clinical personnel who act within the scope of their licensure to practice medical and Behavioral Health/Substance Use Disorder-related profession twenty-four (24) hours, seven (7) days per week;

   c. A description of availability of and instructions on how to utilize the twenty-four (24) hours, seven (7) days per week nurse advice line;

   d. A description of Well-Baby and Well-Child Care services and instructions advising Members about how to access such services;

   e. A description of all available covered services, including Behavioral Health/Substance Use Disorder, Patient-Centered Medical Home, dental, maternity,

pharmacy (including but not limited to information about which generic and name brand medications are covered and information about what tier each medication is on), and preventive services, and an explanation of any service limitations, referral, and Prior Authorization requirements. This description should include that the Member may receive a minimum of a three (3)-day emergency supply for prior authorized drugs until authorization is completed;

f. A description of family planning services and how Members may obtain benefits from Out-of-network Providers;

g. Information about the features of Care Management, how Members are assigned to a Care Management acuity category, the responsibilities of the Contractor for coordination of Member care, and the Member's role in the Care Management process;

h. Information about the Contractor's Transition of Care System;

i. Procedures for notifying Members of the termination or change in any benefits, services, or locations;

j. A description of the enhanced services the Contractor offers, if applicable;

k. A description of the Contractor's confidentiality policies;

l. An explanation of any service limitations or exclusions from coverage; including limitations that may apply to services obtained from Out-of-network Providers;

m. A notice stating that the Member shall be liable only for those services subject to Prior Authorization and not authorized by the Contractor and non-covered services;

n. Circumstances under which an eligible Member may be involuntarily disenrolled from the Contractor and enrolled into another Contractor, and/or from CHIP, including information required by 42 C.F.R. § 457.1207, cross-referencing to 42 C.F.R. § 438.10(f).

10. Instructions on reporting suspected cases of Fraud and Abuse to the Fraud and Abuse Hotline.

11. Member Grievances and Appeals

    a. A description of the Member Grievance and Appeals procedures including but not limited to:

        i. The definition of a Grievance and Appeal and who may file each of these;

ii. Information on filing Grievances and Appeal procedures Appeal procedures as specified in 42 C.F.R. §§ 438.400 through 438.424, with reference to the applicable portions of the Division's Administrative Code and an explanation of the ability to appeal to the Division after the Contractor's appeals process is exhausted;

iii. Time frames to register and receive a response regarding a Grievance or Appeal with the Contractor as described in this Contract;

iv. The availability of assistance in the filing process, including making available reasonable assistance in completing forms and taking other procedural steps, which includes, but is not limited to, providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability;
,

v. The toll-free numbers that the Member can use to file a Grievance or an Appeal by telephone, including numbers to register Grievances regarding Providers and the Contractor;

vi. A description of the continuation of Enrollment process required by 42 C.F.R. § 457.1170 and information describing how the Member may request continuation of Enrollment; and

vii. A description of the continuation of benefits process required by 42 C.F.R. § 438.420 and information describing how the Member may request continuation of benefits, as well as information on how the Member may be required to pay the cost of services furnished while the Appeal is pending if the final decision is adverse to the Member. In accordance with 42 C.F.R. § 438.420, the Contractor must continue the enrollee's benefits when all the following occur:

a) The enrollee files the request for an appeal timely in accordance with 42 C.F.R. § 438.402(c)(1)(ii) a(c)(2)(ii);

b) The appeal involves the termination, suspension, or reduction of previously authorized services;

c) The services were ordered by an authorized provider;

d) The period covered by the original authorization has not expired; and

e) The enrollee timely files for continuation of benefits.

12. Emergency Medical Care

a. How to appropriately use Emergency Services and facilities, including a description of the services offered by the Member Services Call Center;

b. Explanation of the definition of an emergency using the "prudent layperson" standard as defined by this Contract and in accordance with 42 C.F.R. § 438.114, a description of what to do in emergency, instructions for obtaining advice on getting care in an emergency, and the fact that Prior Authorization is not required for Emergency Services. Members are to be instructed to use the emergency medical services available or to activate Emergency Services by dialing 911;

c. A description of how to obtain Emergency Transportation and other medically necessary transportation;

d. Availability in the Provider directory of locations of any emergency settings and other locations at which Providers and hospitals furnish Emergency Services and Post-Stabilization Care Services covered herein;

e. Information indicating that Emergency Services are available without Prior Authorization and Out-of-Network Emergency Services are available without any financial penalty to the Member;

f. Information indicating that Members have a right to use any hospital or other setting for emergency care; and

g. Definition of and information regarding coverage of Post-Stabilization Care Services in accordance with 42 C.F.R. § 422.113(c).

13. Member Identification Cards

a. A description of the information printed on the Member Identification Card;

b. A description of when and how to use the Member Identification Card; and

c. A description of how to obtain a replacement Member Identification Card.

14. Interpretation and Translation Services

a. Information on how to access verbal interpretation services, free of charge, for any non-English language spoken [42 C.F.R. § 457.1207 cross-referencing to 42 C.F.R. § 438.10(d)];

b. A multilingual notice that describes translation services that are available and provides instructions explaining how Members can access those translation services [42 C.F.R. § 457.1207 cross-referencing to 42 C.F.R. § 438.10(d)]; and

c. Information on how to access the handbook in an alternative format for special needs individuals including, for example, individuals with visual impairments [42 C.F.R. §

457.1207 cross-referencing to 42 C.F.R. § 438.10(d)].

15. Member Rights

a. A description of Member rights and protections as specified in 42 C.F.R. § 457.1220, cross-referencing to 42 C.F.R. § 438.100, and Section 5.10, Member Rights and Responsibilities, of this Contract as provided during Open Enrollment;

b. Information explaining that each Member is entitled to a copy of his or her Medical Records and instructions on how to request those records from the Contractor. [42 C.F.R. § 438.100(b)(2)(vi)]; and

c. Information about the Contractor's privacy policies; and

d. Information about the Contractor's compliance with Section 1557 of the PPACA.

16. Member Responsibilities

a. A description of procedures to follow if:

i. The Member's family size changes;

ii. The Member moves out of state or has other address changes; and

iii. The Member obtains or has health coverage under another policy or there are changes to that coverage.

b. Actions the Member can make towards improving his or her own health, Member responsibilities, and any other information deemed essential by the Contractor;

c. Information about the process that Members and Providers must follow when requesting inpatient Prior Authorization and how to notify the Contractor of an inpatient admission;

d. Information about advance directives such as living wills or durable power of attorney, in accordance with 42 C.F.R. § 422.128 and the State's Uniform Health Care Decisions Act (Miss. Code Ann. § 41-41-201, et. seq).; and

e. Information regarding the Member's repayment of capitation premium payments if enrollment is discontinued due to failure to report truthful or accurate information when applying for CHIP;

17. Contractor Responsibilities

a. Additional information that is available upon request, including information about the structure and operation of the Contractor;

b. Additional information about physician incentive plans as set forth in 42 C.F.R. § 457.1201(h), cross-referencing to 42 C.F.R. § 438.6(i); and

c. Notification to the Member that the Division should be notified if the Member has another health insurance policy or Creditable Coverage.

18. A description of the Members subject to Co-Payments and Out-of-Pocket Maximums, the amount of the Co-Payments and Out-of-Pocket Maximums, the mechanism for Members to make Co-Payments for required charges, and a Provider's right to refuse service of Co-Payments are not paid by the Member.

5.5 Provider Directory

The Contractor must develop, regularly maintain, and make available a Provider Directory specific to each of the covered populations: MississippiCAN and CHIP. It is left to the Contractor's discretion as to whether it will produce separate directories for each population type or a combined directory with separate sections for each population.

The Provider Directories must include information for all types of Providers in the Contractor's network, including but not limited to PCPs, hospitals, specialists, Providers of ancillary services, behavioral health/substance use disorder facilities, and any other facilities or locations where a Member may receive services. The Contractor shall not include retail pharmacies from the Contractor's hard copy and web-based Provider Directories. In accordance with 42 C.F.R. § 438.10(h), the Provider Directory shall include but is not limited to the following information for all physicians, specialists, hospitals, behavioral health providers, and any other provider types covered under this Contract:

1. Provider's name as well as any group affiliation;
2. Street address(es);
3. Telephone number(s);
4. Web site URL, as appropriate;
5. Specialty, as appropriate;
6. Whether the provider will accept new enrollees;
7. The provider's cultural and linguistic capabilities, including languages (including American Sign Language) offered by the provider or a skilled medical interpreter at the provider's office, and whether the provider has completed cultural competence training;
8. Whether the provider's office/facility has accommodations for people with physical disabilities including offices, exam room(s) and equipment;

9. Whether the provider offers covered services via telehealth;

10. Identification of PCPs and PCP groups, specialists, hospitals, facilities, and Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) by area of the State;

11. Identification of any restrictions on the Member's freedom of choice among network providers;

12. Identification of Closed Panels (web-based version only);

13. Identification of hours of operation including identification of Providers with non-traditional hours (before 8 a.m. or after 5 p.m., Central Time Zone, or any weekend/holiday hours); and

14. The population type(s) served by the Provider, whether that is the MississippiCAN population, the CHIP population, or both.

The Contractor shall make available hard copy of all Provider directories in State Medicaid Regional Offices, the Contractors' offices, WIC offices, upon Member request, and other locations as directed by the Division, issuing updated directories on a quarterly basis.

The Contractor will implement and maintain a publicly accessible Provider Directory Application Programming Interface in compliance with the requirements of 42 C.F.R. § 431.70. The Contractor must also provide written notice to the Division within five (5) business days of a change to the Provider Network. The Contractor must establish a process to ensure the accuracy of electronically posted content, including a method to monitor and update changes in Provider information. The web-based Provider Directory must be updated within 30 calendar days from receiving updated information. The Contractor must perform monthly reviews of the web-based Provider Directory, subject to random monitoring by the Division to ensure complete and accurate entries. The Contractor must ensure that Members have information about how to access the web-based Provider Directory. The Contractor must also include fields in the web-based Provider Directory allowing Members to search the directory by population type, provider type, and location.

The online Provider Directory must also include the providers' credentials as available.

The Contractor must submit its Provider Directory template(s) to the Division at least sixty (60) days prior to use and before distribution to its Members if there are significant format changes to the directory template.

5.6 Communication Standards

All written material provided to Members or potential Members, including, but not limited to, all Marketing materials, plan booklets, descriptions and information, instructional materials, policies and procedures disclosures, notices and handbooks must meet requirements specified under 42 C.F.R. § 438.10, 45 C.F.R. Part 92, and the following requirements:

1. Documents are comprehensive yet written to meet a Flesch-Kincaid, or other Division-approved standard, total readability level at or below the sixth (6^{th}) grade level of reading comprehension. Materials must set forth the Flesch-Kincaid, or other approved standard, score and certify compliance with this standard. These requirements shall not apply to language that is mandated by Federal or State laws, regulations, or agencies.

2. Documents are available in the prevalent non-English languages in the State of Mississippi, which is defined as five percent (5%) of the Contractor's enrolled Members who speak a common, non-English language, in compliance with the Division's Limited English Proficiency Policy.

3. Documents contain font size no smaller than 12 point and are printed in a font that is clearly readable.

4. Documents can be easily made available in alternative formats and electronically by the Contractor and are available upon request and in an appropriate manner that takes into consideration the special needs of those who, for example, are visually limited, in accordance with 42 C.F.R. § 438.10(d)(6)(iii).

5. Documents include information on how to request auxiliary aids and services, including the provision of the materials in alternative formats written in a conspicuously-visible font size in compliance with 42 C.F.R. § 438.10(d).

Member information required under 42 C.F.R. § 438.10 may be provided electronically by the Contractor if all conditions established by 42 C.F.R. § 438.10(c)(6) are met.

All Enrollment, Disenrollment and educational documents and materials made available to Members by the Contractor must be submitted to the Division for review and approval sixty (60) calendar days prior to release, unless specified elsewhere in this Contract. The Contractor must review all materials on an annual basis and provide a list of these materials to the Division annually indicating the review date. If the Contractor revises these materials, the Contractor will submit the updated materials to the Division for review and approval highlighting and using a redlined format for changes. When requested Deliverables do not have a submission time frame

specified, the Contractor must meet the Division's required time frames for the submission of Deliverables in accordance with Section 16.15, Deliverables, of this Contract. In such cases, the Division will specify the time frame for submission of Deliverables. The Division will notify the Contractor of the time frame it will require for review of Deliverables.

The Contractor shall also make verbal interpretation services available free of charge to each Member for all non-English languages and shall institute a mechanism for all Members who do not speak English to communicate effectively with their PCP and with Contractor staff and Subcontractors. Verbal interpretation services must be available to ensure effective communication regarding treatment, medical history, or health education [42 C.F.R. § 438.10(d)]. The Contractor must provide auxiliary aids available upon request and as no cost to Members or potential enrollees. Such aids include by are not limited to Teletypewriter (TTY), Telecommunications Device for the Deaf (TDD), Video Phones (VP), or American Sign Language interpretation methods for the hearing impaired. Trained professionals shall be used when needed where technical, medical, or treatment information is to be discussed with the Member, family member of the Member, or a friend of the Member.

The Contractor shall notify Members that verbal interpretation services and interpretation services for the hearing impaired and vision-impaired are available and how to access those services.

The Contractor shall participate in the Division's efforts to promote the delivery of services in a culturally competent manner to all Members, including those with limited English proficiency, diverse cultural and ethnic backgrounds, and any conditions that can act as a barrier to delivery of services.

5.7 Additional Requirements for Communication with Contractor's Members

The Contractor shall submit all communication materials with its Members to the Division at least sixty (60) calendar days prior to the planned distribution and the Division must approve these materials before they are released.

All communication activities must fully comply with all relevant Federal and State laws, including, when applicable, the Health Insurance Portability and Accountability Act of 1996, Section 1557 of the Patient Protection and Affordable Care Act, the anti-kickback statute, and civil monetary penalties prohibiting inducements to Members. The Contractor may be subject to sanctions if it offers or gives something of value to a Member that the Contractor knows or should know is likely to influence the Member's selection of a particular provider, practitioner, or supplier of any item or service for which payment may be made, in whole or in part, by Medicaid. Additionally, the Contractor is prohibited from offering rebates or other cash

inducements of any sort to its Members, unless the Contractor has received prior written approval from the Division.

5.7.1 Allowable Contractor Communication Activities

The Contractor may engage in the following activities with the Division's prior approval:

1. Distribution of communication materials to Members pre-approved by the Division; and

2. The Contractor may offer non-cash incentives to its Members for the purposes of rewarding for compliance in immunizations, prenatal visits, participating in Care Management, or other behaviors as pre-approved by the Division. On a case-by-case basis, the Division may approve cash-value incentives upon request by the Contractor, and if adequately justified. The Contractor shall analyze Member data quarterly to conduct a Gap Analysis to identify gaps in care and areas to improve outcomes and make a quarterly report of that Gap Analysis to the Division, including a comparison of the Contractor's performance to targets defined by the Division. In that report, the Contractor must provide to the Division for approval information about the interventions the Contractor will employ to improve upon those gaps, including Member incentives the Contractor will provide to Members, and the expected impact of the incentives, along with a plan to evaluate the impact of those incentives. The Contractor is encouraged to use items that promote good health behavior, e.g., toothbrushes or immunization schedules. This incentive shall not be extended to any individual not yet enrolled in the Contractor. The Contractor must submit all incentive award packages to the Division for written approval at least sixty (60) calendar days prior to planned implementation.

5.7.2 Prohibited Communication Activities

The following are prohibited communication activities targeting Members under this Contract:

1. Engaging in any informational activities that could mislead, confuse, or defraud the Contractor's Members or misrepresent the Division;

2. No assertion or statement (whether written or verbal) that the Contractor is endorsed by the Centers for Medicare and Medicaid Services (CMS), Federal or State government, or similar entity.

5.8 Internet Presence

5.8.1 Internet Presence Generally

All internet-based communication activities must fully comply with all relevant Federal and State laws, including, when applicable, the Health Insurance Portability and Accountability Act of 1996, Section 1557 of the Patient Protection and Affordable Care Act, the anti-kickback statute, and civil monetary penalties prohibiting inducements to Members. The Contractor may be subject to sanctions if it offers or gives something of value to a Member that the Contractor knows or should know is likely to influence the Member's selection of a particular provider, practitioner, or supplier of any item or service for which payment may be made, in whole or in part, by Medicaid. Additionally, the Contractor is prohibited from offering rebates or other cash inducements of any sort to its Members, without prior written approval from the Division.

All internet-based platforms for communication must comply with marketing and communication policies and procedures, requirements for written materials described in this Contract, and must be consistent with applicable State and Federal laws.

Information provided via internet-based platforms must be in a readily accessible format and placed in a location on the Contractor's website that is prominent and easy to find. The information must be provided in a format that can be electronically retained and printed and must be consistent with all applicable content and language requirements. Members must be made aware that all information available via the Contractor's internet presence is available in paper form without charge upon request, and that such information will be provided by the plan to the Member within five (5) business days if such a request is made.

Prior to public release of any web- or internet-based platform being used by the Contractor, the Contractor must deliver to the Division an external penetration test and code analysis conducted via independent assessment. After release, the Contractor must conduct a monthly vulnerability assessment and send that assessment to the Division for review.

5.8.2 Websites

The Contractor shall develop, host, and maintain websites specific to each covered population type, MississippiCAN and CHIP, on unique, secure URLs specific to each program. The Contractor shall provide program-specific, up-to-date information about the Contractor's programs, Provider Network, Member services, Care Management information (including but not limited to contact information, risk category definitions, and ways for the Member to self-refer for Care Management), and Member and Provider Grievance and Appeals systems on a non-secure section of the website. The Contractor shall maintain coverage guidelines and billing instructions specific to the applicable program on a non-secure section of the applicable website in an easily identifiable location. Protected health information (PHI) shall be accessible only through a secure section of the websites that requires two-factor authentication.

The websites must take into consideration the Americans with Disabilities Act Standards for Accessible Design, Plain Language Guidelines, and Section 508 of the Rehabilitation Act of 1973, as amended by the Workforce Investment Act of 1998, and include a translation tool. The website shall also contain all notices required by law.

Each website must support the current version and immediate prior version of, at minimum, the following web browsers: Microsoft Edge, Mozilla FireFox, Google Chrome, and Safari.

Each website must include a tool to measure web portal analytics and statistics, including but not limited to website visits, unique visitors, visitor information, browser, devices, and page views. A comprehensive web portal usage report must be sent to the Division, Office of Coordinated Care, monthly and as requested.

Website design must be responsive to and accommodate for devices such as a mobile phone and tablet, and the website design and organization must be refreshed and updated upon the implementation of the Contract, and periodically thereafter, and upon request by the Division.

Each website must have a news section or an area to post important notices targeted for beneficiaries and providers on their respective web portal homepage. The Contractor must post information provided by Division to the news section within one (1) business day upon request and provide confirmation to the Division, Office of Coordinated Care, within three (3) business days of publication by providing in writing proof of the update, including the URL of the news post, if applicable.

Contractor shall submit proposed final web content pertinent to MississippiCAN and CHIP to the Division for review and approval sixty (60) calendar days prior to making the content available and as updated.

The Contractor shall submit website screenshots to the Division for review and approval prior to making the website available and when updated. Additionally, a live demonstration of the web portal is required prior to activation.

The Division must have secure, read-only access of both the Member Portal and the Provider Portal at all times.

5.8.3 Member Portal

The website shall have a secure Member Portal, requiring unique login credentials for each Member and two-factor authentication at login. The Contractor shall update the Member portal

regularly to ensure it is compliant with appropriate cybersecurity standards, as approved by the Division. PHI must only be accessible through the secure Member Portal.

The Contractor shall include access to the following:

1. A copy of the Member Handbook(s);
2. Information about Member rights and responsibilities;
3. The ability for the Member to download and print their Member Identification Card,
4. Details regarding the Grievances and Appeals process;
5. Social services information and resources, such as housing supports, food programs, etc.;
6. The capability for additional health information to be entered by the Member;
7. Consumer-friendly content that complies with Member education guidelines;
8. A function that connects the Member directly with the 24-hour Nurse Line;
9. A function that allows the Member to self-refer for Care Management;
10. The ability to search for providers by location and specialty;
11. Medical claims information such as lab and imaging results, medications, and key health appointments;
12. The ability for Members to submit questions and comments to the Contractor and for Members to receive responses through a secure communications system; and
13. Any other information or access to services as directed by the Division.

5.8.3.1 Member Portal Mobile Application

The Contractor shall provide a secure Mobile Application, requiring unique login credentials for each Member and adhering to all security requirements of the Member Portal, that acts as access to the secure Member's Portal. This application must be downloadable in GooglePlay, the Apple App Store, and any other commonly used mobile application platforms.

5.8.4 Provider Portal

The Contractor shall dedicate a section of its website to Provider services and is encouraged to promote the use of the Provider portal among Providers. The Provider Portal shall require unique login credentials for each Provider and two-factor authentication to login. The Contractor shall ensure that the Provider Portal is updated regularly to ensure it is compliant with appropriate cybersecurity standards, as approved by the Division.

At a minimum, the Contractor's Provider Portal must provide the following capabilities for Providers:

1. Ability to submit inquiries and receive responses;
2. Access to a copy of the Provider Manual;
3. Access to newsletters, updates, and Provider notices;
4. Access to a searchable Provider Directory;
5. Ability to link to the State's PDL;
6. Ability to submit Prior Authorization requests and view the status of such requests (e.g., approved, denied, pending);
7. Information about the process Providers must follow when requesting inpatient Prior Authorization;
8. Ability to submit, process, edit (only if original submission is in an electronic format), rebill, and adjudicate claims electronically; and
9. Ability to refer Members for Care Management services.

The Provider Portal must have the capability for Providers to submit questions and comments to the Contractor and for Providers to receive responses through a secure communications system.

5.8.5 Social Media

The Contractor may create a Social Media account(s) (e.g., Facebook or Twitter) for the covered programs as long as the account(s) are specific to each program and do not contain any references to any other line(s) of the Contractor's business.

If the Contractor chooses to use a dedicated Social Media account or accounts, the Contractor must abide by all requirements for communication, marketing, and dissemination of information that are outlined in this Contract.

If the Contractor receives a grievance via Social Media, the Contractor must inform the Member of the correct method to file the grievance with the Contractor and ensure that the Member has all information necessary to properly begin that process.

The Contractor must have staff assigned to the management of its Social Media account(s), and that staff must manage the Contractor's Social Media account(s) on a daily basis to monitor and manage Member communications.

On any of the Contractor's Social Media accounts associated with this Contract, the Contractor must post a disclaimer that posts made by the Contractor are the expressions of the Contractor solely and are not in any way representations made or endorsed by the Division.

5.9 Marketing

All marketing activities by the Contractor including, but not limited to, the Contractor's development of marketing materials such as written brochures and fact sheets, shall be in accordance with 42 C.F.R. § 438.104 for MississippiCAN, and 42 C.F.R. § 457.1224, cross-referencing 42 C.F.R. § 438.104, for CHIP.

Marketing plans and materials must be distributed to the Contractor's entire service area as indicated in this Contract. Marketing plans and materials shall not mislead, confuse, or defraud the Members or the Division. Specifically, the Contractor cannot make any assertion or statement, whether written or verbal, that the Member must enroll in the Contractor in order to obtain benefits or to not lose benefits or that the Contractor is endorsed by CMS, the Federal or State government, or similar entity. The Contractor shall submit all marketing materials to the Division sixty (60) calendar days prior to the planned distribution, and the Division must approve these materials before they are released.

The Contractor shall maintain procedures to log and resolve Marketing Complaints, including procedures that address the resolution of Complaints against the Contractor, its employees, affiliated providers, agents, or subcontractors. These procedures shall contain a provision that a Contractor employee outside the Marketing Department resolve or be involved in the resolution of marketing/customer service complaints. Marketing Complaints that cannot be satisfactorily resolved between the Contractor and the complainant must be referred to the Division for further investigation and resolution. The Contractor must also submit the Marketing Complaint tracking log to the Division on a quarterly basis. The Contractor must include any outstanding Marketing Complaints in the log, including Marketing Complaints that have been referred to the Division.

Marketing and promotional activities (including Provider promotional activities) must comply with all relevant Federal and State laws, including, when applicable, HIPAA, Section 1557 of the PPACA, the anti-kickback statute, and civil monetary penalties prohibiting inducements to Members. The Contractor will be subject to sanctions if it offers or gives something of value to a

Member that the Contractor knows or should know is likely to influence the Member's selection of a particular Provider, practitioner, or supplier of any item or service for which payment may be made, in whole or in part, by Medicaid. Additionally, the Contractor is prohibited from offering rebates or other cash inducements of any sort to potential Members of the Contractor.

5.9.1 Marketing Services

The Contractor shall:

1. Submit to the Division for prior written approval a work plan of planned Marketing activities annually;

2. Submit a log of all completed Marketing activities quarterly;

3. Submit all new and/or revised Marketing and informational materials or proposed changes to the Marketing work plan to the Division before their planned distribution or implementation (42 C.F.R. § 438.104). Upon receipt, the Division will specify the time frame for completing review. The Contractor may distribute Marketing materials to Medicaid beneficiaries where the Member is currently enrolled with the Contractor, assuming that the Division has approved the Marketing materials for distribution to Members;

4. Coordinate and submit to the Division all schedules, plans, and informational materials for community education, networking, and outreach programs. The Contractor shall submit the schedule to the Division at least two (2) weeks prior to any event and must be approved by the Division;

5. Certify that the Contractor's Privacy Official and compliance officers have determined that the materials are compliant with current requirements of HIPAA and Section1557 of the PPACA.

6. Assure that all Marketing and informational materials state the Flesch-Kincaid, or other approved standard, readability scores at or below sixth (6^{th}) grade reading level and certify compliance therewith; and

7. Be subject to liquidated damages, a fine, and/or sanctions if it conducts any Marketing activity that is not approved in writing by the Division (42 C.F.R. § 438.700).

5.9.2 Allowable Contractor Marketing Activities

The Contractor may engage in the following promotional activities with prior Division approval:

1. Notification to the public of the Contractor in general in an appropriate manner through appropriate media, throughout its Enrollment area;

2. Distribution of promotional materials pre-approved by the Division;

3. Pre-approved informational materials for media outlets including, but not limited to, television, radio, social media channels and newspaper dissemination;

4. Marketing and/or networking at community sites or other approved locations for name recognition, which must be prior approved by the Division;

5. Hosting or participating in health awareness events, community events, and health fairs, pre-approved by the Division, in which the Division also participates or provides observation of Contractor participation. Prior approved non-cash promotional items are permitted, but not for solicitation purposes. The Division will be responsible for supplying copies of the benefit charts, if distributed at such events.

5.9.3 Prohibited Marketing and Outreach Activities

The following are prohibited Marketing and outreach activities targeting prospective Members under this Contract:

1. Engaging in any informational or Marketing activities that could mislead, confuse, or defraud Members or misrepresent the Division (42 C.F.R. § 438.104);

2. Directly or indirectly, conducting door-to-door, telephonic, email, texting, or other "cold call" Marketing of Enrollment at residences and Provider sites, and events or venues of outreach targeting beneficiaries (42 C.F.R. § 438.104);

3. Sending direct mail;

4. Making home visits for Marketing or Enrollment;

5. Offering financial incentive, reward, gift, or opportunity to eligible Members as an inducement to enroll with the Contractor other than to offer the health care benefits from the Contractor pursuant to their contract or as permitted above;

6. Continuous, periodic Marketing activities to the same prospective Member (e.g., monthly or quarterly), as an inducement to enroll;

7. Accessing or using the Division eligibility database to identify and market itself to prospective Members or any other violation of confidentiality involving accessing, using, sharing or selling Member lists or lists of eligible beneficiaries with any other person or organization for any purpose other than the performance of the Contractor's obligations under this Contract;

8. Engaging in Marketing activities that target prospective Members on the basis of health status or future need for health care services, or that otherwise may discriminate against individuals eligible for health care services;

9. Contacting Members who disenroll from the Contractor by choice after the effective Disenrollment date except as required by this Contract or as part of a Division approved survey to determine reasons for Disenrollment;

10. Engaging in Marketing activities that seek to influence Enrollment or induce giving the Contractor the names of prospective Members in conjunction with the sale or offering of any private insurance (42 C.F.R. § 438.104);

11. No enrollment related activities may be conducted at any Marketing, community, or other event;

12. No educational or enrollment-related activities may be conducted at any offices of the Mississippi Department of Human Services, or the offices of any other public agency of the State of Mississippi, unless authorized in advance by the Division;

13. No assertion or statement (whether written or verbal) that the Contractor is endorsed by the Centers for Medicare and Medicaid Services (CMS); Federal or State government; the Mississippi Division of Medicaid; or any other similar entity (42 C.F.R. § 438.104); and

14. No assertion or statement that the Member must enroll with the Contractor to obtain or lose benefits (42 C.F.R. § 438.104).

5.10 Member Rights and Responsibilities

In accordance with 42 C.F.R. § 438.100, the Contractor shall have written policies and procedures regarding Member rights and shall ensure compliance of its staff and affiliated Providers with any applicable Federal and State laws that pertain to Member rights.

5.10.1 Member Rights

At a minimum, policies and procedures for Member rights must include the right to:

1. Receive information on the Contractor in which the Member is enrolled;

2. Receive information in an easily understood language and format in accordance with 42 C.F.R. § 438.10;

3. Be treated with respect and with due consideration for the Member's dignity and privacy, including all rights under HIPAA and Section 1557 of the PPACA;

4. Receive information on available treatment options and alternatives presented in a manner appropriate to the Member's condition and ability to understand;

5. Participate in decisions regarding his or her health care, including the right to refuse treatment;

6. Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation, as specified in other Federal regulations on the use of restraints and seclusion;

7. Request and receive a copy of his or her Medical Records and request that they be amended or corrected, as specified in 45 C.F.R. §§ 164.524 and 164.526;

8. Free exercise of rights and the exercise of those rights do not adversely affect the way the Contractor and its Providers treat the Member; and

9. Be furnished health care services in accordance with 42 C.F.R. § 438.206 through 438.210 for MississippiCAN Members, and 42 C.F.R. § 457.1230 for CHIP Members.

The written policies and procedures shall also address the responsibility of Members to pay for unauthorized health care services obtained from non-participating Providers and their right to know the procedures for obtaining authorization for such services. The Contractor shall also have policies addressing the responsibility of each Member to cooperate with those providing health care services by supplying information essential to the rendition of optimal care, following instructions and guidelines for care that they have agreed upon with those providing health care services, and showing courtesy and respect to Providers and staff. A written description of the rights and responsibilities of Members shall be included in the Member information materials provided to new Members. A copy of the Contractor's policies and procedures regarding Member rights and responsibilities shall be provided to all Network Providers and any Out-of-Network Providers to whom Members may be referred.

5.10.2 Member Protections

The Contractor agrees to protect Members from certain payment liabilities and not hold Members liable for:

1. Any debts of the Contractor if it should become insolvent;

2. Payment for services provided by the Contractor if the Contractor has not received payment from the State for the service(s), or if the Provider, under contract or other arrangement with the Contractor, fails to receive payment from the State or Contractor;

3. The payments to Providers that furnish covered services under a contract or other arrangement with the Contractor that are in excess of the amount that normally would be paid by the Member if the services had been received directly from the Contractor; and

4. The Contractor agrees to honor and be bound by Section 1128B(d)(1) of the Balanced Budget Act of 1997, which protects Members against balance billing by Subcontractors.

5.11 Member Grievances and Appeals

5.11.1 Requirements Applying to All Members

The Contractor shall provide Members as a part of the Member handbook(s) information on how they or their representative(s) can file a Grievance or an Appeal and the resolution process. The Contractor shall review Grievance and Appeal procedures at least annually for amending as needed, with the prior written approval of the Division, to improve the system and procedures.

The Division shall have the right to intercede on any Member's behalf at any time during the Contractor's Grievance and/or Appeal process whenever there is an indication from the Member, or, where applicable, authorized person, that a serious quality of care issue is not being addressed timely or appropriately. Additionally, the Member may be accompanied by a representative of the Member's choice to any proceedings.

Nothing in this Contract shall be construed as removing any legal rights of Members under State or Federal law, including the right to file judicial actions to enforce rights.

The Contractor shall use the definitions for Grievances and Appeals as set forth in this section and adhere to time frames required by this Contract and Federal and State requirements. Appeals may be submitted orally or in writing.

5.11.2 Requirements Applying to MississippiCAN

The Contractor shall draft and disseminate to Members, Providers, and Subcontractors a program-specific system and procedure that the Division has approved in writing for the receipt and adjudication of Grievances and Appeals or requests for a State Fair Hearing by Members. The Grievance and Appeal policies and procedures shall be in accordance with 42 C.F.R. Part 438, Subpart F and the State's Quality Strategy, with the modifications that are incorporated in the Contract and Exhibit D, Member Grievances and Appeals Process, of this Contract. The Contractor shall not modify the Grievance and Appeal procedure without the prior approval of the Division and shall provide the Division with a copy of the modification.

The Member information shall advise MississippiCAN Members of their right to file a request for a State Fair Hearing with the Division of Medicaid upon notification of the Contractor's Adverse Benefit Determination and after exhaustion of the Contractor's Appeals process of the Contractor's Adverse Benefit Determination. The Member must exhaust the Contractor-level Appeal procedure prior to requesting a State Fair Hearing with the Division. The Contractor will refer the Member and/or the Member's authorized representative to Title 23, Part 300 of the Mississippi Administrative Code for information pertaining to the Member's rights to a State Fair Hearing and the procedures necessary to execute a hearing request.

A MississippiCAN Member may make a written request for continuation of benefits within ten (10) calendar days of notice of Adverse Benefit Determination, pending the determination of a State Fair Hearing.

Should a State Fair Hearing result in the reversal of an Adverse Benefit Determination made by the Contractor, , the Contractor shall bear all costs associated with the hearing. These costs may include, but are not limited to, medical appropriateness reviews by the Division contracted Independent Physician Reviewers, hearing officer's fees, attorney's fees, and court reporter's fees..

Table 5.1 below and Exhibit D, Member Grievances and Appeals, of this Contract outline additional specific requirements pertaining to Grievances, Appeals, and State Fair Hearings.

Table 5.1 Summary of MississippiCAN Member Grievances and Appeals Requirements

Party	Action	Time Frame	Extensions Available
Grievance: An expression of dissatisfaction, regardless of whether identified by the Member as a "Grievance," received by any employee of the Contractor orally or in writing about any matter or aspect of the Contractor or its operation, other than a Contractor Adverse Benefit Determination as defined in this Contract. Grievances may include but are not limited to the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the enrollee's rights regardless of whether remedial action is requested. Grievance includes an enrollee's right to dispute an extension of time proposed by the Contractor, PIHP or PAHP to make an authorization decision.			
Member or Authorized Representative	File a Grievance	At any time after the Grievance has occurred.	
Contractor	Confirm receipt of Grievance in writing and expected date of resolution	Within five (5) calendar days of receipt of the Grievance	
Contractor	Resolve a Grievance	Within thirty (30) calendar days of the date the Contractor receives the Grievance or as expeditiously as the Member's health condition requires	Contractor may extend time frames by up to fourteen (14) calendar days in accordance with 42 C.F.R. § 438.408(c)
Appeal: A request for review to be performed by the Contractor of a Contractor's Adverse Benefit Determination related to a member. In the case of a Member, the Contractor Adverse Benefit Determination may include determinations on the health care services a Member believes the Member is entitled to receive, including delay in providing, arranging for, or approving the health care services (such that a delay would adversely affect the health of the Member).			
Member or Authorized Representative	File an Appeal	Within sixty (60) calendar days from the date on the Contractor's Adverse Benefit Determination	
Contractor	Confirm receipt of the Appeal in writing and expected date of resolution	Within ten (10) calendar days of receipt of the Appeal	

Party	Action	Time Frame	Extensions Available
Contractor	Resolve an Appeal	Within thirty (30) calendar days of the date the Contractor receives the Appeal or as expeditiously as the Member's health condition requires. No longer than seventy-two (72) hours after the Contractor receives the request for an Expedited Resolution of an Appeal	Contractor may extend time frames by up to fourteen (14) calendar days in accordance with 42 C.F.R. § 438.408(c)
State Fair Hearing: A hearing conducted by the Division of Medicaid or its Subcontractor in accordance with 42 C.F.R. § 438.408. Any Adverse Benefit Determination or Appeal that is not resolved wholly in favor of the Member by the Contractor may be Appealed by the Member or the Member's Authorized Representative to the Division for a State Fair Hearing conducted in accordance with 42 C.F.R. Part 431, Subpart E.			
Member or Authorized Representative	File a request for a State Fair Hearing	Within one hundred and twenty (120) calendar days from the date of the Contractor's notice of resolution.	

5.11.3 Requirements Applying to CHIP Members

The Contractor shall draft and disseminate to Members, Providers, and Subcontractors a program-specific system and procedure that the Division has been approved in writing for the receipt and adjudication of Grievances and Appeals or requests for an Independent External Review by Members. The Grievance and Appeal policies and procedures shall be in accordance with 42 C.F.R. Part 438, Subpart F, and the State's Quality Strategy, with the modifications that are incorporated in the Contract and Exhibit D, Member Grievances and Appeals Process, of this

Contract. The Contractor shall not modify the Grievance and Appeal procedure without the prior approval of the Division and shall provide the Division with a copy of the modification.

The Contractor shall provide Members as a part of the Member handbook, information on how they or their representative(s) can file a Grievance or an Appeal, and the resolution process. The Member information shall also advise Members of their right to file a request for an Independent External Review following the outcome of the Appeal to Contractor, upon notification of a Contractor Adverse Benefit Determination, subsequent to an Appeal of the Contractor Adverse Benefit Determination. The Member must exhaust all Contractor level Appeal procedures prior to requesting an Independent External Review.

Table 5.2 below and Exhibit D, Member Grievances and Appeals, of this Contract outline additional specific requirements pertaining to Grievances and Appeals.

Table 5.2 Summary of CHIP Member Grievances and Appeals Requirements

Party	Action	Time Frame	Extensions Available
Grievance: An expression of dissatisfaction, regardless of whether identified by the Member as a "Grievance," received by any employee of the Contractor orally or in writing about any matter or aspect of the Contractor or its operation, other than a Contractor Adverse Benefit Determination as defined in this Contract. Grievances may include but are not limited to the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the enrollee's rights regardless of whether remedial action is requested. Grievance includes an enrollee's right to dispute an extension of time proposed by the Contractor, PIHP or PAHP to make an authorization decision.			
Member or Authorized Representative	File a Grievance	At any time after the Grievance has occurred.	
Contractor	Confirm receipt of Grievance in writing and expected date of resolution	Within five (5) calendar days of receipt of the Grievance	
Contractor	Resolve a Grievance	Within thirty (30) calendar days of the date the Contractor receives the Grievance or as expeditiously as the Member's health condition requires	Contractor may extend time frames by up to fourteen (14) calendar days in accordance with 42 C.F.R. § 438.408(c)

Party	Action	Time Frame	Extensions Available
Appeal: A request for review to be performed by the Contractor of a Contractor's Adverse Benefit Determination related to a member. In the case of a Member, the Contractor Adverse Benefit Determination may include determinations on the health care services a Member believes the Member is entitled to receive, including delay in providing, arranging for, or approving the health care services (such that a delay would adversely affect the health of the Member).			
Member or Authorized Representative	File an Appeal	Within sixty (60) calendar days from the date on the Contractor's Adverse Benefit Determination	
Contractor	Confirm receipt of the Appeal in writing and expected date of resolution	Within ten (10) calendar days of receipt of the Appeal	
Contractor	Resolve an Appeal	Within thirty (30) calendar days of the date the Contractor receives the Appeal or as expeditiously as the Member's health condition requires. No longer than seventy-two (72) hours after the Contractor receives the request for an Expedited Resolution of an Appeal	Contractor may extend time frames by up to fourteen (14) calendar days in accordance with 42 C.F.R. § 438.408(c)
Independent External Review: A review of any Adverse Benefit Determination conducted by the State or a Contractor other than the Contractor responsible for the matter subject to external review. In accordance with 42 C.F.R. §457.1150.			

Party	Action	Time Frame	Extensions Available
Member or Authorized Representative	File a request for an Independent External Review	Within one hundred and twenty (120) calendar days from the date of the Contractor's notice of resolution.	

5.12 State Issues

State Issues regarding Members received by the Division and forwarded to the Contractor must be acknowledged upon receipt. Action must be taken on the State Issue within seven (7) days of receipt, and resolutions should be included in the Contractor's Grievance and Appeals reporting.

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MISSISSIPPI DIVISION OF MEDICAID

6. Provider Network

The Contractor must submit reports related to Provider Networks in accordance with Section 16, Reporting Requirements of this Contract, and the MississippiCAN and CHIP Reporting Requirements (Exhibit H), which are incorporated into this document via reference.

6.1 General Requirements

The Contractor and its Subcontractor or delegated vendors shall recruit and maintain a Provider Network for each population type, using Provider contracts as approved by the Division. The Contractor is responsible for ensuring network adequacy by identifying any coverage gaps and taking the necessary steps to recruit additional providers as needed to maintain a sufficient network. The Contractor must comply with federal regulations regarding Provider Network adequacy as stated in 42 C.F.R. §§ 438.68, 438.206, 438.207, 457.1218, 457.1230, and any other applicable federal regulations, and must comply with state regulations regarding reconsideration of inclusion per Miss. Code Ann. §§ 83-41-409; 83-9-6.

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 provides the items and services included in Section 4, Covered Services and Benefits, of this Contract. 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 more than thirty (30) miles or thirty (30) minutes from the beneficiaries home. If the Contractor cannot satisfy this standard for FQHC and RHC access at any time, the Contractor must allow its Members to seek care from non-network FQHCs and RHCs and shall reimburse these non-network FQHCs and RHCs at a rate no less than FQHCs and RHCs in network.

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.

The Contractor shall ensure that its network of Providers is adequate to guarantee access to all covered services, and that all Providers are verified by the Division or the Division's Credentialing Verification Organization, by using the provided data from the Division of Medicaid. The Contractor may not close their Provider Network for any Provider type without prior approval from the Division.

Pursuant to, 42 C.F.R. §438.610(d)(2), the Contractor shall not employ or contract with Providers excluded from participation in Federal health care programs under either Section 1128 or Section 1128A of the Social Security Act. The Contractor is prohibited from employing or contracting a Provider that has been excluded by the Division, other state Medicaid agencies, or other state CHIP.

6.2 Provider Network Requirements

6.2.1 Geographic Access Standards

In addition to maintaining in its network a sufficient number of Providers to provide all services to its Members, the Contractor shall meet the geographic access standards for all Members set forth in Table 6.1. The Division reserves the right to reevaluate, update, amend, or otherwise change these standards as needed.

Table 6.1. Geographic Access Standards

Provider Type	Urban	Rural
PCPs: Adult and Pediatric	Two (2) within fifteen (15) miles	Two (2) within thirty (30) miles
Hospitals	One (1) within thirty (30) minutes or thirty (30) miles	One within sixty (60) minutes or sixty (60) miles
Specialists: Adult and Pediatric	One (1) within thirty (30) minutes or thirty (30) miles	One within sixty (60) minutes or sixty (60) miles
General Dental Providers Adult and Pediatric	One (1) within thirty (30) minutes or thirty (30) miles	One within sixty (60) minutes or sixty (60) miles
Dental Subspecialty Providers	One (1) within thirty (30) minutes or thirty (30) miles	One within sixty (60) minutes or sixty (60) miles
Emergency Care Providers	One (1) within thirty (30) minutes or thirty (30) miles	One (1) within thirty (30) minutes or thirty (30) miles
Urgent Care Providers	One (1) within thirty (30) minutes or thirty (30) miles	Not Applicable
OB/GYN	One (1) within thirty (30) minutes or thirty (30) miles	One within sixty (60) minutes or sixty (60) miles
Behavioral Health Providers (Mental Health Providers and Substance Use Disorder) (Adult and Pediatric)	One (1) within thirty (30) minutes or thirty (30) miles	One within sixty (60) minutes or sixty (60) miles

Provider Type	Urban	Rural
Durable Medical Equipment Providers	One (1) within thirty (30) minutes or thirty (30) miles	One with sixty (60) minutes or sixty (60) miles
Dialysis Providers	One (1) within sixty (60) minutes or sixty (60) miles	One within ninety (90) minutes or ninety (90) miles

The Division shall specify the urban and rural designation of counties within Mississippi. Each listed travel time is the maximum amount of time it takes a Member, using usual travel means in a direct route to travel from their home to the Provider. The Division recognizes that Non-Emergency Transportation Providers may not always follow direct routes due to multiple passengers.

If the Contractor is unable to identify a sufficient number of Providers located within an area to meet the geographic access standards or is unable to identify a sufficient number of Providers within a Provider type or specialty, the Contractor will submit documentation to the Division verifying the lack of Providers and proof of best effort to identify such providers. The Division may approve exceptions to the geographic access standards in such cases.

The Contractor must pay for services covered under the Contract on an Out-of-Network basis for the Member if the Contractor's Provider Network is unable to provide such services within the geographic access standards. Services must be provided and paid for in an adequate and timely manner, as defined by the Division, for as long as the Contractor is unable to provide them.

The Contractor shall submit a Network Geographic Access Assessment (GeoAccess) Report on a quarterly basis to the Division demonstrating compliance with these requirements.

6.2.2 Accessibility

The Contractor shall have in its network the capacity to ensure that the appointment scheduling does not exceed those set forth in Table 6.2.

Table 6.2. Appointment Scheduling Time Frames

Type	Appointment Scheduling Timeframes
PCP (Well Care Visit)	Not to exceed thirty (30) calendar days
PCP (Routine Sick visit)	Not to exceed seven (7) calendar days with an Urgent Care visit schedule (see below); otherwise, not to exceed twenty-four (24) hours
PCP (Urgent Care visit)	Not to exceed twenty-four (24) hours
Specialists	Not to exceed forty-five (45) calendar days

Type	Appointment Scheduling Timeframes
Dental Providers (routine visits)	Not to exceed forty-five (45) calendar days
Dental Providers (Urgent Care)	Not to exceed forty-eight (48) hours
Behavioral Health/Substance Use Disorder Providers (routine visit)	Not to exceed fourteen (14) calendar days
Behavioral Health/Substance Use Disorder Providers (urgent visit)	Not to exceed twenty-four (24) hours
Behavioral Health/Substance Use Disorder Providers (post- discharge from an acute psychiatric hospital when the Contractor is aware of the Member's discharge)	Not to exceed seven (7) calendar days
Urgent Care Providers	Not to exceed twenty-four (24) hours
Emergency Providers	Immediately (twenty-four (24) hours a day, seven (7) days a week) and without Prior Authorization

Each network physician shall maintain hospital admitting privileges with a network hospital as required for the performance of the physician's practice or have a written agreement with a network physician who has hospital admitting privileges.

All network Providers must be accessible to Members and must maintain a reasonable schedule of operating hours. At least every six (6) months, the Contractor must conduct a review of the accessibility and availability of its Providers and take corrective action against those Providers who do not meet the accessibility and availability standards set forth by the Division in this Contract. The Contractor must include a health equity analysis in its assessment. The Contractor will submit the findings from this review in writing to the Division.

The Division shall have the right to periodically review the adequacy of service locations and hours of operation and will require corrective action to improve Member access to services.

Pursuant to 42 C.F.R. §438.206(c)(1)(ii), Contractor shall ensure that the network providers offer hours of operation that are no less than the hours of operation offered to commercial enrollees or comparable to Medicaid FFS, if the provider serves only Medicaid enrollees.

Pursuant to 42 C.F.R. §438.206(c)(1)(iii), Contractor shall make services included in this contract available 24 hours a day, 7 days a week, when medically necessary.

Pursuant to 42 C.F.R. §438.206(c)(1)(vi), Contractor shall take corrective action if there is a failure by a network provider to comply with the accessibility requirements of this section.

The Contractor shall also demonstrate that there are sufficient Indian Tribe, Tribal Organization, or Urban Indian Organization (I/T/U) providers in the network to ensure timely access to services under the Contract for Indian members who are eligible and have enrolled in a Contractor to receive services from such providers.

6.2.3 Direct Access to a Women's Health Specialist

The Contractor must provide Members requiring obstetric and/or gynecological care with direct access to a women's health specialist within the network for covered care necessary to provide routine and preventive health care services. This is in addition to the Member's designated source of primary care if the Member's PCP is not a women's health specialist.

6.2.4 Second Opinions

Upon request, the Contractor must provide for a second opinion from a Network Provider or arrange for the Member to obtain one outside the network from an Out- of-Network Provider, at no cost to the Member.

6.2.5 Patient-Centered Medical Homes

The Contractor shall develop an NCQA-recognized Patient-Centered Medical Home (PCMH) program in compliance with Miss. Code Ann. § 41-3-61 for each medium- and high-risk Member identified through the Health Risk Screening and Comprehensive Health Assessment. See Section 7.4.3, Assignment of Risk Levels, of this Contract for more guidance on Health Risk Screenings and Comprehensive Health Assessments. The Contractor will present its PCMH Strategy to the Division in writing within ninety (90) days of the Contract award, and it is subject to review and approval by the Division. The Contractor will revise its approach as requested by the Division and will submit any subsequent updates to the Division for approval.

Based on collaboration with the Division, the Division will define specific reporting requirements that may change as the initiative is implemented and will be listed in the MississippiCAN and CHIP Reporting Requirements (Exhibit H), which are incorporated into this Contract via reference, and/or the Mississippi Division of Medicaid Value-Based Purchasing Work Plan. The Division will notify the Contractor of new reporting requirements or any changes in reporting requirements in writing sixty (60) calendar days before the report containing the required information is due. PCMHs will be part of the Division's Value-Based Purchasing requirements, as further delineated in Section 8.8, Value-Based Purchasing. of this Contract. The Contractor's PCMH program should work alongside its Care Management System, as described in Section 7 of this Contract.

6.2.6 MississippiCAN EPSDT Providers

MississippiCAN EPSDT wellness (screening) services shall be administered in accordance with the Mississippi Administrative Code, the State Plan, and written communication from the Division to the Contractor. For CMS mandatory reporting purposes, including but not limited to CMS 416 reporting, EPSDT wellness (screening) services must be provided by enrolled Medicaid providers, including but not limited to the Mississippi State Department of Health, other public and private agencies, private physicians, Rural Health Clinics, comprehensive health clinics, public schools and/or public school districts certified by the Mississippi Department of Education, and similar agencies that provide various components of the EPSDT services that have signed an EPSDT-specific provider agreement with the Division. The Division will provide the Contractor with a list of qualified EPSDT providers monthly.

6.2.7 Family Planning

The Contractor shall demonstrate that its network includes sufficient family planning providers to ensure timely access to covered services, "sufficient" meaning that the Contractor can provide services to all Members within its service area within the timeframe of maximum number of days for an appointment.

6.2.8 Accessibility Considerations

The Contractor must ensure that Network Providers provide physical access, reasonable accommodations as defined by the Americans with Disabilities Act, and accessible equipment for Members with physical or mental disabilities. The Contractor must also ensure that Network Providers maintain language access plans and provide Members other meaningful access required by Section 1557 of the PPACA.

6.2.9 CHIP Direct Contracting with School Clinics and School-Based Providers

The Contractor shall contract with school-based Providers and clinics to serve CHIP Members. Any qualified school-based Provider or clinic willing to accept the Contractor's operating terms including but not limited to its schedule of fees, covered expenses, and utilization management requirements shall be allowed to participate as a Network Provider.

6.2.10 Indian Health Services

6.2.10.1 IHS Network Adequacy

In addition to the network adequacy requirements described in Section 6.2, Provider Network Requirements, of this Contract, the Contractor must demonstrate that there are sufficient Indian Health Care Providers (IHCPs) participating in the Contractor's provider network to ensure timely access to services available under the Contract from such providers for Indian enrollees

who are eligible to receive services. The Contractor shall pay Indian Health Care Providers for covered services provided to Indian Members who are eligible to receive services from such providers as described in 42 C.F.R. § 438.14 (and 42 C.F.R. § 457.1209, cross-referencing 42 C.F.R. § 438.14) and 42 C.F.R. § 440.90 as interpreted and enforced by CMS.

6.2.10.2 Out-of-Network Providers Permitted

The Contractor shall permit any Indian member who is enrolled with the Contractor and who is eligible to receive services from an Indian Health Care Primary Care Provider participating as a network provider to choose that IHCP as the Member's PCP, as long as that provider has the capacity to provide services.

Indian Members shall be permitted to obtain services covered under this Contract from Out-of-Network Indian Health Care Providers from whom the Member is otherwise eligible to receive such services.

6.2.10.3 Lack of IHCPs

If access to covered services cannot be ensured due to few or no Indian Health Care Providers, the Contractor will be considered to have met these requirements if:

1. Indian Members are permitted by the Contractor to access out-of-state Indian Health Care Providers; or

2. If this circumstance is deemed to be good cause for the Member to choose disenrollment from both the Contractor and MississippiCAN or CHIP in accordance with 42 C.F.R. § 438.56 (b) and (c) and 42 C.F.R. § 457.1212 (as applicable).

6.2.10.4 IHCP Payment Requirements

The Contractor must permit an Out-of-Network Indian Health Care Provider to refer an Indian enrollee to a network provider. The Contractor shall comply with the following Indian Health Care Provider payment requirements of 42 C.F.R. § 438.14(c) including, but not limited to:

1. When an Indian Health Care Provider is enrolled in Medicaid as a FQHC but not a participating provider of the Contractor, it must be paid an amount equal to the amount the Contractor would pay an FQHC that is a network provider but is not an Indian Health Care Provider, including any supplemental payment from the State to make up the difference between the amount the Contractor pays and what the Indian Health Care Provider FQHC would have received under Fee-for-Service.

2. When an Indian Health Care Provider is not enrolled in Medicaid as a FQHC, regardless of whether it participates in the Contractor's network or not, it has the right to receive its applicable encounter rate published annually in the Federal Register by the Indian Health Service, or in the absence of a published encounter rate, the amount it would receive if the services were provided under the State plan's Fee-for-Service payment methodology.

The Contractor will meet the requirements of Fee-for-Service timely payment for all Indian Tribe, Tribal Organization, or Urban Indian Organization (I/T/U) providers in its network, including the paying of ninety percent (90%) of all clean claims from practitioners (i.e., those who are in individual or group practice or who practice in shared health facilities) within thirty (30) calendar days of the date of receipt; and paying ninety-nine percent (99%)of all clean claims from practitioners (who are in individual or group practice or who practice in shared health facilities) within ninety (90) days of the date of receipt.

The Contractor must update its rates within fourteen (14) calendar days of any update to rates published in the Federal Register by the Indian Health Service. At all times, the Contractor must reimburse providers at the appropriate and most current rate for the date of service.

6.2.10.5 No Cost Sharing

The Contractor must exempt from all cost sharing any Indian who is currently receiving or has ever received an item or service furnished by an IHCP or through referral under contract health services.

6.2.11 Additional Requirements

The Contractor's Provider Network shall reflect, to the extent possible, the diversity of cultural and ethnic backgrounds of the population served, including those with limited English proficiency. The Contractor must also consider the expected utilization of services, given the characteristics and health care needs of the population.

The Contractor shall also not prohibit, or otherwise restrict, a health care professional acting within the lawful scope of practice, from advising or advocating on behalf of the Member who is his or her patient for the following:

1. The Member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered;

2. Any information the Member needs in order to decide among all relevant treatment options;

3. The risks, benefits, and consequences of treatment or non-treatment;

4. The Member's autonomy and right to participate in decisions regarding the Member's health care, including the right to refuse treatment, and to express preferences about future treatment decisions; or

5. The Member may be responsible for non-covered item(s) and/or service(s) only if the Provider ensures that written documentation in compliance with the Advance Beneficiary Notification (ABN) is received by the Member that an item(s) or service(s) rendered is a non-covered item and/or service(s) and that the Member will be financially responsible for the item(s) and/or service(s).

6.2.12 Hemophilia Treatment Centers (HTC)

The Affordable Care Act specifies that entities covered under section 340B(a)(4) of the Public Services Act, which includes federally recognized Hemophilia Treatment Centers (HTC), be designated as essential community providers and that designation requires that qualified health plan networks to include HTCs. HTCs with 340B programs integrate clinical and pharmacy services to provide comprehensive high-quality care to patients and closely monitor drug utilization, allowing for more changes in treatment and better management of treatment costs. The National Hemophilia Program administered by the Health Resources & Services (HRSA) provides grants that help establish and maintain regional networks of HTCs across the United States. These HTCs provide comprehensive services. The HTC in Mississippi is the Mississippi Center for Advanced Medicine. Therefore, the Contractor, as well as the Division of Medicaid (DOM) shall include the HTCs in their provider networks.

6.3 PCP Responsibilities

6.3.1 PCP Responsibilities Applicable to All Members

6.3.1.1 Specialists as PCPs

Members with disabling conditions, chronic illnesses, or child(ren) with special health care needs may request that their PCP be a specialist. Additionally, a Member's Care Manager may request that a Member's PCP be a specialist, based on the Care Manager's assessment. The designation of a specialist as a PCP must be pursuant to a treatment plan approved by the Contractor, in consultation with the PCP to which the Member is currently assigned, the Member and, as appropriate, the specialist. When possible, the specialist must be a Provider participating in the Contractor's network.

The specialist as a PCP must agree to provide or arrange for all primary care, including routine preventive care, and to provide those specialty medical services consistent with the Member's disabling condition, chronic illness, or special health care need in accordance with the Contractor's standards and within the scope of the specialty training and clinical expertise. To accommodate the full spectrum of care, a specialist acting as a PCP must also have admitting privileges at a hospital in the Contractor's network.

The Contractor shall have in place procedures for ensuring access to needed services for these Members. The Contractor shall grant requests for a specialist as PCP when it is in the best interest of the Member and to the extent reasonably feasible.

6.3.1.2 Care Management

Within sixty (60) days of award of the Contract, the Contractor must deliver to the Division its strategy to ensure that PCPs are interacting as often as possible with Care Management for the benefit of the Contractor's Members. In this strategy, the Contractor must include its methods for driving engagement, educating PCPs about Care Management and the Contractor's system, methods by which the PCPs can interact with the Care Management system, methods for addressing health equity concerns, and best practices to ensure engagement, as well as any other details of the Contractor's strategy. The Division will review the Contractor's strategy and create a baseline consolidated strategy for all Contractors under this Contract, entitled the Mississippi Division of Medicaid Consolidated PCP Care Management Engagement Strategy. The Division will also include in the MississippiCAN and CHIP Reporting Requirements (Exhibit H) reports that will measure adequacy and efficacy of PCP Care Management engagement along with distribution of the Division's Consolidated PCP Care Management Engagement Strategy.

Full details regarding Care Management requirements are in Section 7, Care Management.

6.3.1.3 PCPs and PCMH

A Member's PCP should also act as the Member's Patient-Centered Medical Home where possible. As part of its PCMH Strategy presentation required by 6.2.5., Patient-Centered Medical Homes, above, the Contractor should include any circumstances it foresees in which PCP and PCMH services should not generate from the same Provider.

6.3.2 PCP Responsibilities Specific to MississippiCAN

The Contractor shall require MississippiCAN PCPs to meet the following requirements:

1. PCPs who serve EPSDT-eligible Members and are qualified EPSDT providers in accordance with Section 4.1.3, EPSDT Services, of this Contract, are responsible for conducting EPSDT screens for all EPSDT-eligible Members on their Panel. Should the PCP be unable to conduct the necessary EPSDT screens, the PCP is responsible for

arranging to have the necessary EPSDT screens conducted by another network Provider and ensure that all relevant medical information, including the results of the EPSDT screens, are incorporated into the Member's PCP Medical Record.

2. PCPs currently enrolled as Mississippi Medicaid providers who have signed an EPSDT-specific provider agreement and serve EPSDT-eligible Members must report Member Encounter Data associated with EPSDT screens using a format approved by the Division to the Contractor within ninety (90) calendar days from the date of service.

3. PCPs are responsible for contacting new Members identified in the quarterly encounter lists sent by the Contractor that indicate who has not had an encounter during the first six (6) months of Enrollment. The Contractor must require the PCP to:

    a. Contact Members identified in the quarterly Encounter lists as not complying with EPSDT periodicity and immunization schedules for children;

    b. Identify to the Contractor any such Members who have not come into compliance with the EPSDT periodicity and immunization schedules within one (1) month of such notification to the site by the Contractor; and

    c. Document the reasons for noncompliance, where possible, and to document its efforts to bring the Member's care into compliance with the standards.

6.3.3 PCP Responsibilities Specific to CHIP

The Contractor shall require CHIP PCPs to meet the following requirements:

1. PCPs who serve Members under the age of nineteen (19) are responsible for conducting all Well-Baby and Well-Child Care services. Should the PCP be unable to conduct the necessary Well-Baby and Well-Child Care services screens, the PCP is responsible for arranging to have the necessary Well-Baby and Well-Child Care services screens conducted by another network Provider and ensure that all relevant medical information, including the results of the Well-Baby and Well-Child Care services screens, are incorporated into the Member's PCP Medical Record

2. PCPs who serve Members under the age of nineteen (19) report encounter data associated with Well-Baby and Well-Child Care services, using a format approved by the Division, to the Contractor within one hundred eighty (180) calendar days from the date of service.

3. PCPs are responsible for contacting new Members identified in the quarterly encounter

lists sent by the Contractor that indicate who has not had an encounter during the first six (6) months of Enrollment. The Contractor must require the PCP to:

a. Contact Members identified in the quarterly Encounter lists as not complying with Well-Baby, Well-Child Care, and immunization schedules for Children;

b. Identify to the Contractor any such Members who have not come into compliance with Well-Baby, Well-Child Care, and immunization schedules within one (1) month of such notification to the site by the Contractor; and

c. Document the reasons for noncompliance, where possible, and to document its efforts to bring the Member's care into compliance with the standards.

6.4 Provider Terminations

If a Member's PCP, PCMH, specialist, or other Provider is no longer available to the Member through the Contractor's network, the Contractor shall implement a Provider Termination Work Plan to ensure continuity and coordination of care and to assist the Member in selecting a network Provider.

6.4.1 Provider Termination Work Plan

Under every circumstance involving a Provider Termination, the Contractor must submit to the Division a Provider Termination Work Plan and supporting documentation. The Provider Termination Work Plan shall document work steps and due dates and shall include but not be limited to the following:

1. Provider Impact and Analysis, including a GeoAccess Report with the Provider to be terminated removed to demonstrate continued network adequacy after the Provider's termination;

2. Updated Provider Network and/or Provider Affiliation File;

3. Provider Notification of the Termination;

4. Member Impact and Analysis;

5. Member Notification of the Termination;

6. Member Transition and Continuity of Care;

7. Systems Changes;

8. Provider Directory Updates for the Division's Agent (include date when all updates will appear on Provider files);

9. Contractor Online Directory Updates;

10. Submission of Required Documents to the Division (Member notices for prior approval);

11. Submission of Final Member Notices to the Division;

12. Communication with the public related to the termination; and

13. Termination Retraction Plan, if necessary.

6.4.2 Termination by the Contractor

The Contractor must notify the Division in writing of its intent to terminate a Network Provider and services provided by a Network Provider (which includes but is not limited to a specialty unit within a facility and/or a large Provider group) sixty (60) calendar days prior to the effective date of the termination. At the discretion of the Division, the Contractor must submit a Provider Termination Work Plan and supporting documentation within ten (10) business days of the Contractor's notification to the Division of the termination and must provide weekly updates to this information. This work plan shall document works steps and due dates and, as applicable, may include, but is not limited to the submission of:

a. Provider Impact and Analysis;
b. Updated Provider Network and/or Provider Affiliation File;
c. Provider Notification of the Termination;
d. Member Impact and Analysis;
e. Member Notification of the Termination;
f. Member Transition and Continuity of Care;
g. Systems Changes;
h. Provider Directory Updates for the Division's Agent (include date when all updates will appear on Provider files);
i. Contractor Online Directory Updates;
j. Submission of Required Documents to the Division (Member notices for prior approval);
k. Submission of Final Member Notices to the Division;
l. Communication with the public related to the termination; and
m. Termination Retraction Plan, if necessary.

The Contractor shall also provide all additional background information regarding the Provider termination, including but not limited to a summary of the issues, reasons for the termination, any other requirement of 42 C.F.R. § 455.416 and information on negotiations or outreach between the Contractor and Provider. The Contractor shall provide any additional information regarding the Provider termination requested by the Division within two (2) business days of the request.

The Contractor must deny or revoke a Provider Agreement for cause for any reasons set forth in 42 C.F.R. §§ 455.416, 455.420, 457.935, 1001.1001, and Miss. Code Ann. § 43-13-121(7), or if the Provider's credentialling has been denied or revoked by the Credentialing Verification Organization

Unless the Provider is being terminated for cause, the Contractor must allow a Member to continue an ongoing course of treatment from the Provider for up to sixty (60) calendar days from the date of the letter sent by the Contractor notifying the Member of the termination or pending termination of the Provider, or for up to sixty (60) calendar days from the date of Provider termination, whichever is greater. A Member is considered to be receiving an ongoing course of treatment from a Provider under the following circumstances:

1. During the previous twelve (12) months, the Member was treated by the Provider for a condition that requires follow-up care or additional treatment or the services that have been prior authorized;

2. An adult Member with a previously scheduled appointment shall be determined to be in receipt of an ongoing course of treatment from the Provider, unless the appointment is for a well adult check-up;

3. Any MississippiCAN EPSDT-eligible Member with a previously scheduled appointment, including an appointment for well child care, shall be determined to be in receipt of an ongoing course of treatment from the Provider;

4. Any CHIP Member with a previously scheduled appointment, including an appointment for well child care, shall be determined to be in receipt of an ongoing course of treatment from the Provider; or

5. A Member who is pregnant may continue to receive care from the Provider that is being terminated through the completion of the Member's postpartum care.

The transitional period may be extended by the Contractor if the extension is determined to be clinically appropriate. The Contractor shall consult with the Member and the health care Provider in making the determination. The Contractor must review each request to continue an ongoing course of treatment and notify the Member of the decision as expeditiously as the Member's health condition requires, but no later than two (2) business days. If the Contractor determines that what the Member is requesting is not an ongoing course of treatment, the Contractor must issue the Member a denial notice.

The Contractor must also inform the Provider that to be eligible for payment for services provided to a Member after the Provider is terminated from the network, the Provider must agree to meet the same terms and conditions as participating Providers.

Failure of the Contractor to substantiate cause for termination, to provide Member access to care, or other reasons adversely affecting the program, may result in the Division's denial of the termination.

6.4.3 Termination by the Provider

If the Contractor is informed by a Provider that the Provider intends to no longer participate in the Contractor's Network, the Contractor shall provide notice to the Division in writing within two (2) business days after receiving notice from the Provider. The Contractor must make every reasonable effort to notify the Division sixty (60) calendar days prior to the date the Provider will no longer participate in the Contractor's network.

At the discretion of the Division, the Contractor must submit a Provider Termination Work Plan within ten (10) business days of the Contractor notifying the Division of the termination and must provide weekly status updates to the work plan.

6.4.4 Termination for Cause

The Contractor must terminate any provider (any individual or entity furnishing services to MississippiCAN or CHIP Members under Fee-for-Service or Coordinated Care arrangements) from participation in the Mississippi Coordinated Care program that has been terminated for cause by the Division. The Contractor must terminate the provider upon notification from the Division.

For cause may include but is not limited to termination for reasons based upon fraud, integrity, or quality. A termination for cause occurs when action has been taken to revoke a provider's billing privileges, a provider has exhausted all applicable appeal rights or timeline for appeal has expired, and there is no expectation on the part of the provider or the Division that the revocation is temporary.

The Contractor must notify the provider of its termination in writing. The notice must state the reason(s) for termination and the effective date. The Contractor must submit to the Division a copy of the provider's notification within twenty-four (24) hours of the termination. The Contractor must also submit to the Division proof that the Contractor has connected affected Members with a new, appropriate Provider within (10) business days of the Division's notice to the Contractor that the Provider must be terminated.

6.4.5 Member Notification

No matter the reason for the Provider's termination from the Contractor's Network, the Contractor must send written notice to Members who receive primary care from a Provider, who are treated on a regular basis by a provider, or who are affected by the loss of the Provider for other reasons. Notice to the Member must be provided by the later of thirty (30) calendar days prior to the effective date of the termination, or fifteen (15) calendar days after receipt or issuance of the termination notice. The written notice shall include information about selecting a new Provider, how a Member can continue using services during a transition period, and a date after which Members who are receiving an ongoing course of treatment cannot use the terminated Provider. The Contractor shall seek prior approval from the Division for Member notices.

6.5 Provider Credentialing and Qualifications

The Division utilizes a Centralized Credentialing Verification Program to simplify the Medicaid, MississippiCAN, and CHIP enrollment process for Providers and improve efficiencies by reducing administrative burden. The Provider must submit an electronic application and complete a Council for Affordable Quality Healthcare (CAQH) profile, including granting authorization and attesting to the CAQH information every 120 days, unless the provider's taxonomy is exempt from credentialing or the provider is credentialed through a Delegated Credentialing Entity contracted with DOM. The Division's Fiscal Agent and Credentialing Verification Organization (CVO) will process the Provider credentialing and re-credentialing information to apply for participation in MississippiCAN, and CHIP delivery systems and create a credentialing portfolio for review by the Credentialing committee. Contractor's Medical Director shall participate as a member of the Division's credentialing committee.
. The Contractor will not conduct separate credentialing and re-credentialing processes for the Division's lines of business and shall accept the credentialing and re-recredentialing determinations of the Division's Credentialing Committee. Additionally, the contractor shall not delay moving forward with the contracting process due to any required credentialing for any other lines of business. The Contractor cannot appeal the CVO's credentialing decision. However, the contractor will retain the authority as to which providers it will contract with for network adequacy. Only the Provider may appeal the CVO's credentialing decision, and that appeal must be made to the Division. The Contractor cannot require Providers to submit

supplemental or additional information for purposes of conducting a second credentialing process by the Contractor for Medicaid lines of business.

The Contractor shall coordinate with the Division's contracted Fiscal Agent to confirm the status of Providers who are requesting to enroll with the Contractor and to confirm recredentialing status.

The Contractor shall refer providers to the Fiscal Agent's website to complete the credentialing, re-credentialing, and provider data maintenance process prior to enrolling and/or during enrollment with the Contractor. The Contractor will refer all Providers who are not Medicaid providers and who are requesting to enroll to the Division's Fiscal Agent.

The Fiscal Agent and its CVO update the Provider Credentialing Portal and notify the Division of the Credentialing status. If Credentialing is successful, the CVO sends a file with all of the Provider's enrollment data to the Fiscal Agent to update the MES/MMIS to include the necessary Provider information. The Fiscal Agent will send the Provider a welcome letter and notify any MississippiCAN and/or CHIP Contractor in which the Provider has requested to also enroll.

The Contractor must ensure that all Network and Non-Network Providers are enrolled with the State as Medicaid providers consistent with the provider disclosure, screening, and enrollment requirements of 42 C.F.R. Part 455, subparts B and E. This provision does not require the Network Provider to render services to Fee-for-Service beneficiaries. All Contractor Network and Non-Network Providers must also be enrolled in the Mississippi Medicaid program using the same National Provider Identifier (NPI) numbers and Mississippi Medicaid Provider Numbers with active enrollment segments. Additionally, all Contractor Network and Non-Network Providers must be enrolled as Group or Individual providers consistent with enrollment with the Division. Contracted nurse practitioners acting as PCPs shall be held to the same requirements and standards as physicians acting at PCPs.
The Contractor shall maintain a file for each Provider. All required data for the Provider File will be transmitted from the Division to the contractor via a file transfer that will occur on regularly scheduled intervals as determined by the Division. The contractor shall load all provider extracts received from the Division of Medicaid and shall utilize the data contained therein to ensure compliance with all federal and state requirements.

The Contractor shall notify the Provider concerning approval or denial of the Provider's request to contract with the Contractor within seven (7) calendar days of receipt of the interface file from the DOM Fiscal Agent to the Contractor that contains the Provider's credentialing approval as well as an indicator the provider wishes to obtain in-network status with the Contractor. The Contractor will in no event take longer than twenty (21) calendar days from the date of notification from the Division to complete the contracting process and load the Provider

information into its claims processing system. However, any such days the contract is waiting for the Provider shall not count as part of the twenty-one (21) calendar days. It is the Contractor's responsibility to keep a record of the twenty-one (21) calendar day period should the Provider's lack of responsiveness be the cause of the delay.

Pursuant to Miss. Code Ann. §43-13-117(H)(6), effective July 1, 2022, no health maintenance organization, coordinated care organization, provider-sponsored health plan, or other organization paid for services on a capitated basis by the Division under any managed care program, or coordinated care program implemented by the Division, and under this section shall require its providers to be credentialed by the organization in order to receive reimbursement from the organization for MSCAN and /or MSCHIP lines of business, but those organizations shall recognize the credentialing or screening of the providers by the Division.

Contractor will be provided with a provider data extracts from the Division.

The Contractor must have signed contracts or participation agreements with the providers, in accordance with 42 C.F.R. § 438.214 and Mississippi Insurance Department Regulation 98-1. The Contractor must utilize a universal contracting process for MississippiCAN and/or MSCHIP Providers as established or approved by the Division. Provider must be contained within the provider data extracts as provided by DOM before final execution of the contract with the Provider.

The Contractor's policies and procedures must meet the requirements within 42 C.F.R.§ 438.12 and must not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment. The Contractor may not employ or contract with providers excluded from participation in Federal health care programs under either section 1128 or section 1128A of the Act.

The Contractor must verify that all Network Providers and any Out-of-network Providers to whom Members may be referred are enrolled with the State as Medicaid providers consistent with the provider disclosure, screening and enrollment requirements of 42 C.F.R. Part 455, subparts B and E and have in effect appropriate policies of malpractice insurance as may be required by the Contractor and the Division. This provision does not require the Network Provider to render services to fee-for-service beneficiaries.

All Contractor Network Providers for Medicaid lines of business must also be enrolled in the Mississippi Medicaid program using the same National Provider Identifier (NPI) numbers and Mississippi Medicaid Provider Numbers with active enrollment segments. Additionally, all Contractor Network Providers must be enrolled as Organization or Individual providers

consistent with enrollment with the Division. Contractor must ensure that all contracted nurse practitioners acting as PCPs shall be held to the same requirements and standards as physicians acting at PCPs. The Contractor may execute Network Provider agreements pending the outcome of the process in § 438.602 (b)(1), but must terminate a Network Provider immediately upon notification from the State that the Network Provider cannot be enrolled, or upon the expiration of one hundred and twenty (120) days after the start date of the provider agreement and notify affected enrollees.

In contracting with Providers, Contractor will abide by all applicable Federal regulations, including, but not limited to, 42 C.F.R. 438.608(b).

Contractor shall verify inclusion of Providers in the provider data extracts as provided by DOM. Pursuant to 42 C.F.R. 455.410, the Division will conduct all Provider screenings to include, but not be limited to the following databases: HHS-OIG's List of Excluded Individuals and Entities (LEIE), System of Award Management (SAM), CMS' Medicare Exclusion Databank (MED), State Board of Examiners, National Practitioner Data Bank (NPDB), Health Integrity and Protection Databank (HIPDB), and any State listings of excluded Providers.

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In the event the Contractor decides to deny a provider's a request to contract, the Contractor shall notify the Provider and the Division within seven (7) calendar days of the Provider request to contract either for program integrity-related reasons, due to limitations placed on the Provider's ability to participate for program integrity-related reasons, or the Contractor's decisions not to allow a Provider to participate in the network. .

Contractor will load Provider information into its claims processing system within () calendar days of provider contract approval.

The Contractor must submit reports as required in Section 16.2.1, Provider Services Reports, of this Contract.

6.6 Provider Agreements

The Contractor must have written agreements with a sufficient number of Providers to ensure Member access to all Medically Necessary Services covered by the MississippiCAN and CHIP, "sufficient" meaning that the Contractor has the ability to provide services to all Members within its service area within the timeframe of maximum number of days for an appointment and that

services can be furnished without compromising the quality of care. Insufficiency will be determined by the Division at its discretion.

Neither the Contractor, Subcontractor, nor representatives of Contractor shall provide false or misleading information to Providers in an attempt to recruit Providers for the Contractor's network. The Contractor must have written policies and procedures for the selection and retention of network providers.

The Contractor must ensure that all Members receiving inpatient and PRTF services are provided with a transition of care plan that includes outpatient follow-up and/or continuing treatment prior to discharge from the inpatient setting or PRTF. All provider agreements entered into after the effective date of this Contract must include provisions to this effect.

In all Provider agreements, the Contractor must comply with the requirements specified in 42 C.F.R. § 438.214 and Miss. Code Ann. § 83-41-409 (e). The Contractor's Provider agreements must include at least the following provisions:

1. A requirement that the Contractor must not exclude or terminate a Provider from participation in the Contractor's Provider Network because the Provider serves high-risk populations and/or specializes in conditions that require costly treatment, or due to the cost of care for one or more of the Provider's patients.

2. A requirement to ensure that Members are entitled to the full range of their health care Providers' opinions and counsel about the availability of Medically Necessary Services under the provisions of this Contract. Any contractual provisions, including gag clauses or rules, that restrict a health care Provider's ability to advise patients about medically necessary treatment options violate Federal law and regulations.

3. A requirement that the Contractor cannot prohibit or restrict a Provider acting within the lawful scope of practice from discussing Medically Necessary care and advising or advocating appropriate medical care with or on behalf of a Member including information regarding the nature of treatment options, risks of treatment, alternative treatments, or the availability of alternative therapies, consultation or tests that may be self-administered.

4. A requirement that the Contractor cannot prohibit or restrict a Provider acting within the lawful scope of practice from providing information the Member needs in order to decide among all relevant treatment options and the risks, benefits, and consequences of treatment or non-treatment.

5. A requirement that the Contractor cannot terminate a contract or employment with a Provider for filing a Grievance or Appeal on a Member's behalf.

6. A requirement securing cooperation with the QM and UM Program standards outlined in Section 8, Quality Management, of this Contract.

7. A requirement that PCPs comply with applicable requirements of Section 6.3, PCP Responsibilities, of this Contract.

8. A requirement that the Provider must provide the Contractor sixty-five (65) calendar days' notice prior to terminating its agreement with the Contractor for any reason.

9. A requirement that the Contractor include in all capitated Provider agreements a clause which requires that should the Provider terminate its agreement with the Contractor, for any reason, the Provider will provide services to the Members assigned to the Provider under the Contract up to the end of the month in which the effective date of termination falls.

10. A requirement that the Provider must comply with all applicable laws and regulations pertaining to the confidentiality of Member Medical Records, including obtaining any required written Member consents to disclose confidential Medical Records.

11. A requirement that the Provider comply with Section 1557 of the PPACA and all applicable civil rights laws.

12. A requirement that the Provider must make referrals for social, vocational, education or human services when a need for such service is identified and coordinate with the Member's Care Manager or Care Management Team when doing so. For more details, see Section 7, Care Management, of this Contract.

13. In the event the Contractor becomes insolvent or unable to pay the participating Provider, a requirement that the Provider shall not seek compensation for services rendered from the State, its officers, Agents, or employees, or the Members or their eligible dependents.

14. A requirement that the Provider must submit claims within one hundred eighty (180) calendar days from the date of service. Claims filed within the appropriate time frame but denied may be resubmitted to the Contractor within ninety (90) calendar days from the date of denial.

15. A requirement that the Provider must first seek relief through the Contractor's appeals process for any instances in which the Provider wishes to dispute a Contractor's refusal to renew a provider agreement, a Contractor's suspension or termination of the Provider, breach of contract, or any other action or determination by the Contractor with which the Provider disagrees, other than Claims Denials. The requirement must also state that if the Provider is dissatisfied with the outcome of matter(s) after the exhaustion of the Contractor's appeals process, the Provider must seek relief through the Division's Provider Appeals process as described in the Mississippi Administrative Code. If after the exhaustion of both the Contractor's and the Division's appeals processes the Provider is still dissatisfied, the provider may pursue post-hearing relief as described in the Mississippi Administrative Code.

16. A description of the Claims Denials procedure as required under Section 9.1.4, Claims Denials, of this Contract.

The Contractor may not enter into a Provider agreement that:

1. Prohibits the Provider from contracting with another Contractor,

2. Prohibits or penalizes the Contractor for contracting with other Providers, and/or

3. Requires a Provider who agrees to participate in MississippiCAN and/or CHIP to contract with the Contractor's other lines of business.

with the Contractor's other lines of business.

6.7 Provider Incentive Payment Programs

The Contractor may establish performance-based incentive programs for its Providers. The Contractor shall follow the requirements for developing Provider incentive payment programs within this section and subsections. The Contractor shall obtain the Division's approval prior to implementing any Provider incentive payment program and before making any changes to an approved incentive arrangement. The Division encourages creativity in designing incentive programs that encourage positive Enrolled Member engagement and health Outcomes tailored to issues prevalent among Enrolled Membership as identified by the Contractor. The Contractor shall provide information concerning its Provider incentive payment program plan, upon request, to its Enrolled Members and in any Marketing Materials in accordance with the disclosure requirements stipulated in federal regulations.

6.7.1 Information Regarding Provider Incentive Payment Programs

The Contractor shall make available, upon request, any physician incentive plans, defined as provider incentive payment programs within Section 6.7 and reported within the Exhibit C: Medical Loss Ratio (MLR) Requirements.

6.7.2 Provider Incentive Payment Program Contract Requirements

The Contractor's Provider incentive payment program contracts with network Providers shall:

a) Have a defined performance period that can be tied to the applicable MLR reporting period(s).

b) Be signed and dated by all appropriate parties prior to the commencement of the applicable performance period.

c) Include clearly-defined, objectively measurable, and well-documented clinical or quality improvement standards the provider must meet to receive the incentive payment.

d) Specify a dollar value or percentage of a verifiable dollar amount that can be clearly linked to successful completion of the metrics defined in the incentive payment contract; including a date of payment for the incentive.

e) Provide for similar provider incentive payment metrics, evaluation, and payment terms, regardless of whether the provider is a related or unrelated party.

See: 42 C.F.R. § 438.3(i)(3); 42 C.F.R. § 457.1201(h).

6.7.3 Provider Incentive Payment Program Documentation Requirements

The Contractor's Provider incentive payment programs shall:

a) Maintain detailed documentation to support the provider incentive payment programs and all requested data elements in accordance with the Division's instructions outlined in the Reporting Requirements (Exhibit H).

- Detailed documentation should include, but is not limited to:
  - Contracts
  - Provider incentive payment listings
  - Provider incentive payment calculations
  - Scorecards, including detail to demonstrate metrics are met and reconcile to payment terms within the calculations
  - Copy of paid checks or other disbursement documentation

- Estimates or anticipated payments
- Reconciliations to the general ledger

b) Prohibit the use of attestations from network providers as supporting documentation as this type of documentation is not acceptable.

c) Make Provider incentive payment program contracts and other supporting documentation as detailed in 6.7.3(a) available, upon request and at any routine frequency in accordance with the Division's instructions outlined in the Reporting Requirements Exhibit.

6.8 Medical Records

The Contractor shall ensure the maintenance of current, detailed, organized Medical Records by health care Providers for each Member sufficient to disclose the quality, quantity, appropriateness, and timeliness of Covered Services performed pursuant to this Contract. As described in 42 C.F.R. Part 456, Subparts C and D, Medical Record content must include, at a minimum for general acute-care hospitals and psychiatric hospitals:

1. Identification of the Member;
2. Physician name(s);
3. Date of admission and dates of application for and authorization of Medicaid benefits if application is made after admission;
4. The plan of care;
5. Initial and subsequent continued stay review dates;
6. Reasons and plan for continued stay if applicable;
7. Other supporting material the committee believes appropriate to include.
8. For non-psychiatric hospitals only;
    a. Date of operating room reservation; and
    b. Justification of emergency admission if applicable.

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Medical records shall be accessible and made available by Providers providing services to Members enrolled with the Contractor, and to the Division for purposes of Medical Record review. The Contractor shall follow applicable policies and procedures in accordance with Division Administrative Code. For any services billed by a Provider for which the medical record cannot be provided to support the services rendered, the Contractor is instructed to recoup the reimbursement paid to the Provider for those services.

6.9 Mainstreaming

The Contractor must ensure that network Providers do not intentionally segregate their Members in any way from other persons receiving services.

The Contractor must investigate Complaints regarding Providers and take affirmative action so that Members are provided covered services without regard to race, color, national origin, sex, sexual orientation, gender identity, disability, creed, religion, age, ancestry, marital status, language, health status, disease or pre-existing condition (including genetic information), anticipated need for health care or physical or behavioral/mental disorders, except where medically indicated. Examples of prohibited practices include but are not limited to the following:

1. Denying or not providing a Member any Medicaid- or CHIP-covered service (as applicable) or availability of a facility within the Contractor's network. Health care and treatment necessary to preserve life must be provided to all Members who are not permanently unconscious or who are not adult Members undergoing hospice care, except where a competent Member objects to such care on the Member's own behalf.

2. Subjecting a Member to segregated, separate, or different treatment, including a different place or time from that provided to other Members, public or private patients, in any manner related to the receipt of any Medicaid- or CHIP-covered service (as applicable), except where medically necessary.

3. The assignment of times or places for the provision of services on the basis of the race, color, national origin, sex, sexual orientation, gender identity, disability, creed, religion, age, ancestry, marital status, income status, program membership, language, health status, disease or pre-existing condition, anticipated need for health care or physical or mental disability of the Members to be served.

If the Contractor knowingly executes an agreement with a Provider with the intent of allowing or permitting the Provider to implement barriers to care (e.g., the terms of the Provider agreement are more restrictive than this Contract), the Contractor shall be in breach of this contract.

6.10 Provider Services

The Contractor must submit reports in accordance with Section 16.2.1, Provider Services Reports, of this Contract, and the MississippiCAN and CHIP Reporting Requirements Exhibit (Exhibit H), which are incorporated into this Contract via reference.

6.10.1 Provider Services Call Center

The Contractor must operate Provider services call center functions at a minimum during regular business hours (7:30 a.m. to 5:30 p.m. Central Time, Monday through Friday). Provider services functions include, but are not limited to, the following:

1. Assisting Providers with questions concerning Member eligibility status;
2. Assisting Providers with Contractor Prior Authorization and referral procedures;
3. Assisting Providers with claims payment procedures and handling Provider disputes and issues;
4. Handling Provider Grievances and Appeals;
5. Facilitating transfer of Member Medical Records among and between medical Providers, as necessary;
6. Educating Providers as to covered medical services, excluded medical services, and benefit limitations;
7. Providing to PCPs a monthly list of Members who are under their care, including identification of new and deleted Members. An explanation guide detailing use of the list must also be provided to PCPs;
8. Referring Providers to the Fraud and Abuse Hotline;
9. Developing a process to respond to Provider inquiries regarding current enrollment;
10. Coordinating the administration of Out-of-Network services and
11. Assisting Provider in escalating issue to Provider Representatives.

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.

The Contractor must develop appropriate, interactive scripts for call center staff to use when making outbound calls to Providers and to respond to Providers calls. The Contractor must develop special scripts for emergency and unusual situations, as requested by the Division. All scripts must be clear and easily understood. All scripts shall promote the use of the Contractor's web-based Provider portal. The Contractor must review the scripts annually to determine any necessary revisions. The Division reserves the right to request and review call center scripts at any time. All call center scripts must be submitted by the Contractor to the Division for review and approval sixty (60) calendar days prior to use.

The Contractor will review trends in calls in order to identify and resolve common issues among providers. The Contractor will provide a Call Trend report noting the most frequent categories of calls to the Division monthly. The Contractor shall review the call trend category each month and compare with the past six months reports to determine and remedy the reoccurring issue. Should the Division receive Provider communications that indicate a global issue that has not been addressed by the Contractor, then the Contractor must take steps to contact affected Providers and produce a global resolution within ten (10) business days of the receipt of the trend information from the Division.

The Contractor shall maintain a monthly service level of answering no less than 85 percent (85%) of all calls by representatives within the first 60 seconds of their delivery to the queuing system. Initial call resolution representatives will handle no less than 80 percent of the calls to completion during the initial contact with the representative. A call is considered resolved during the initial contact if it does not require a return call by a customer service representative.

6.10.1.1 Staff Training

The Contractor's Provider services call center staff must receive trainings at least quarterly. Trainings must include education about Medicaid, MississippiCAN, and CHIP. Staff must receive updates about continued Medicaid changes and requirements, including "Late Breaking News" articles; Provider Bulletins; State Plan Amendments, CHIP State Health Plan Amendments, and Administrative Code Filings; Provider Billing Handbook; and MississippiCAN and CHIP updates. The Contractor will submit quarterly reports detailing the trainings conducted, topics covered, and the number and positions of staff completing the trainings.

6.10.1.2 Additional Call Center Sufficiency Standards

1. The average monthly speed to answer after the initial automatic voice response is one hundred twenty (120) seconds or less;

2. The average monthly abandonment rate is no more than four percent (4%);

3. Appropriate number of qualified staff are available on-site to ensure on a monthly basis the Call Center Sufficiency Standards are met;

4. The Contractor shall submit to the Division a monthly deliverable report which includes the Call Center staffing to call ratio. The report shall include recommendations by the Contractor to the Division regarding appropriate staffing based on Call Center Sufficiency Standards.

5. The Division may require the Contractor to increase the number of available on-site staff at no charge to the Division based on noncompliance with Call Center Sufficiency Standards.

6. All reporting criteria as required by the Division is captured and met;

7. The Contractor shall randomly select, and record calls received at the call center and monitor no less than three percent (3%) of calls for compliance with customer care guidelines. The Contractor will report the findings of these audits to the Division via a quarterly Deliverable report. The Contractor will make recordings available to the Division upon request within five (5) business days. The Contractor shall maintain the recordings for at least twelve (12) months.

8. In the event of a power failure or outage, the Contractor shall have a back-up system capable of operating the telephone system for a minimum of eight (8) hours, at full capacity, with no interruption of data collection identified in this bid. The Contractor shall notify DOM immediately when its phone system is on an alternative power source or is inoperative. Contractor shall have a manual back-up procedure to continue to take requests if the computer system is down. The Contractor shall submit the plan to the Division sixty (60) days prior to Operations Start Date and the plan must be approved by the Division prior to the Contractor commencing operations.

6.10.2 Provider Manual

The Contractor must develop and maintain a manual for network Providers for MississippiCAN and CHIP. It is left to the Contractor's discretion as to whether it will produce separate manuals for each population type or a combined manual with separate sections. Copies of the Provider manual(s) must be distributed in a manner that makes them easily accessible to all participating

Providers, including provision of an electronic version through the web portal. The Provider manual(s) must be submitted to the Division for approval ninety (90) calendar days prior to implementation and must be approved by the Division prior to use.

The Provider manual(s) must be updated at least annually and submitted to the Division for approval. The Division may grant an exception to this annual requirement upon written request from the Contractor provided there are no major changes to the manual.

6.10.2.1 MississippiCAN Provider Manual

The Provider manual must include, at a minimum, the following information:

1. Introduction to MississippiCAN, which explains the Contractor's organization and administrative structure;

2. Description of the Care Management System and protocols;

3. Description of the role of a PCP (including the PCP's importance to the Care Management team) and Covered Services, including excluded services, co-payments, and benefit limitations;

4. Description of the role of a PCMH;

5. Emergency room utilization (appropriate and non-appropriate use of the emergency room);

6. Information about how Members may access specialists, including standing referrals and specialists as PCPs;

7. Contact information including: relevant telephone number(s), email address(es), and websites;

8. Contact follow-up responsibilities for missed appointments;

9. Information regarding written translation and verbal interpretation services for Members with Limited English Proficiency and alternate methods of communication for those requesting communication in alternate formats, and that said items are available at no cost;

10. Information about filing Provider disputes;

11. Prior authorization review and reconsideration, Grievance, Appeal, State Administrative Hearing information for Providers, and State Fair Hearing information for Members;

12. Member Grievance, Appeal, and State Fair Hearing procedures and timeframes as specified in 42 C.F.R. 438.400 through 42 C.F.R. 438.424 and described in Section 5.11 of this Contract, the Member's right to file Grievances and Appeals, the availability of assistance to the Member for filing Grievances and Appeals, and the Member's right to request a continuation of benefits;

13. Prior authorization clinical and technical criteria guidelines for all services requiring prior authorization;

14. Billing instructions, including claims submission time frame requirements and manual or invoice pricing requirements;

15. Provider performance expectations, including disclosure of quality management and utilization management criteria and processes;

16. Information about EPSDT screening requirements and EPSDT services;

17. Provider responsibility to follow up with Members who are not in compliance with the EPSDT screening requirements and EPSDT services;

18. A definition of "medically necessary" consistent with the language in this Contract;

19. Prior authorization requirements, including the requirement that a Member may receive a minimum of a three (3) day emergency supply for drugs requiring prior authorization until authorization is completed;

20. Information about Member privacy and confidentiality requirements;

21. Information about the process for communicating with the Contractor on limitations on Panel size;

22. Information about the process for contacting the Contractor regarding assignment of a Member to an alternate PCP/PCMH;

23. Explanation of the Division's requirements that the Contractor may not require the Provider to agree to non-exclusivity requirements nor to participate in the Contractor's other lines of business to participate in MississippiCAN; and

24. Description of information available through the Contractor's provider web portal and the process for accessing it.

6.10.2.2 CHIP Provider Manual

The CHIP Provider manual must include, at a minimum, the following information:

1. Introduction to CHIP, which explains the Contractor's organization and administrative structure;

2. Description of the Care Management System and protocols;

3. Description of the role of a PCP (including the PCP's importance to the Care Management team) and Covered Services, including excluded services, co-payments, and benefit limitations;

4. Description of the role of a PCMH;

5. Emergency room utilization (appropriate and non-appropriate use of the emergency room);

6. Information about how Members may access specialists, including standing referrals and specialists as PCPs;

7. Contact information including: relevant telephone number(s), email address(es), and websites;

8. Contact follow-up responsibilities for missed appointments;

9. Information regarding written translation and verbal interpretation services for Members with Limited English Proficiency and alternate methods of communication for those requesting communication in alternate formats, and that said items are available at no cost;

10. Information about filing Provider disputes;

11. Prior authorization review and reconsideration, Grievance, Appeal, State Administrative Hearing information for Providers and Independent External Review information for Members;

12. Member Grievance, Appeal, and Independent External Review procedures and timeframes as specified in 42 C.F.R. § 457.1150 and described in Section 5.11 of this Contract, the Member's right to file Grievances and Appeals, and the availability of assistance to the Member for filing Grievances and Appeals, and the Member's right to request a continuation of benefits;

13. Prior authorization clinical and technical criteria guidelines for all services requiring prior authorization;

14. Billing instructions, including claims submission time frame requirements and manual or invoice pricing requirements;

15. Provider performance expectations, including disclosure of quality management and utilization management criteria and processes;

16. Information about Well-Baby and Well-Child Care services, including Immunizations;

17. Provider responsibility to follow up with Members who are not in compliance with Well-Baby and Well-Child Care services in accordance with the ACIP Recommended Immunization Schedule;

18. A definition of "medically necessary" consistent with the language in this Contract;

19. Prior authorization requirements, including the requirement that a Member may receive a minimum of a three (3) day emergency supply for prior authorized drugs until authorization is completed;

20. Information about Member privacy and confidentiality requirements;

21. Information about the process for communicating with the Contractor on limitations on Panel size;

22. Information about the process for contacting the Contractor regarding assignment of a Member to an alternate PCP/PCMH;

23. Explanation of the Division's requirements that the Contractor may not require the Provider to agree to non-exclusivity requirements nor to participate in the Contractor's other lines of business to participate in CHIP; and

24. Description of the information available through the Contractor's web portal and the process for accessing it.

6.10.3 Provider Education and Training

6.10.3.1 MississippiCAN Provider Education and Training

The Contractor shall develop an education and training plan and materials for Contract providers and provide education and training to Contract providers and their staff regarding key requirements of this Contract. For MississippiCAN Providers, training must include information about EPSDT services, and for CHIP member, training must include Well-Baby and Well-Child Care services.

The Contractor shall develop and submit a Provider training manual and prospective training plan no later than sixty (60) days prior to the initial education and training for Providers prior to the implementation of this Contract.

6.10.3.1 Initial Training

The Contractor shall conduct initial education and training for Providers no later than thirty (30) days prior to implementation by this Contract. The Contractor shall conduct initial education and training to newly Contract Providers during at least thirty (30) calendar days prior to the start date of operations.

This initial education and training shall include but not be limited to:

1. An overview of the Mississippi Medicaid, CHIP and Coordinated Care programs;

2. Enrollment of MississippiCAN and CHIP Members and providers;

3. Service authorization requirements and processes;

4. The role and responsibilities of the Care Manager for Members;

5. The importance of ensuring health equity, addressing implicit bias, and maintaining cultural competency in the delivery of services;

6. Requirement to provide services in accordance with an approved Provider Customer Service Program including the amount, frequency, duration and scope of each service in accordance with the Member's service schedule;

7. The role and responsibilities of other Providers;

8. How to submit clean claims;

9. Information about abuse/neglect (which includes abuse, neglect and exploitation of Members who are adults and suspected brutality, abuse, or neglect of Members who are children), including how to assess risk for abuse/neglect, how to identify abuse/neglect, and how to report abuse/neglect to CPS and the Contractor;

10. Critical incident reporting and management for behavioral health Providers;

11. The Member grievance and appeal processes;

12. The Provider grievance and appeal processes; and

13. The process for and importance of making in-network referrals when practicable.

Additionally, for any Providers expected to provide care to children, the Contractor must also include training the following:

1. Social and emotional development;

2. Trauma-informed care;

3. Valid developmental screening instruments;

4. Identifying and referring developmental delays in young children;

5. Required documentation for reimbursement of EPSDT services; and

6. The schedule of recommended Well-Baby and Well-Child visits and screenings and related issues in its initial training for that Provider population.

No later than thirty (30) days after completion of the trainings, the Contractor will submit to the Division reports on the trainings conducted, topics covered, the number and positions of staff completing the trainings.

The 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.

6.10.3.2 Ongoing Provider Training

For a period of at least twelve (12) months following implementation in each county covered by this Contract, the Contractor shall conduct monthly education and training for Providers regarding claims submission and payment processes, which shall include but not be limited to an explanation of common claims submission errors and how to avoid those errors.

The Contractor shall provide training and technical assistance services for Primary Care Providers (PCPs) and behavioral health Providers to assist them in participating in Patient-Centered Medical Home (PCMH) program for Members who qualify for a PCMH.

The Contractor shall prepare Providers to proactively coordinate activities and improve relationships with other healthcare stakeholders.

The Contractor shall assist Providers in monitoring and improving performance on select adult and child quality measures.

The Contractor shall assist Providers in reducing avoidable utilization and decreasing unnecessary spend.

In order to effectively train Providers, the Contractor shall have a working knowledge of the Contractor tool and web portal and be able to communicate about the basic functionality of the tool and how it can be used to meet Provider Clinical Transformation goals.

The Contractor shall work collaboratively with the other CCOs in planning and executing the Large Format In-person Conferences/workshops and webinars. Each CCO shall be responsible for hosting/payment for a total of six (6) conferences throughout the year and an additional five (5) webinars. The conference sessions shall be non-duplicative material not otherwise covered in webinars.

All training sessions shall be recorded and posted on the Division's website for those Providers who are unable to attend.

The Contractor shall provide the Division with detailed notes on the proceedings of the trainings, including lists of attendees, discussions initiated by the audience, and frequently asked questions.

The Division shall approve the training session topics in writing prior to the training session content being developed and advertised to Providers. The Contractor must submit topics to the Division no later than ninety (90) days prior to the training session date.

The Contractor shall conduct live, hosted webinars with live question and answer sessions on a bi-monthly basis for Providers. The Contractor will coordinate with any other Mississippi Coordinated Care contractor(s) so that each contractor is responsible for the same number of

webinars each year. The Contractor shall collaborate with the other CCOs in planning an annual schedule for webinars. The webinars shall comply with the following requirements:

1. The webinars shall be non-duplicative, including material not otherwise covered in large format conferences;

2. The Contractors shall facilitate all aspects of the webinars including but not limited to, communicating to Providers, RSVPs, hosting the webinar platform, and content;

3. The Contractors shall track attendance and share the attendance data with the Division;

4. The content can be targeted to all Provider types;

5. All live webinars shall be recorded and posted on the Division's website for those Providers that are unable to attend, and the Division shall approve the webinar topics in writing prior to the webinar content being developed and advertised to Providers; and

6. The Contractors shall provide documented and routine education and training to Providers regarding proper billing.

The Contractor shall conduct ongoing Provider education, training, and technical assistance as deemed necessary by the Contractor and the Division in order to comply with this Contract. This shall include training and technical assistance in person-centered supports and compliance with this contract.

6.10.3.3 Provider Representatives

The Contractor shall implement policies to monitor and ensure compliance of Providers with the requirements of this Contract. The Contractor shall retain a proportional number of Provider Representatives to assist Providers. This number shall not be fewer than thirty (30), including Subcontractors. These Provider Representatives shall have appropriate training by the Contractor. These Provider Representatives shall assist Providers with claims, enrollment, credentialing, and all areas required for assistance. Provider Representatives are required to develop relationships with Providers located in their coverage area through regular contact. The Division shall reserve the right to modify or change the provider representative requirements during the term of the Contract.

6.10.3.4 Annual Review

The Contractor shall submit to the Division an Annual Review at the end of each calendar year of all Provider services and education, including the number of Provider complaints, issues, problems, technical assistance, and will include resolutions, timeliness of resolutions, and actual description of resolutions. The Annual Review shall also include all training conducted, specific

reasons for training, including Provider request or problem, and regularly scheduled training. Timeframes of resolution must be included. The Division will also contact various Providers who have contacted the state with concerns, including those Providers listed in the Annual Review.

6.11 Provider Grievance, Appeal, and State Administrative Hearing Process

The Contractor shall draft and disseminate to Providers and Subcontractors, a system and procedure, which has the prior written approval of the Division for the receipt and adjudication of Grievances and Appeals by Providers. The Grievance and Appeal policies and procedures shall be in accordance with the State's Quality Strategy, with the modifications that are incorporated in the Contract. The Contractor shall not modify the Grievance and Appeal procedure without the prior approval of the Division and shall provide the Division with a copy of the modification for review and approval at least sixty (60) days before the Contractor plans to implement the modification.

The Contractor shall review the Grievance and Appeal procedure at least annually for amending as needed, with the prior written approval of the Division, in order to improve said system and procedure.

The Division shall have the right to intercede on a Provider's behalf at any time during the Contractor's Grievance, and/or Appeal process whenever there is an indication from the Provider, or, where applicable, authorized person, that a serious quality of care issue is not being addressed timely or appropriately.

The Contractor shall provide Providers as a part of the Provider Manual information on how and when they or their representative(s) can file a Grievance or an Appeal, and the resolution process. The information shall also advise Providers of their right to file a request for a State Administrative Hearing with the Division of Medicaid, upon notification of a Contractor's decision with which the Provider disagrees, subsequent to an Appeal of the Contractor. The Provider must exhaust all Contractor-level Appeal procedures prior to requesting a State Administrative Hearing with the Division and must exhaust all Contractor and Division Appeal procedures before seeking relief through any other process.

Should a State Administrative Hearing result in the reversal of a decision with which the Provider disagrees made by the Contractor, the Contractor shall bear all costs associated with the hearing. These costs may include but are not limited to medical appropriateness reviews by the Division's contracted Independent Physician Reviewers, hearing officer's fees, attorney's fees, and court reporter's fees.

The Contractor shall use the definitions for Grievances and Appeals as set forth in this section and adhere to time frames required by this Contract and Federal regulations. Table 6.3 below outlines additional specific requirements pertaining to Grievances and Appeals.

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Table 6.3. Summary of MississippiCAN Provider Grievances and Appeals Requirements

Party	Action	Time Frame	Extensions Available
Grievance: An expression of dissatisfaction, regardless of whether identified by the Provider as a "Grievance," received by any employee of the Contractor orally or in writing about any matter or aspect of the Contractor or its operation, other than an Adverse Provider Determination as defined in this Contract.			
Provider	File a Grievance	Within thirty (30) calendar days of the date of the event causing the dissatisfaction	
Contractor	Confirm receipt of the Grievance in writing and expected date of resolution	Within five (5) calendar days of receipt of the Grievance	
Contractor	Resolve a Grievance	Within thirty (30) calendar days of the date the Contractor receives the Grievance	Contractor may extend time frames up to fourteen (14) calendar days
Appeal: A request to be performed for review by the Contractor of a Contractor Adverse Provider Determination related to a Provider. The Adverse Provider Determination may include, but is not limited to, for cause termination by the Contractor, or delay or non-payment for covered services.			
Provider	File an Appeal	Within thirty (30) calendar days of receiving the Contractor's notice of Adverse Provider Determination	
Contractor	Confirm receipt of the Appeal in writing and expected date of resolution	Within ten (10) calendar days of receipt of the Appeal	
Contractor	Resolve an Appeal	Within thirty (30) calendar days from the date on the Contractor receives the Appeal	Contractor may extend time frames by up to fourteen (14) calendar days
State Administrative Hearing: A hearing conducted by the Division of Medicaid or its Subcontractor. Appeal that is not resolved wholly in favor of the Provider by the Contractor may be appealed by the Provider or the Provider's authorized representative to the Division for a State Administrative Hearing.			
Provider	File a request for a State Administrative Hearing	Within thirty (30) calendar days of the final decision by the Contractor	

Table 6.4 Summary of CHIP Provider Grievances and Appeals Requirements

Party	Action	Time Frame	Extensions Available
Grievance: An expression of dissatisfaction, regardless of whether identified by the Provider as a "Grievance," received by any employee of the Contractor orally or in writing about any matter or aspect of the Contractor or its operation, other than an Adverse Provider Determination as defined in this Contract.			
Provider	File a Grievance	Within thirty (30) calendar days of the date of the event causing the dissatisfaction	
Contractor	Confirm receipt of Grievance in writing and expected date of resolution	Within five (5) calendar days of receipt of the Grievance	
Contractor	Resolve a Grievance	Within thirty (30) calendar days of the date the Contractor receives the Grievance	Contractor may extend time frames up to fourteen (14) calendar days
Appeal: A request to be performed for review by the Contractor of a Contractor Adverse Provider Determination related to a Provider. The Adverse Provider Determination may include, but is not limited to, for cause termination by the Contractor, or delay or non-payment for covered services.			
Provider	File an Appeal	Within thirty (30) calendar days from the date on the Contractor's Adverse Provider Determination	
Contractor	Confirm receipt of the Appeal in writing and expected date of resolution	Within ten (10) calendar days of receipt of the Appeal	
Contractor	Resolve an Appeal	Within thirty (30) calendar days from the date on the Contractor receives the Appeal	Contractor may extend time frames up to fourteen (14) calendar days
State Administrative Hearing: A hearing conducted by the Division of Medicaid or its Subcontractor. Appeal that is not resolved wholly in favor of the Provider by the Contractor may be appealed by the Provider or the Provider's authorized representative to the Division for a State Administrative Hearing.			

Party	Action	Time Frame	Extensions Available
Provider	File a request for a State Administrative Hearing	Within thirty (30) calendar days of the final decision by the Contractor	

Nothing in this Contract shall be construed as removing any legal rights of Providers under State or Federal law, including the right to file judicial actions to enforce rights.

6.12 State Issues

State Issues regarding Providers received by the Division and forwarded to the Contractor must be acknowledged upon receipt. Action must be taken on the State Issue within seven (7) days of receipt, and resolutions should be included in the Contractor's Grievance and Appeals reporting.

6.13 Provider Discrimination Prohibited

Pursuant to 42 C.F.R. § 438.12, the Contractor shall not discriminate against Providers with respect to participation, reimbursement, or indemnification for any Provider acting within the scope of that Provider's license or certification under applicable State law or regulation solely on the basis of the Provider's license or certification.

The Contractor shall not discriminate against particular Providers that serve high-risk populations or specialize in conditions that require costly treatment. If the Contractor declines to include individual or groups of Providers in its network, it must provide the affected Providers written notice of the reason for its decision. Denials of Provider enrollment due to excess network capacity must receive Division approval prior to Provider notification.

Nothing in this provision, however, shall preclude the Contractor from using reimbursement amounts greater than the Division's Fee-for-Service fee schedule for different specialties or for different practitioners in the same specialty, or preclude the Contractor from establishing measures that are designed to maintain quality of services and control costs and are consistent with its responsibilities to Members.

7. Care Management

The Contractor is responsible for Care Management, which is defined a set of Member-centered, goal-oriented, culturally relevant, and logical steps to assure that a Member receives needed services in a supportive, effective, efficient, timely and cost-effective manner. Care Management includes but is not limited to Continuity of Care, Transition of Care, and Discharge Planning. The aim of Care Management is to ensure and promote timely access and delivery of health care and services required by Members, continuity of Members' care, and coordination and integration of Members' care in accordance with 42 C.F.R. §§ 438.208 and 457.1230, including but not limited to physical and Behavioral Health/Substance Use Disorder Services. The Contractor must provide coordination using appropriate resources, including community-based organizations, to reduce socioeconomic disparities and address Social Determinants of Health, including but not limited to housing, employment, and nutrition programs, as well as closed-loop referrals. The Contractor must also address health equity challenges through Care Management.

All Members will have access to Care Management at all risk levels, which will include services and supports to promote evidence-based health education and disease prevention, continuity of care, transition of care, and discharge planning. Care Management programs must meet applicable National Committee for Quality Assurance (NCQA) and/or URAC accreditation standards.

7.1 Care Management System

The Contractor is required to develop, implement, and maintain a Care Management System in accordance with the standards and requirements stated in this section. That system will be presented to the Division in writing no later than sixty (60) calendar days after the award of this contract, and it is subject to review and approval by the Division. The Contractor will revise its approach as requested by the Division and will submit any subsequent updates to the Division for approval. Any subsequent changes must be submitted to the Division for approval no less than sixty (60) days prior to the implementation of the change.

7.2 Care Management Partnerships

Integral to Care Management in Mississippi is the development of partnerships with community-based organizations and other agencies. The Contractor must develop relationships with both state and local agencies, as well as state and local community-based organizations for both input on Care Management strategies and for referral of Members for services. As part of its initial Care Management System presentation, the Contractor must create a Care Management Partnership and Referral Report detailing partner agencies and community-agencies it plans to utilize in its Care Management strategy. This report will include a list of agencies and

community-based organization contacts that the Contractor plans to utilize for referrals. This report will cover all regions of the state. The report will include whether partnerships and referrals will be used for MississippiCAN Members, CHIP Members, or both. The Contractor must submit its Care Management Partnership and Referral Report as part of its Care Management System presentation, within sixty (60) calendar days after the award of the contract.

Such agreements will be designed to support the implementation of coordinated, culturally competent care strategies and will include but are not limited to protocols for:

1. Data sharing and data protection;
2. Implementing health promotion and disease prevention initiatives;
3. Coordinating service delivery with the Member's PCMH and/or PCP, as appropriate;
4. Tracking Member outcomes and measuring success; and
5. Making and tracking of closed-loop referrals.

7.3 Care Managers

The goal of each Care Manager is to support Members in improvement of their overall health, assist with coordination of care, and help Members and their families understand and make informed decisions about treatment options. All Care Managers hired by the Contractor must be located within the State of Mississippi. The number of Care Managers hired must equal at least a 40:1 ratio of Members for each Care Manager. Care Managers must have appropriate skills and training to engage with Members of different acuity levels, including training and experience in healthcare delivery, health education and coaching, supporting access to needed resources, and assisting in adherence to treatment plans. Care Managers must additionally receive Cultural Competency training. Additionally, the Contractor must hire at least one Care Manager with special training and knowledge of Care Management practices relevant to Mississippi's Native American community. The Contractor must submit its Care Management hiring and development plan as part of its Care Management System proposal, within sixty (60) calendar days after the award of the contract.

7.4 Care Management Duties

Care Management Duties include, but are not limited to, the following:

7.4.1 Closed-loop Referrals and Warm Handoffs

Care Managers are required to use closed-loop referrals for all referrals made for Members, using the warm handoff method when possible, meaning that the referral will be made through connecting the Member directly to the entity in receipt of the referral, no matter if that is a health care provider or a state or community-based organization. If a referral is made for a Member, the Care Manager must follow-up with the Member about that referral within seven (7) calendar days of the referral. When the referral is made, the Care Manager must discuss any challenges in utilizing the referral with the Member and work to resolve any issues the Member may have in accessing the referral. At follow-up, the Care Manager must determine why the referral was not utilized and assist the Member in utilizing the referral. The Contractor will report on the number and type of referrals made, warm handoffs made, follow ups, and number of referrals completed by Members quarterly.

7.4.2 Primary Care Providers (PCPs) and Patient-Centered Medical Homes (PCMHs)

As described in Section 6.2.5., Patient-Centered Medical Homes, of this Contract, the Contractor is required to utilize a PCMH as the PCP for higher acuity (medium- and high-risk) Members. Whether a PCP or PCMH is utilized for a Member, the Contractor is required to inform that provider of referrals made so that the provider can document the referrals in their own records. The Contractor is also required to inform the provider if the acuity level of the Member changes for any reason, and transition Members who experience an increase in acuity levels from a PCP to a PCMH system as necessary, working with a PCP to enable the PCP to act as a PCMH as appropriate.

7.4.3 Assignment of Risk Levels

The Contractor shall develop a Care Management program that addresses the varying needs and differing levels of Care Management needs for Members. The Contractor's Care Management program must provide for the completion of a Health Risk Screening, to be followed by a Comprehensive Health Assessment as necessary. The goal of this process is to accurately assign risk stratification levels (e.g., low, medium, high) to Members that determine the intensity of interventions and follow-up care that is required for each Member.

Members may be considered for receiving Care Management services for Provider referral, State Agency referral and Member self-referral. At a minimum, Contractor shall provide Care Management services to all Members identified with the following chronic conditions: hemophilia, diabetes, asthma, hypertension, obesity, congestive heart disease, chronic kidney disease, and organ transplants.

The Contractor is required to share with the Division the results of any identification and assessment of a Member's needs upon the Division's request.

7.4.3.1 Heath Risk Screening

The process starts with the Health Risk Screening (HRS). The HRS must comply with or exceed National Committee for Quality Assurance standards and be approved by the Division for all Members to identify Members who may require assignment into Medium- or High-Risk levels for Care Management.

Questions for the Health Risk Screening must be submitted to the Division for approval no later than ninety (90) calendar days after the award of the contract, and the HRS questions are subject to review and approval by the Division. If the Contractor wishes to change the HRS questions at any time during the term of the Contract, the Contractor must submit the changes to the Division for written approval at least sixty (60) days prior to the date of the implementation of the change.

The Health Risk Screening may be conducted via telephone, via mail, or via secure web portal. Communications with Members must be clear and understandable. The HRS must be conducted at the following times:

1. Within ninety (90) calendar days for all Members upon contract implementation;

2. Within thirty (30) calendar days from the effective date of Enrollment for newly enrolled Members after contract operations begin; and

3. Within thirty (30) calendar days from the date of a self-referral by a Member or a Provider's referral of a Member.

When a Member's HRS reveals that the Member's risk level may be Medium or High, the contractor must conduct a Comprehensive Health Assessment.

7.4.3.2 Comprehensive Health Assessment

The Contractor will conduct a Comprehensive Health Assessment (CHA) either in person or via telephone to make a determination of the Member's risk level. The CHA must include both qualitative data reported by the Member and available quantitative data to support appropriate stratification. The CHA must evaluate the Member's medical condition(s), including physical, behavioral, social, and psychological needs; evaluate Social Determinants of Health, including but not limited to the following topics: education level, employment status, housing status, access to basic utilities, access to nutrition, access to transportation, and other social stressors, such as violence and other adverse factors in the home environment; and any other risk factors that may affect the Member's health outcomes.

The goal of this assessment is to confirm the Member's need for Care Management, identify the Member's existing and/or potential health care needs, determine the types of services needed by the Member, including referrals to state agencies, community-based organizations, and partner organizations, and begin the development of the treatment plan.

The Contractor will determine the need for an on-site visit at the Member's residence to complete this assessment. This detailed Health Risk Assessment must occur during the following times:

1. Within thirty (30) calendar days after a Member's completion of the Health Risk Screening during the contract implementation period;

2. Within thirty (30) calendar days after a newly enrolled Member's Health Risk Screening after contract operations begin;

3. Within thirty (30) calendar days after the Contractor receives information from any source that the Member's acuity level may have changed; and

4. Immediately following a Health Risk Screening that identifies a Member with a potentially high-risk condition, a Member with a potentially high-risk chronic condition, a Member with any potential Behavioral Health condition, or a Member who is pregnant.

The detailed Health Risk Assessment must be reviewed by a qualified health professional appropriate for the Member's health condition. The detailed Comprehensive Health Assessment shall address the following, at a minimum:

1. Identification of the severity of the Member's conditions/disease state (e.g. medical, Behavioral Health/Substance Use Disorder, any chronic conditions, etc.) and review of documentation of recent treatment history and current medications;

2. Evaluation of co-morbidities, or multiple complex health care conditions;

3. Demographic information (including but not limited it ethnicity, education, living situation/housing, legal status, employment status);

4. Social Determinants of Health; and

5. The Member's current treatment Providers and treatment plan, if available. The treatment plan for the Member must be completed within thirty (30) calendar days of the completion of the Comprehensive Health Assessment, if appropriate.

The Contractor shall conduct initial and ongoing predictive modeling to identify and evaluate the Member's risk level, which must incorporate the use of pharmacy utilization data. In addition, in consideration of the fact complete claims data may not be available for the coordinated care population or subpopulations, particularly for Members new to coordinated care, the Contractor must propose other analyses used to identify and stratify Members who may need Care Management services and include this analysis with its Care Management System proposal. Whenever available, the Contractor shall use findings from an initial Health Risk Screening for new Members.

7.4.3.3 Risk-Level Assignment

The Contractor shall prioritize and assign Members to low, medium, or high levels based on the identified risk and level of need. Members who have high costs or potentially high costs or otherwise qualify, include but are not limited to Members with persistent and/or preventable inpatient readmissions, pregnant women under twenty-one (21), high risk pregnancies (in cooperation with MSDH, described in Section 7.5.4, below), serious and persistent behavioral health conditions, Substance Use Disorder, Members with serious SDOH challenges, foster children, and infants and toddlers with established risk for developmental delays, shall be assigned to the medium or high risk level. Members being discharged from an acute inpatient psychiatric stay or PRTF shall be assigned to the high-risk level and receive Care Management services. Members with less intensive needs will be assigned to the low risk level and will be monitored and managed by the Contractor's Care Management teams.

7.4.3.3.1 Mandatory Assignments

The Contractor shall automatically enroll all members identified as having one of the following conditions into the high-risk Care Management category:

1. Pregnancy;

2. Diabetes, asthma, cardiovascular diseases, and/or chronic kidney disease;

3. Members with persistent and/or preventable inpatient readmissions

4. Serious and persistent behavioral health conditions;

5. Substance Use Disorder;

6. Serious SDOH challenges;

7. Foster Children;

8. Infants and toddlers with established risk for developmental delays; and/or

9. Members who have high costs or potentially high costs or otherwise qualify.

7.4.3.4 Screening and Assessment Reporting

The Contractor shall report on:

1. Health Risk Screening information, including but not limited to:

    a. The number of Members for whom the Contractor attempted to conduct a Health Risk Screening;

    b. The number of Members for whom a Health Risk Screening was conducted;

    c. The number of completed Health Risk Screenings that stratified a Member to low-, medium-, or high-risk;

    d. The number of Members who could not be reached for a Health Risk Screening, including methods used and number of attempts to reach the Members; and

    e. The number of Members accepting Care Management services after completing the Health Risk Screening.

2. Comprehensive Health Assessment information, including but not limited to:

    a. The number of Members requiring a Comprehensive Health Assessment;

    b. The number of Members for whom a Comprehensive Health Assessment was completed;

    c. The number completed Comprehensive Health Assessments that stratified a Member to low-, medium-, or high risk;

    d. The number of Members who could not be reached for a Health Risk Screening, including methods used and number of attempts to reach the Members; and

e. The number of Members accepting Care Management services after completing the Health Risk Screening.

The Contractor shall report this information as part of the Care Management Reports, which shall be made as directed by the MississippiCAN and CHIP Reporting Requirements (Exhibit H), and any other Care Management reporting as required by the Division.

Members may also be considered for receipt of Care Management services through Provider referral, State Agency referral, community-based organization referral, and Member self-referral at any time. At a minimum, the Contractor will provide Medium- or High-Risk Care Management services to all Members identified with the following conditions: diabetes, prediabetes, asthma, hypertension, obesity, attention deficit disorder, congestive heart disease, organ transplants, behavioral health conditions, foster children, substance use disorders, perinatal conditions. The Contractor may also add any conditions to this list for Medium- or High-Risk Care Management as the Contractor sees fit.

Following the Health Risk Assessment, the Contractor shall update the risk level assignment when there has been a change in the health status, needs, or a significant health care event relevant to the Member's risk level assignment.

The Contractor must submit other analysis used to identify a Member's risk level to the Division at least sixty (60) days prior to use. The Contractor shall modify its approach upon Division request. Additionally, the Contractor shall provide alternate solutions if the implemented approach does not achieve the targeted outcomes and savings over time.

All Members shall have access to the Care Management Team, and the Contractor must provide all Members with information on how to contact this Team through the Contractor Member Information Packet.

7.4.4 Reduce Overutilization

To the extent practicable to support a Member's health, a Care Manager must provide services to reduce unnecessary hospital readmissions, inappropriate lengths of hospital stay, and emergency department visits. This responsibility is expected to be addressed both for individual Members and holistically for the Contractor's entire membership, and the Contractor will report data to the Division regarding these efforts as required by the MississippiCAN and CHIP Reporting Requirements, which are incorporated into this Contract via reference as an Exhibit.

7.4.5 Hospital Discharge Follow-Up

Within seventy-two (72) hours of a Member's discharge from a hospital, a Care Manager must contact the Member and assist with follow-up care, including but not limited to assessing whether the Member has complied with discharge instructions and providing assistance to the Member thorough referral, scheduling any needed transportation for appointments (if an MSCAN Member), contacting the Member's PCP or PCMH, ensuring that the Member has already scheduled any follow-up appointments (and helping the Member do so if the Member has not), assisting the Member with accessing prescriptions, and utilizing any other Care Management functions available to ensure that the Member has the best opportunity to recover.

7.5 Care Management Services

Member information shall be maintained by the Contractor and accessible twenty- four (24) hours per day, seven (7) days per week by members of the Care Management Team.

Members identified as medium risk or high risk will be individually assigned a specific Care Manager. A medium- or high-risk member will have the same individually assigned Care Manager unless the Member requests another Care Manager, the Care Manager is no longer employed by the Contractor, or the Care Manager is otherwise rendered unavailable. Required services are depicted in Table 7.1, below, and more thoroughly explained in the subsections that follow Table 7.1:

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Table 7.1 Care Management Services	All & Low-Risk	Medium Risk	High Risk
Assignment to a Care Management team	✓	✓	✓
Access to a Member services call center	✓	✓	✓
Assistance with care coordination and access to primary care, inpatient services, Behavioral Health/Substance Use Disorder Services, preventive and specialty care, as needed	✓	✓	✓
Coordination of discharge planning and follow-up to care post inpatient discharge	✓	✓	✓
Coordination of discharge planning and follow-up to care post discharge from a PRTF	✓	✓	✓
Coordination with other health and social programs such as MSDH's PHRM/ISS Program, Individuals with Disabilities Education Act (IDEA),the Special Supplemental Food Program for Women, Infants, and Children (WIC); Head Start; school health services, and other programs for children with special health care needs, such as the Title V Maternal and Child Health Program, and the Department of Human Services; Developing, planning and assisting Members with information about community-based organizations, free care initiatives, and support groups; and follow up with both the Member and any organizations to which the Member has been referred within seven (7) calendar days of referral, with assistance offered to the Member to overcome any barriers to access to the utilization of the referral organization	✓	✓	✓
Responding to Member clinical care decision inquiries in a manner that promotes Member self-direction and involvement	✓	✓	✓
Identifying participating Providers upon a Member's Request, and facilitating access and assisting with appointment scheduling when necessary	✓	✓	✓
Providing information about the availability of services and access to those services	✓	✓	✓
Working with Members, Providers, and other Contractors to ensure continuity of care	✓	✓	✓
Monitoring and following up with Members and Providers, which may include regular mailings, newsletters, telephone calls, or face-to-face meetings, as appropriate	✓	✓	✓
Facilitate relapse prevention plans for Members with substance use disorder, depression, and other high-risk behavioral health conditions and their PCPs/Community Mental Health Centers/Private Mental Health Centers (e.g., patient education, extra clinic visits, and follow-up phone calls)		✓	✓
Partner with Provider practices having higher medication adherence rates to identify best practices and leverage tools and education to support practices with lower rates of adherence		✓	✓
Educate Provider office staff about symptoms of exacerbations and how to communicate with patient		✓	✓
Develop speaking points and triggers for making emergency appointments		✓	✓
Develop specific forms and monitoring tools to support monitoring of conditions, behaviors, risk factors or unmet needs		✓	✓
Communicate with the Member at least monthly to ensure that needs are being met. Communication may be via phone calls or face-to-face		✓	✓
Form inter-disciplinary treatment teams to assist with development and implementation of individual medical treatment plans			✓
Provide list of community resources including Medicaid PCPs/PCMHs, Certified Diabetic Educators, free exercise classes, nutritional support, community-based organizations, etc.; and make referrals, when needed			✓

Identify Providers with special accommodations (e.g., sedation dentistry)			✓
Educate staff about barriers Members experience in making and keeping appointments			✓
Facilitate group visits to encourage self-management of various physical, substance use disorder, and behavioral health conditions/diagnoses, including but not limited to pregnancy, diabetes, and tobacco use			✓
Communicate on a patient-by-patient basis on gaps/needs to assure patient has baseline and periodic medical evaluations from the PCP/PCMH			✓

7.5.1 Services for All Members/Low Risk Members

The Contractor must develop and adopt policies and procedures to ensure all Members, including low-risk Members, have access to required services. At a minimum, the following services will be available to all Members:

1. Assignment to a Care Management team: The Contractor must assign a point of contact for each Member, and that point of contact must be a member of the Member's Care Management team;

2. Access to a Member services call center;

3. Assistance with care coordination and access to primary care, inpatient services, Behavioral Health/Substance Use Disorder Services, preventive and specialty care, as needed;

4. Coordination of discharge planning and follow-up to care post inpatient discharge;

5. Coordination of discharge planning and follow-up to care post discharge from a PRTF;

6. Coordination with other health and social programs such as MSDH's PHRM/ISS Program, Individuals with Disabilities Education Act (IDEA),the Special Supplemental Food Program for Women, Infants, and Children (WIC); Head Start; school health services, and other programs for children with special health care needs, such as the Title V Maternal and Child Health Program, and the Mississippi Department of Human Services; Developing, planning and assisting Members with information about community-based organizations, free care initiatives, and support groups; and follow up with both the Member and any organizations to which the Member has been referred within seven (7) calendar days of referral, with assistance offered to the Member to overcome any barriers to access to the utilization of the referral organization;

7. Responding to Member clinical care decision inquiries in a manner that promotes Member self-direction and involvement;

8. Identifying participating Providers upon a Member's Request, and facilitating access and assisting with appointment scheduling when necessary;

9. Providing information about the availability of services and access to those services;

10. Working with Members, Providers, and other Contractors to ensure continuity of care; and

11. Monitoring and following up with Members and Providers, which may include regular mailings, newsletters, telephone calls, or face-to-face meetings, as appropriate.

In addition, the Contractor must develop and adopt policies and procedures to address the following:

1. A strategy to ensure that all Members and/or authorized family members or guardians are involved in treatment planning, as appropriate;

2. Methods for actively engaging Members in need of Care Management who are unresponsive to contact attempts or disengaged in Care Management;

3. An approach that uses pharmacy utilization data to tailor Care Management services;

4. Procedures and criteria for making referrals to specialists and sub-specialists;

5. Procedures and criteria for maintaining treatment plans and referral services when the Member changes PCPs/PCMHs;

6. Documentation of referral services and medically indicated follow-up care in each Member's Medical Record;

7. Documentation in each Medical Record of all Urgent Care, emergency encounters and any medically indicated follow-up care; and

8. Ensuring that when a Provider is no longer available through the Contractor, the Contractor allows Members who are receiving an ongoing course of treatment to access services from Out-of-Network Providers for sixty (60) calendar days, and the Contractor coordinates with the member (and current Provider if necessary) in finding and transferring the Member to a new Provider thereafter.

7.5.2 Services for Medium-Risk Members

The Contractor shall provide Members assigned to the Medium-Risk level all services included in the Low-Risk level and the following services, at a minimum:

1. Facilitate relapse prevention plans for Members with substance use disorder, depression, and other high-risk behavioral health conditions and their PCPs/Community Mental Health Centers/Private Mental Health Centers (e.g., patient education, extra clinic visits, and follow-up phone calls);

2. Partner with Provider practices having higher medication adherence rates to identify best practices and leverage tools and education to support practices with lower rates of adherence;

3. Educate Provider office staff about symptoms of exacerbations and how to communicate with patient;

4. Develop speaking points and triggers for making emergency appointments;

5. Develop specific forms and monitoring tools to support monitoring of conditions, behaviors, risk factors or unmet needs; and

6. Communicate with the Member at least monthly to ensure that needs are being met. Communication may be via phone calls or face-to-face.

7.5.3 Services for High-Risk Members

The Contractor shall provide Members assigned to the High-Risk Level all the services included in the Low-Risk and Medium-Risk levels and the following services, at a minimum:

1. Form inter-disciplinary treatment teams to assist with development and implementation of individual medical treatment plans;

2. Provide list of community resources including Medicaid PCPs/PCMHs, Certified Diabetic Educators, free exercise classes, nutritional support, community-based organizations, etc.; and make referrals, when needed;

3. Identify Providers with special accommodations (e.g., sedation dentistry);

4. Educate staff about barriers Members experience in making and keeping appointments;

5. Facilitate group visits to encourage self-management of various physical, substance use disorder, and behavioral health conditions/diagnoses, including but not limited to pregnancy, diabetes, obesity, and tobacco use; and

6. Communicate on a patient-by-patient basis on gaps/needs to assure patient has baseline and periodic medical evaluations from the PCP/PCMH.

7.5.4 Perinatal High Risk Management/Infant Services System

The Contractor shall coordinate with the Division's agent(s) for high-risk pregnant women who may be eligible for Perinatal High Risk Management/Infant Services System (PHRM/ISS). The Contractor will work with the Division's agent(s) to identify Members who meet the Program criteria. The Division's agent(s) will provide case management services to those Members. Should the Members have additional needs, the Contractor will provide additional Care Management and coordinate with the Division's agent'(s)' case managers to create an individual medical treatment plan for the Members. Members shall have freedom of choice regarding PHRM/ISS services provided by the Division's agent(s) or the Contractor. Should the Member choose PHRM/ISS services through the Division's agent(s), the Contractor will conduct health care assessments for pregnant womenand offer the women the option of care management by the Contractor or case management by the Division's agent(s) for high-risk pregnant women who may be eligible for PHRM/ISS. The Contractor will coordinate with the Division's agent(s) to confirm the case manager will support all of the Members' health care needs.

7.6 Continuity of Care

When Members disenroll from the Contractor or change to another Contractor's plan, the Contractor is responsible for transferring to the Division the Member's Care Management history, six (6) months of claims history, and pertinent information related to any special needs of transitioning Members. The Contractor, when receiving a transitioning Member, is responsible for coordinating care with the Contractor from which the Member is disenrolling so that services are not interrupted and active referrals can be completed and tracked, and for providing the new Member with service information, emergency numbers, and instructions on how to obtain services.

7.7 Reporting

The Contractor will submit reports to the Division as required by this Contract and the MississippiCAN and CHIP Reporting Requirements (Exhibit H), which are incorporated into this

Contract via reference, and make any other such reports as requested by the Division in the requested time, manner, and format.

Reports will include but not be limited to information concerning the number of Members in each acuity level; services rendered to Members; referrals, closed-loop referrals, and warm handoffs made; completion rate for all referrals; and any other data the Division requests.

7.8 Transition of Care Management

Transitions of care occur when Members move from one setting of care (hospital, nursing facility, primary care physician care, home health care, or specialist care) to another. The Care Manager is the patient advocate and charged with engaging the clinical team in sharing the Member's needs and preferences. With an understanding that poor transitions contribute to hospital readmissions, medical error, and miscommunication, the Care Manager works with the Member to improve adherence with medications and treatment, and helps to ensure the Member and any family caregiver(s) are informed and understand what they need to do.

7.8.1 Transition of Care System

The Contractor shall have a transition of care policy consistent with requirements of 42 C.F.R. § 438.62. The Contractor must submit in writing no later than sixty (60) calendar days after the award of this contract its Transition of Care System, which is subject to review and approval by the Division. The Contractor will revise its approach as requested by the Division and will submit any subsequent updates to the Division for approval no less than sixty (60) days prior to implementation. The proposal must include details for implementing the requirements stated herein, as well as the Contractor's methods for identifying Members in need of Transitions of Care Management.

7.8.2 Transition of Care Partnerships and Referrals

The Contractor must develop relationships with both state and local agencies, as well as state and local community-based organizations for both input on Transitional Care Management strategies and for referral of Members for services. As part of its initial proposal, the Contractor must create a Transition of Care Partnership and Referral Report detailing partner agencies and community-agencies it plans to utilize in its Transition of Care strategy. This report will include a list of agencies and community-based organization contacts that the Contractor plans to utilize for referrals. The Contractor must submit to the Division its Transition of Care Partnership and Referral Report as part of its Transition of Care System proposal, within sixty (60) calendar days after the award of the contract.

7.8.3 Transition of Care Team

The Contractor shall have an interdisciplinary transition of care team to design and implement the transition of care plan and provide oversight and management of all transition of care processes. The transition of care team will consist of transitional care nurses in addition to any staff necessary to enhance services for Members and provide support for their return to the home or other community setting, and team members must be located within the State of Mississippi. The Member's Care Manager or specific contact on the Member's Care Management Team (depending on Care Management acuity level) should be on the Transition of Care team unless that staff member is unavailable. The Transition of Care Team Representative should be the Member's Care Manager or specific contact on the Member's Care Management Team (depending on Care Management acuity level) unless that staff member is unavailable.

7.8.4 Closed-loop Referrals and Warm Handoffs

Transition of Care Teams are required to use closed-loop referrals for all referrals made for Members, using the warm handoff method when possible, meaning that the referral will be made through connecting the Member directly to the entity in receipt of the referral, no matter if that is a health care provider or a state or community-based organization. If a referral is made for a Member, a Transition of Care Team representative must follow-up with the Member about that referral within forty-eight (48) hours after the referral is made. When the referral is made, a Transitional of Care Team Representative must discuss any challenges utilizing the referral with the Member and work to resolve any issues the Member may have in accessing the referral. At follow-up, the Transition of Care Team Representative must determine why the referral was not utilized and assist the Member in utilizing the referral. The Contractor will report on the number and type of referrals made, follow ups, and number of referrals completed by Members quarterly.

7.8.5 Transition of Care General Requirements

Contractor shall maintain and operate a formalized Transitional Care Management program to support Members' transition of care when discharged from an institutional clinic or inpatient setting to include, but not limited to:

1. Collaborating with hospitals, hospital discharge planners, PCPs/PCMHs, and Behavioral Health staff;

2. Ensuring appropriate home-based support and services are available and delivered in a timely manner;

3. Implementing medication reconciliation in concert with the PCP/PCMH, Behavioral Health/Substance Use Disorder provider and any other provider, including by not limited to physicians and pharmacists, to assure continuation of needed therapy following inpatient discharge;

4. Notify PCP/PCMH, Behavioral Health/Substance Use Disorder provider, or other specialist within seven (7) calendar days of Member's discharge from inpatient setting to allow for follow-up appointments to be made;

5. Ensuring that the Member receives the necessary supportive equipment and supplies without undue delay;

6. Limiting future institutional and/or inpatient setting re-admissions;

7. Making closed-loop referrals to providers and community-based organizations for follow up care as appropriate;

8. Promoting the ability, confidence, and change in self-management of chronic conditions; and

9. Providing Care Management services as needed based on acuity level.

7.8.6 Transition of Care Process

The Contractor will manage and assist with transition of care and continuity of care for new Members and for Members moving from an institutional clinical or inpatient setting, or from a PRTF, back to the Member's home or other community setting. Contractor's process for facilitating continuity of care will include:

1. Identification of Members needing transition of care;

2. Communication with entities involved in a Member's transition;

3. Making accommodations such that all community supports, including housing, community-based organizations, support groups, and other support services, are in place prior to the Member's transition and that treating providers are fully knowledgeable and prepared to support the Member, including interface and coordination with and among social supports, community-based organizations, and medical and/or Behavioral Health/Substance Use Disorder services;

4. Environmental adaptions, equipment and other technology the Member needs for a successful care setting transition;

5. Stabilization and provision of uninterrupted access to Covered Services for the Member;

6. Summary of Member's history and current medical, Behavioral Health, Social Determinants of Health, and any other social needs and concerns;

7. Assessment of Member's short-term, and long-term goals, including progress and revision of goals where appropriate; and

8. Monitoring of continuity and quality of care, and services provided, including the use of closed-loop referrals.

7.8.7 Additional Transition of Care Contractor Requirements

The Contractor must make its transition of care policy publicly available and provide instructions to Members and Potential Enrollees on how to access continued services upon transition. The transition of care policy must be explained to Members in the materials to Members and Potential Enrollees in accordance with 42 C.F.R. § 438.10. The Contractor must provide training to Providers about Transition of Care requirements and resources at least twice a year. Providers must participate in this training. The training may be conducted in person or in an online format.

In the event a Member enrolling with the Contractor, either as a new Member or transferring from another Contractor, and is receiving medically necessary services or other prenatal services the day before enrollment, the Contractor shall be responsible for the costs of continuation of such medically necessary services, without any form of prior authorization and without regard to whether such services are being provided by a Network Provider or non-contract providers.

For medically necessary covered services, the Contractor shall provide continuation of such services for up to ninety (90) calendar days or until the Member may be reasonably transferred to a Network Provider without disruption of services, whichever is less. The Contractor may require prior authorization for continuation of services beyond thirty (30) calendar days; however, the Contractor is prohibited from denying authorization solely on the basis that the provider is a non-contract provider.

For medically necessary covered services being provided by a Network Provider, the Contractor shall provide continuation of such services from that provider. Members who are transitioning to another provider when a provider currently treating their chronic or acute medical or behavioral health/substance use disorder condition, or currently providing prenatal services has terminated participation with the Contractor, will receive continuation of coverage for such provider for up to ninety (90) calendar days or until the member may be reasonably transferred to another provider without disruption of care, whichever is less.

For members in their second or third trimester of pregnancy, the Contractor shall allow continued access to the Member's prenatal care provider and any provider currently treating the Members chronic, acute medical or behavioral health/substance use disorder condition through the postpartum period.

7.8.8 Potentially Preventable Hospital Returns

The Contractor shall work with the Division through review of its Potentially Preventable Hospital Returns (PPHR) reporting process, received from the Division on a quarterly basis, to reduce the overall hospital Potentially Preventable Readmissions and Potentially Preventable Emergency Department visits. The Contractor is expected to partner with hospitals where Members are experiencing hospital readmissions to develop means of tracking those Members' post discharge and to coordinate their Care Management services to prevent future readmissions.

The Contractors overall comparison of PPHR rates shall be measured by the Actual to Expected ratio. This ratio measures the actual number of hospital readmissions compared to the case-mix adjusted level of readmissions for that hospital's discharges for Members assigned to Contractor.

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8. Quality Management

The Contractor must submit reports related to quality management in accordance with Section 11, Reporting Requirements, the MississippiCAN and CHIP Reporting Requirements, (Exhibit H). The Contractor will have a unified Quality Management program for MississippiCAN and CHIP, but the Contractor will report on the populations separately as required in the MississippiCAN and CHIP Reporting Requirements (Exhibit H). The Contractor is responsible for submitting any reports requested by the Division, and for assuring the accuracy, completeness, and timely submission of each report. The Contractor shall provide such additional data and reports as may be requested by the Division. The Division will furnish the Contractor with the appropriate reporting formats, instructions, and timetables for submission.

8.1 General Requirements

The Contractor shall support and comply with the Mississippi Division of Medicaid Comprehensive Quality Strategy, including all reporting requirements in formats to be determined by the Division.

The Contractor shall comply with the Mississippi Division of Medicaid Quality Management (QM) requirements to improve the health outcomes for all Members. Improved health outcomes will be documented using Performance Measures as referenced in Section 8.5 of this Contract and the Performance Measures Manual, which is incorporated into this Contract via reference.

The Contractor is required to develop, implement, and maintain a QM program in accordance with the standards and requirements stated in this section and in compliance with 42 C.F.R. §438.330. That system will be presented to the Division in writing no later than sixty (60) calendar days after the award of this contract, and it is subject to review and approval by the Division. The Contractor will revise its approach as requested by the Division and will submit any subsequent updates to the Division no later than sixty (60) days prior to implementation for approval.

The Division, in collaboration with the Contractor, retains the right to determine and prioritize QM activities and initiatives based on areas of importance to the Division and CMS. Review of QM activities and initiatives will take place at least twice yearly at intervals to be decided by the Division and the Contractor.

The Contractor shall cooperate with all of the Division's vendors, including the Division's Utilization Management and Quality Improvement Organization (UM/QIO) vendor for the completion of Independent Verification & Validation (IV&V) quality and clinical reviews at the request of the Division.

The Contractor shall participate and shall recruit network Providers to participate in the Mississippi Coordinated Care Quality Workgroup. Membership of the MCCQW is outlined below:

1. Contractor Representatives: Each Contractor must provide the following representatives from their organization:

    a. Medical Director

    b. Contractor Quality Managers and Health Service Managers

    c. Other Contractor Executives and representatives, as designated by the Division

2. Providers: As specified by in the DOM Comprehensive Quality Strategy, Providers from each Contractor who are actively involved in providing services to Members shall participate in the MCCQW. At least one (1) of these Providers from each Contractor will be acting as a current PCMH.

3. Members receiving MississippiCAN and CHIP services, as chosen by the Contractor

4. Division staff, as chosen by the Division

8.2 Accreditation

The Contractor shall be accredited by the National Committee for Quality Assurance (NCQA) and provide to the Division, on an annual basis, any and all documents related to achieving such accreditation. The Division will post accreditation status publicly on its website in accordance with 42 C.F.R. §§ 438.332 and 457.1240. Accreditation status must also be posted to the related website(s) operated by the Contractor for all lines of business associated with this Contract.

The Contractor must also have an NCQA Distinction in Multicultural Health Care.

The Contractor must authorize the NCQA to provide the Division with the Contractor's most recent NCQA review, including:

1. Accreditation status, survey type, and level (as applicable);

2. Recommended actions or improvements, corrective action plans, and summaries of findings; and

3. The expiration date of the accreditation.

8.3 External Quality Review

In accordance with 42 C.F.R. § 438.350, the Contractor will cooperate fully with any external evaluations and assessments of its performance authorized by the Division under this Agreement and conducted by the Division's contracted External Quality Review Organization (EQRO) or other designee. Independent assessments will be performed at least annually and will include but not be limited to any independent evaluation required or allowed by Federal or State statute or regulation. See Exhibit B, External Quality Review, of this Contract for additional requirements of the Contractor.

The Contractor shall address any deficiencies or contract variances identified by the EQRO expediently, on a schedule to be determined by the Division.

8.4 Quality Management System and Quality Improvement Program

The Contractor will be required to participate in meetings with the Division of Medicaid Quality Leadership Team as directed by the Division, at the Division's discretion.

The Contractor shall implement and operate an internal quality management (QM) system and quality improvement (QI) program in compliance with 42 C.F.R. § 438.330 that:

1. Provides for review by appropriate health professionals of the process followed in providing covered services to Members;

2. Provides for systematic data collection of performance and patient outcomes;

3. Provides for interpretation and dissemination of performance and outcome data to Network Providers and Out-of-Network Providers approved for referrals for primary and specialty care;

4. Provides for the prompt implementation of modifications to the Contractor's policies, procedures and/or processes for the delivery of covered services as may be indicated by the foregoing;

5. Provides for the maintenance of Member Encounter Data to identify each practitioner providing services to Members, specifically including the unique National Provider Identifier (NPI) number for each physician; and

6. Complies with Miss. Code Ann. § 83-41-313 et seq. (1972, as amended), of the Health Maintenance Organization, Preferred Provider Organization and Other Prepaid Health

Benefit Plan Protection Act and Miss. Code Ann. § 83-41-409 (1972, as amended) of the Patient Protection Act of 1995.

8.4.1 Annual Quality Management Work Plan

The Contractor will create an Annual Quality Management Program Work Plan that focuses on health outcomes. As part of the Annual Quality Management Program Work Plan, the Contractor will also create a Program Description and an Annual Quality Management Program Evaluation.

The Contractor's Annual Quality Management Program Work Plan will include the following information:

1. A written Program Description, including:
    a. Detailed objectives, accountabilities, and time frames;
    b. Definition of the scope of the QM program, and
    c. An overview of the Contractor's review requirements under its Annual Quality Management Program Evaluation.
2. A timetable for the coming year that clearly identifies target dates for implementation and completion of all phases of all QM activities, consistent with the clinical Performance Measures and targets put forth by the Division, including, but not limited to:
    a. Data collection and analysis;
    b. Evaluation and reporting of findings;
    c. Implementation of improvement actions where applicable; and
    d. Individual accountability for each activity.
3. Composition of the QM committee, including both physical and behavioral health Providers.
4. Procedures for remedial action when deficiencies are identified.
5. Specific types of problems requiring corrective action.

6. Provisions for monitoring and evaluating corrective action to ensure that actions for improvement have been effective.

7. Procedures for Provider review and feedback on results.

8. The Annual Quality Management Program Evaluation, which will serve as an integral part of the Internal Audit of the QM Program. The Annual Quality Management Program Evaluation includes:

    a. Description of completed and ongoing QM activities including Care Management effectiveness evaluation;

    b. Identified issues, including tracking of issues over time, both for Members and Providers;

    c. Trending of measures to assess performance in quality of clinical care and quality of service to Members;

    d. An analysis, including a Cost-Effectiveness Analysis, of whether there have been demonstrated improvements in Members' health outcomes, the quality of clinical care, and quality of service to Members, with an explanation of methods and data used to conduct the analysis and access to raw data if requested by the Division; and

    e. Overall effectiveness of the QM program (e.g., improved HEDIS® scores, improved State Custom Performance Measures).

9. The Contractor must have in effect mechanisms to assess the quality and appropriateness of care furnished to Members with special health care needs. The assessment mechanism must use health care professionals who are trained and qualified to assess and address special health care needs.

10. Additional, detailed requirements are included in Exhibit F, Quality Management, of this Contract.

Within sixty (60) calendar days of the awarding of the Contract, the Contractor will submit a copy of its proposed Annual Work Plan to the Division for review and approval; and the Contractor will submit this document to the Division for review and approval yearly thereafter. The Contractor will also submit regular quarterly work plan updates to the Division. The Division reserves the right to expand the QM Program as needed to assure quality Member care.

The Program Description and other information reported to the Division, including reporting on required standards, such as network adequacy, will be published on the Division's website.

The Contractor will make available to its Members and Providers information about its QM program and report on the Contractor's progress in meeting its goal every six (6) months through publication on its website. This information must be submitted to the Division at least thirty (30) calendar days prior to publication for review and approval by the Division.

8.5 Performance Measures

The Contractor shall comply with the Division's Quality Management requirements to improve the health outcomes for all Members. The Contractor shall meet specific performance targets, as outlined in the Performance Measures Manual, incorporated into this Contract via Reference. The Contractor shall also meet performance targets identified in the Mississippi Division of Medicaid Value-Based Payment Work Plan. The Contractor shall, on an annual basis, measure and report to the Division on its performance using the standard Performance Measures as defined by the Division and submit to the Division data, as specified by the Division, that enables the Division to calculate the Contractor's performance using the standard measures identified by the Division.

The Division has the right to update performance targets, include additional Performance Measures, or remove Performance Measures from the list of required Performance Measures and required targets at any time during the Contract period. The Division and the Contractor(s) shall have an ongoing collaborative process on the development, addition, and modification of Performance Measures and setting of performance targets to identify opportunities for improving health outcomes.

Many of the Mississippi Coordinated Care Performance Measures are based on the Healthcare Effectiveness Data and Information Set (HEDIS®), requirements from the State Legislature, CMS Core Sets, and other quality measurement organizations. The Contractor shall use the standardized methodology as outlined in Volume 2, HEDIS® Technical Specifications[1], to calculate its performance rates. The Contractor shall contract with a Certified HEDIS® Audit Firm to conduct a certified audit of its HEDIS® rates, and shall report the findings of that audit, including the actual report submitted by the auditor to NCQA, to the Division. The Contractor shall report rates for all Performance Measures to the Division, regardless of whether they are based on HEDIS® technical specifications.

[1]NCQA publishes the Technical Specifications annually to assist in the calculation of HEDIS® measures. Contractor shall use the version, which represents the reporting year for HEDIS® rates (e.g., health plans report calendar year 2019 rates in 2020 based on Volume 2-2020 Technical Specifications).

While the Contractor must meet the Division Performance Measure Targets for each measure, it is equally important that the Contractor continually improve health outcomes from year to year.

The Division will publish all HEDIS® and Performance Measures results on the Division's website.

8.6 CAHPS® Member Satisfaction Survey

The Contractor shall contract with an NCQA certified survey vendor to administer an annual CAHPS® Member Survey. The results of the survey and action plans derived from these results must be filed with the Division within ninety (90) calendar days following the Contractor's receipt of the survey findings from its certified survey vendor.

The Division will publish all CAHPS® Member Survey results on the Division's website.

8.7 Provider Satisfaction Survey

The Contractor shall conduct annual Provider satisfaction surveys. The Contractor must create and submit a draft survey for each line of business covered by this Contract – MississippiCAN, and CHIP – including questions and methodology to the Division by March 1 for the current calendar year. The Division will reconcile submissions by all Contractors and create uniform surveys for use by all Contractors. The results of the surveys and action plans derived from these results must be filed with the Division at least ninety (90) calendar days following the completion of the surveys and no later than December 1 for the current calendar year.

The Division will publish all Provider Satisfaction Survey results for each line of business covered by this Contract on the Division's website.

8.8 Value-Based Purchasing

As permitted by state and federal law, the Division will collaborate with the Contractor and any other CCO Contractors to develop details of an Integrated Primary Care (IPC) value-based purchasing (VBP) model. Within ninety (90) calendar days of the award of the Contract, each Contractor will submit to the Division its proposal for an IPC VBP model, using Patient-Centered Medical Homes and Care Management as key aspects of the model. The Contractor will include information regarding provider recruitment, reimbursement methodology (including what percentage of payments to providers should be devoted to VBP and proposed Alternative Payment Models (APMs)), how utilization review will inform VBP development and implementation, timelines, expected challenges in implementation, how VBP should affect enrollment (as discussed in Section 3.2.1), and any other information relevant to the development and success of the model. The Contractor should also assess and address any possible health

equity concerns in the development of the model. The model should be developed using stakeholder input, including but not limited to providers, Members, community-based organizations, other State organizations, and Division staff. Upon receipt of proposals from all Contractors, the Division will evaluate the proposals and determine a final uniform model prior to the implementation of the Contract.

The Contractor will be required to comply with the final model promulgated by the Division, as well as produce and disseminate reports as outlined under in the MississippiCAN and CHIP Reporting Requirements (Exhibit H), which are incorporated in this document via reference, and comply with relevant requirements of the Performance Measures Manual, which is incorporated into this document via reference.

At the end of the development process, the Division will publish a separate document detailing the final VBP program, the Mississippi Division of Medicaid Value-Based Payment Work Plan. This document will reflect all updates to the Division's VBP policy and is incorporated, along with any updates, in this Contract by reference. The Work Plan will comply with all applicable provisions of 42 C.F.R. §438.6(c).

The Division has the right to alter the VBP program, Work Plan, Reporting Requirements, and/or Performance Measures at any time, at its discretion.

8.10 Population Health Management

The Population Health Management program will address, at minimum, the elements identified in this subsection. The Division must review and approve the Population Health Management program, including policies and procedures, prior to implementation by the Contractor, and semi-annually thereafter. Population Health Management program requirements include the following requirements.

8.10.1 Data Analytics

The Contractor must submit raw data pertaining to quality as requested by the Division. The Contractor may choose to leverage its own technologies to support Member data analytics, and the Contractor will be financially responsible for ensuring that such technology will be accessible in the manner and format defined by the Division. The Contractor must utilize any common data platform, analytical framework, or other data use architecture provided by the Division.

8.10.2 Reducing Health Disparities

The Contractor will develop and implement strategies to address disparities in health outcomes and access to care based on factors such as geographic location, race, ethnicity, income level,

age, gender, language barriers, and physical disabilities. While each Contractor will provide coverage across the state, strategies implemented here must reflect significant regional variation in these factors. For more information, refer to Section 7, Care Management, of this Contract.

8.10.3 Community Partnerships

The Contractor will seek out and enter into agreements with community-based and social services organizations in each region of the state. For more guidance on this requirement, refer to Section 7, Care Management, and Section 8, Quality Management, of this Contract.

8.10.4 Health Education and Promotion

The Contractor will employ creative and innovative educational programs that are designed to raise Member awareness, enhance Member participation in self-care, and promote ongoing engagement. Programs must focus on helping Members identify and understand common risk factors and evidence-based strategies that they can employ to reduce their own health risk. Such programs may include those designed by the Contractor as well as coordinated referral to programs operated by local public health or community-based organizations. Program design must consider the appropriate use of multiple information sources, which may include social media and other web-based initiatives, as well as telephonic and paper-based resources and in-person events.

8.10.5 Risk Screenings, Assessment, and Stratification

The Contractor will use Health Risk Screenings and Comprehensive Health Assessments for the purposes of stratification and assignment of risk levels (low-, medium-, or high-risk). Details concerning this requirement are located in Section 4, Covered Services and Benefits, and Section 7, Care Management.

8.10.6 Care Management

The Contractor will provide Care Management using a set of Member-centered, goal-oriented, culturally relevant, and logical steps to assure that a Member receives needed services in a supportive, effective, efficient, timely and cost-effective manner as clearly defined in Section 7, Care Management, of this Contract.

8.10.7 Targeted Interventions

The Contractor will offer evidence-based interventions to address subpopulations experiencing unique health risks. Subpopulations may include Members with disabilities, specific chronic conditions or comorbidities, those with specific environmental risk factors, or those with a history of high or inappropriate service utilization. This requirement is discussed more in Section 7, Care Management, of this Contract.

8.10.8 Health Literacy Campaigns

The Division will collaborate with the Contractor and any other CCO Contractors to develop a strategy for Health Literacy Campaigns. Within ninety (90) calendar days of the award of the Contract, each Contractor will submit to the Division its proposal for a Health Literacy Campaign Strategy. The Contractor will include modes of information delivery (print, electronic messaging, social media, etc.), media strategies (production of videos, infographic examples, targeting information), and any other information relevant to the development and success of the strategy. The campaign should be developed using stakeholder input, including but not limited to providers, Members, community-based organizations, other State organizations, and Division staff. Upon receipt of proposals from all Contractors, the Division will evaluate the proposals and determine a final uniform campaign prior to the implementation of the Contract.

The Contractor will be required to comply with the final campaign promulgated by the Division, as well as produce and disseminate reports as outlined under in the Reporting Requirements (Exhibit H), which is incorporated in this document via reference, and comply with relevant requirements of the Performance Measures Manual, which is incorporated into this Contract via reference. The Contractor will also perform a Cost-Effectiveness Analysis quarterly of each campaign.

At the end of the development process, the Division will publish a separate document detailing the final campaign, the Mississippi Division of Medicaid Health Literacy Collaboration Campaign. This document will reflect all updates to the Division's Health Literacy Campaign policy and is incorporated, along with any updates, in this Contract by reference.

The Division has the right to alter the Health Literacy Campaign, the Collaboration, Reporting Requirements, and/or Performance Measures at any time, at its discretion.

8.10.9 Health Equity

The Contractor will ensure that Health Equity is addressed in all Population Health programs, including Health Equity-related action steps in the design of each program as well as measurements used to evaluate the efficacy of the Health Equity action steps for each. The Contractor will be required to provide data insights to the Division in agreed upon formats which may include raw data files and reports.

8.11 Performance Improvement Projects

For MississippiCAN and CHIP, the Contractor shall also perform a minimum of five (5), either clinical or non-clinical, Performance Improvement Projects (PIP) for each line of business each year on topics prevalent and significant to the population served. A PIP can cover both programs

and count for both programs if the Contractor identifies a goal mutual to both programs. All PIPs must be submitted to the Division for approval. PIPs expected to begin concurrently with the beginning of the operational period of this Contract must be submitted no later than sixty (60) calendar days after the award of this Contract. PIPs expected to begin during the life of the Contract must be submitted no later than ninety (90) calendar days prior to the expected start date of the PIP.

8.11.1 General Requirements

PIPs shall meet all relevant CMS requirements and shall be designed to achieve significant improvement, sustained over time, in health outcomes and enrollee satisfaction. A PIP includes measuring the impact of the interventions or activities toward improving the quality of care, health equity, and service delivery. For each PIP, the Contractor shall:

1. Include aims that are expressed as Specific, Measurable, Actionable, Realistic, and Time-bound (SMART);

2. Connect the specific health outcomes prioritized to the Mississippi Division of Medicaid Quality Strategy;

3. Create and use key drive diagram(s) (or other cause-and-effect diagram(s)) to show the theory of improvement or how the interventions being tested are thought to affect the project goal (SMART Aim);

4. Design and implement a method to incorporate Members' voices and concerns into the topic choice and/or theory of improvement;

5. Use clear descriptions of methods used to identify key drivers, associated interventions, and prioritization of interventions (e.g., process mapping, Pareto analysis, root cause analysis, Failure Mode & Effects Analysis, Gemba walk, etc.);

6. Reflect examples of intervention tests (Plan-Do-Study-Act Cycles, or PDSAs) and lessons learned;

7. Use objective quality indicators to measure performance, including:

    a. Whether the measure is a process measure, an outcome measure, or a balancing measure;

    b. Data sources for the measure;

c. The intervention or driver to which the measure is linked;

d. The frequency of measurement;

e. The frequency of review of longitudinal (time series) measurement data;

f. Stratification of key data by race and other demographic factors to assess for disparities; and

g. Mention of methods used to draw conclusions from the data (e.g., identification of special cause or the degree of variance in processes).

8. Use longitudinal (trended) depictions (run charts, control charts, line graphs) of the PIP's outcomes over time with annotation of intervention periods and special cause identification;

9. Include results and lessons learned from PIPs and describe how these are communicated within and across the organization, as well as how they are integrated into the Contractor's Quality Assurance/Performance Improvement Program; and

10. Defined processes or procedures that have been or will be put in place to sustain and propagate successful interventions.

The Contractor shall include information on PIPs in the Quality Management program description and work plan submitted to the Division.

In addition to those set forth herein, CMS, in consultation with the State, and other stakeholders, may specify additional Performance Measures and topics for PIPs to be undertaken by the Contractor. The Division may also require Quality Improvement Projects (QIPs) and other quality projects as necessary.

Each Contractor under this Contract is required to collaborate with the other Contractors under this Contract to create and administrate at least one PIP for each program.

8.11.2 MississippiCAN PIPs

For MississippiCAN PIPs, due to the critical importance of the areas of obesity, Serious Mental Illness (SMI), and EPSDT screening to the Medicaid population, these areas should be selected annually for study providing continuous evaluation. The Contractor will complete two (2) other PIPs focusing on clinical or health service delivery areas defined annually by the Division, completing the required total of five (5) PIPs. The Contractor may propose additional PIPs as well. The Division will pre-approve all PIPs. The Division may require the Contractor to

implement additional PIPs focusing on specified conditions beyond the four initial PIPs. The Contractor will include study questions and study indicators agreed upon by the Division and the Contractor.

8.11.3 CHIP PIPs

For CHIP PIPs, due to the critical importance of the areas of obesity, Serious Mental Illness (SMI), and Well-Baby and Well-Child Services to the CHIP population, these areas should be selected annually for study providing continuous evaluation. The Contractor will complete two (2) other PIPs focusing on clinical or health service delivery areas defined annually by the Division, completing the required total of five (5) PIPs. The Contractor may propose additional PIPs as well. The Division will pre-approve all PIPs. The Division may require the Contractor to implement PIPs focusing on specified conditions. The Contractor will include study questions and study indicators agreed upon by the Division and the Contractor.

8.11.3 PIPs and Incentive Arrangements

At its discretion, when defining PIPs for Contractors, the Division may choose the same three (3) PIPs for all Contractors, and the PIPs chosen by the Division may relate to measures included in Incentive Arrangements, as discussed in Section 11.1.1.4, Incentive Arrangements, or any other incentive or withhold arrangements the Division chooses to implement during the life of the Contract.

8.12 Disenrollment Survey

The Contractor shall contact Members who disenroll from the Contractor to determine the reason for their Disenrollment. The Contractor must administer Disenrollment surveys to Members via phone or mail within five (5) business days of the Member disenrolling from the Contractor. The Contractor must submit survey questions and methodology to the Division for review and approval.

The Contractor shall report findings quarterly from the Disenrollment survey and a work plan for addressing results of the Disenrollment survey to the Division.

8.13 Quality Management Committee

The Contractor must have Quality Management Committee. The QM Committee must implement a formal organizational structure for oversight of the QM program. The formal organizational structure of each committee must include at a minimum, the following:

1. Established parameters of operation including specifics regarding role, function and structure;

2. The Contractor's Medical Director;

3. A designated health care practitioner, qualified by training and experience, to serve as the QM Director;

4. A committee that includes representatives from the Provider groups as well as clinical and non-clinical areas of the organization;

5. A senior executive who is responsible for program implementation;

6. A beneficiary or beneficiary's representative from MississippiCAN and CHIP each;

7. QM activities must be distinctly separate from the Utilization Review activities and the distinction must be well-defined;

8. The QM committee must meet no less than quarterly to oversee QM activities and must demonstrate that the committee is following up on all findings and required actions;

9. Records that document the committee's activities, findings, recommendations, actions, and results; and

10. Accountability to the governing body of the organization to which it reports on activities, findings, recommendations, actions, and results on a scheduled basis.

8.14 Standards

Each QM Program shall provide continuous performance of quality of care studies, health service delivery studies and other monitoring activities using objective, measurable and current standards for service delivery, quality indicators, or pre-established practice guidelines.

8.15 Clinical Practice Guidelines

The Contractor shall collaborate with other Contractors to develop standard clinical practice guidelines for Providers of all Contractors and make those standard guidelines available to all Providers providing services to Members covered under this Contract. The clinical practice guidelines must be consistent with national standards for disease and chronic illness management of Members. Clinical practice guidelines shall be based on reasonable scientific evidence, reasonable medical evidence, reviewed annually by Network Providers who can recommend

adoption of clinical practice guidelines to the Contractors, reviewed and updated as frequently as needed and at least annually by the Contractors to conform with the most up-to-date guidelines, and communicated to those whose performance will be measured against them. Development of guidelines must take into account the needs of Members. Clinical guidelines are provided by the Contractors to physicians and other Network Providers as appropriate. The Contractors will submit these guidelines for annual review and approval by the Division by January 1 of each calendar year.

Each Contractor, on an annual basis, shall measure its Providers' performance against at least four (4) of the clinical practice guidelines and provide the Division the results of the study and a summary of any corrective actions taken to ensure compliance with the guidelines.

Practice guidelines must be disseminated to Members and potential enrollees upon request.

Decisions regarding utilization management, enrollee education, coverage of services, and other areas to which practice guidelines apply should be consistent with the established practice guidelines.

8.16 Utilization Review

The Contractor will provide for a system of utilization review consistent with the requirements of 42 C.F.R. Part 456, 42 C.F.R. § 438.210, and in accordance with Miss. Code Ann. § 41-83-1 et seq. and other applicable sections (1972, as amended). The Contractor will submit this system for annual review and approval by the Division by January 1 of each calendar year.

The Contractor shall have a written Utilization Review Program descriptions for each line of business covered by this Contract that outline the program structure and accountability and includes, at a minimum:

1. Criteria and procedures for the evaluation of medical necessity of medical services for Members;

2. Criteria and procedures for pre-authorization and referral that include review, reconsideration, Appeal, and Grievance mechanisms for Providers;

3. Criteria and procedures for pre-authorization and referral that include review, reconsideration, Appeal, and Grievance mechanisms for Members;

4. Mechanisms to detect and document underutilization as well as overutilization of medical and behavioral health services;

5. Mechanisms to assess the quality and appropriateness of care, treatment, and/or any service plan furnished to a Member with special health care needs at least every twelve (12) months, or more often when the Member's circumstances or needs change significantly, or at the request of the Member;

6. Availability of utilization review criteria to Providers;

7. Involvement of actively practicing, board certified physicians who are licensed in Mississippi in the program to supervise all review decisions and to review denials for medical appropriateness;

8. Availability of physician reviewer to discuss determinations by telephone with physicians who request such;

9. Evaluation of new medical technologies and new application of existing technologies and criteria for use by Network Providers;

10. Annual evaluation of the utilization review program to determine effectiveness and need for changes;

11. Process for measuring Provider performance against at least four (4) of the clinical guidelines on an annual basis;

12. Process and procedure to address disparities in health care, which shall be included in the Quality Improvement Work Plan;

13. A process for identifying clinical issues and analyzing the issues by appropriate clinicians, and when appropriate, developing corrective action(s) taken to improve services;

14. Development of disease management programs that focus on diseases that are chronic or very high cost including but not limited to diabetes, asthma, hypertension, obesity, congestive heart disease, organ transplants, attention deficit disorder, and Serious Mental Illness/Substance Use Disorder HIV/AIDS, sickle cell anemia, and high-risk pregnancies; and

15. A comprehensive health education program that will support the Care Management programs.

At its discretion, the Contractor may elect to extend Covered Services beyond the benefit limitations and/or cover alternative benefits for cost-effective health care services and supplies

that are not otherwise covered. The decision to provide extended or alternative benefits shall be made on a case-by-case basis to Members who meet the UM Program's criteria. Any decision regarding the provision of extended or alternative benefits shall be made as part of the UM Program. The Contractor shall be responsible for the payment of any such benefits and shall not authorize any services specifically excluded from the CHIP State Health Plan or the Medicaid State Plan. Payment for such services will not be used as part of the Contractor's Capitation Rate calculation.

The Contractor shall annually evaluate its UM program and submit a copy of this evaluation to the Division annually. The UM program description will be submitted to the Division for written approval annually.

The Contractor shall provide utilization review criteria on the Contractor's provider portal at all times, as well as in hard copy upon request.

Under no circumstances may the Contractor compensate individuals or entities that conduct utilization management activities through a structure that incentivizes denying, limiting, or discontinuing medically necessary services to any Member.

8.17 Reporting Maternity Admissions for Delivery

Mississippi Medicaid covers maternity services including, but not limited to, delivery services, the care involved in the actual birth, and continued care for two (2) months following the birth of the newborn. Hospitals must report all admissions for deliveries, both vaginal and Cesarean section, as required by the Division.

Medicaid policy exempts certain maternity admissions for delivery from the reporting requirement and providers are not required to submit reports for these situations. No report is required if the beneficiary has Medicare Part A and Part B coverage for the hospitalization time frame and the Medicare benefits are not exhausted. No review is required if the beneficiary's Medicaid eligibility is only for the Family Planning Waiver.

The Contractor shall issue a written notification for issuance of a Prior Authorization Number to the requesting provider within two (2) business days from receipt of completed report.

8.18 Internal Audit

The Contractor shall annually review, evaluate, and modify as necessary the quality management system, including:

1. The Medical Record system,

2. Data collection system,
3. System for ensuring that the Provider is properly credentialed,
4. All quality management policies and procedures,
5. Grievance procedures,
6. Clinical care standards,
7. Practice guidelines,
8. Member utilization,
9. Access to covered services,
10. Treatment outcomes,
11. Beneficiary privacy, and
12. Any other systems necessary to the accuracy of the quality management system.

See Section 11.2.9, Reporting Requirements: Reporting Requirements: Internal Audit Reporting, of this Contract, for more information.

8.19 Clinical Audit

The Division will conduct clinical audits of the Contractor during which the Division will identify and collect management data, including information on the use of services and Enrollment and Disenrollment policies, performance data, and any other necessary data to ensure that the Contractor furnishes quality and accessible health care to enrolled Members. The Division will review any of the Contractor's policies and procedures for compliance with the terms of this Contract and any policies and procedures for services.

The Clinical Audit will be a component of the Division's overall quality improvement assessments of the Contractor. The Contractor shall comply with all requests for information within fourteen (14) calendar days of the request. The request may come at any time, but at a minimum, the Division will request information twice a year.

These requests in no way replace requests made by the EQRO during its auditing process. The Contractor will comply with all requests made by the EQRO as part of that process.

8.20 MississippiCAN EPSDT Screening and Immunization Rates Validation

For MississippiCAN, the Division will evaluate CMS 416 reports to determine compliance by the Contractor with the requirements of this Contract for provision of Division-defined EPSDT Services to EPSDT-eligible Members.

The Contractor must achieve the screening rates in Table 8.1 to comply with this Contract. The identified targets may be updated by the Division periodically.

Table 8.1 EPSDT Screening and Immunization Rates

Measure	Rate Targets
Screenings	Eighty-five percent (85%) of enrolled Members under age one (1) had required screenings; Seventy-five percent (75%) of enrolled Members between the ages of one (1) and twenty-one (21) had required screenings.
Immunizations	Eighty-five percent (85%) of enrolled Members under age one (1) had required immunizations; Seventy-five percent (75%) of enrolled Members between the ages of one (1) and twenty-one (21) had required immunizations.

The screening rate will be calculated using the reportable number for -the Screening Ratio of the EPSDT CMS 416 report. The Contractor shall submit Form CMS-416: Annual EPSDT Participation Report in accordance with the instructions outlined by the Federal Government. Immunization compliance means that the child is up to date with immunizations based on the ACIP and AAP Bright Futures immunization schedule.

The Contractor shall publish screening rates in required educational and Marketing presentations to potential Members, as well as on the Contractor's website. The Contractor must provide proof to the Division that publication of screening rates in the listed manners has been completed.

8.21 CHIP Well-Care Child Assessments and Immunizations Rates Validation

In conjunction with the clinical audit, complete well-care assessments and immunizations claims data for the Contractor and a sample of Medical Records will be evaluated by the Division annually to determine compliance by the Contractor with the requirements of this Contract for provision of these services to Members.

The Contractor must achieve the screening rates in Table 8.2 to comply with this Contract. The identified targets are in effect for the first year of operations, and the Division will update these targets annually.

Table 8.2 Well-Care Child Assessments and Immunizations Rates

Measure	Rate Targets
Screenings	Eighty-five percent (85%) of enrolled Members had required screenings
Immunizations	Ninety percent (90%) of enrolled Members had required immunizations

The Contractor shall publish screening rates in required educational and Marketing presentations to potential Members, as well as on the Contractor's website. The Contractor must provide proof to the Division that publication of screening rates in the listed manners has been completed.

8.22 Medicaid Managed Care Quality Rating System

The Division will develop and implement a Medicaid managed care quality rating system in accordance with 42 C.F.R. § §438.334 and 457.1240. Upon development and implementation of the quality rating system, the Division may issue an annual quality rating for each Contractor based on collected data and using the Medicaid managed care quality rating system adopted under this authority. The Division will prominently display the quality rating given by the Division to the Contractor on the Division's external website in a manner that complies with the standards in 42 C.F.R. § 438.10(d).

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MISSISSIPPI DIVISION OF MEDICAID

Section 9. Claims and Reimbursement

9.1 Claims Management

9.1.1 Claims Payment Generally

The Contractor will be responsible for processing claims in accordance with the requirements of this Contract, state and federal law, and at the direction of the Division. The Contractor will meet all requirements of Fee-for-Service timely payment. Pursuant to 42 C.F.R. § 447.45(d)(5) and (6), the date of receipt of a claim is the date the Contractor receives the claim, as indicated by the date stamp on the claim. The date of payment is the date of the check or other form of payment is remitted by the Contractor.

As required under 42 C.F.R. § 447.46, the Contractor must pay at least ninety percent (90%) of all Clean Claims (as defined by 42 C.F.R. § 447.45) for covered services, within thirty (30) calendar days of receipt and pay at least ninety-nine percent (99%) of all Clean Claims within ninety (90) calendar days of receipt, except to the extent an alternative payment schedule has been agreed to in the Contract.

For other claims, the Contractor shall notify the Provider of the status (e.g., pend, deny, or other reason) of the claim, and if applicable, in the status report as referenced in the paragraph below, the reason the claim cannot be paid within thirty (30) calendar days of the adjudication of the claim. The Contractor must pay all other claims, except those from Providers under investigation for Fraud and Abuse, within one hundred twenty (120) calendar days of the date of receipt.

After the first thirty (30) calendar days of the operational start date of the Contract, the Contractor shall run at least one (1) provider payment cycle per week, on the same day each week, as determined by the Contractor and approved in writing by the Division. With each claims payment cycle, the Contractor shall provide an electronic status report indicating the disposition for every adjudicated claim for each claim type submitted by providers. The status report shall contain appropriate explanatory information related to payment, denial, or recoupment of the claims, including but not limited to TPL data.

Claims pending or suspended for additional information must be processed (paid or denied) by the thirtieth (30th) calendar day following the receipt of information requested; otherwise, the Contractor must close (pay or deny) any other suspended claim if all requested information is not received prior to the expiration of the thirty (30) calendar day period.

9.1.1.1 Emergency and Family Planning Services

Claims for Emergency Medical Services and Family Planning Services shall be paid at the applicable Medicaid Fee-for-Service rate in the absence of an agreement otherwise between the Contractor and the Out-of-Network Provider.

9.1.1.2 Out-of-Network Providers

The Contractor shall submit to the Division for review and approval sixty (60) calendar days prior to use its criteria for authorization or denial of payment for services rendered by Out-of-Network Providers. The Division shall review all such criteria for conformity with the Division's Policy for Claims Payment and must approve the criteria prior to implementation by the Contractor. The Contractor shall distribute its criteria for approval or denial of Out-of-Network services to all Out-of-Network Providers to whom Members are referred and shall distribute its criteria for approval of outside Emergency Services to all facilities providing Emergency Medical Services known to the Contractor and located within a thirty (30) mile radius of the Member's residence. All criteria shall be kept current.

9.1.2 Claims Processing and Information Retrieval Systems

The Contractor's claims processing system must have the capability to process claims consistent with timeliness and accuracy requirements identified in this Contract. Any updates to the Contractor's claim system must be completed within sixty (60) calendar days of notice by the Division. The Contractor shall implement all subsequent updates using the same effective dates as the Division. Unless otherwise approved by the Division, the Contractor must implement changes in State Plan Amendments by the effective date of those Amendments.

The Contractors' claims processing and information retrieval systems must comply with all components of 42 C.F.R. § 433.116.

The Contractor's information retrieval system must have the capability to accept claims history data from the Division or its Agent.

9.1.3 Inpatient Claims

The Contractor shall follow all the Division's guidelines for payment of inpatient hospital services for all enrolled MississippiCAN Medicaid Members using the same mapper and grouper version, health care-acquired condition (HCAC) utility, Never Events, and all inpatient payment parameters as are used by the Division for other Medicaid Members. The Contractor shall implement all subsequent updates using the same effective dates as the Division.

The Contractor shall submit to the Division reports related to hospital claims activity in the Division required format. Refer to Section 16, Reporting Requirements, of this Contract and the Reporting Requirements (Exhibit H), which is incorporated into this Contract via reference, for more information.

For a Member who opts out or otherwise loses MississippiCAN enrollment but is in a hospital stay on the last day of MississippiCAN coverage and the stay continues into the next month, the Contractor will be financially responsible for payment of the inpatient hospital claim and ancillary services for the entire stay until the Member is discharged from the hospital based on the Division's guidelines. However, if the person is no longer eligible for Mississippi Medicaid inpatient hospital benefits, payment for services beyond the end of Medicaid eligibility is not required.

9.1.4 Claims Denials

The Contractor shall have written policies and procedures, in form and content acceptable to the Division, providing a mechanism for Providers to Appeal the denial of claims by the Contractor. The Contractor must address every part of a Denial Notification, being explicit about every reason that the claim is or may be denied so that the Provider may address any and/or all issues with the claim at one time. If a claim is partially or totally denied on the basis the Provider did not submit any required information or documentation with the claim, then the Denial Notification shall specifically identify all such information and documentation.

The Contractor shall respond to provider inquiries promptly and resolve provider claims within a thirty (30) calendar day period for incorrectly paid or incorrectly denied claims.

9.1.5 Pattern of Denials and Delays

The determination that a pattern of inappropriate denials or delays of provider payments exists is at the sole discretion of the Division.

9.1.6 Off-System Adjustments

The Contractor shall not employ off-system adjustments when processing corrections to payment errors unless it requests and receives prior written authorization from the Division.

9.1.7 Ventilators

The Contractor is prohibited from setting a maximum dollar amount of reimbursement for noninvasive ventilators or ventilation treatments properly ordered and used in an appropriate setting. The Contractor must reimburse durable medical equipment suppliers for home use of

noninvasive and invasive ventilators on a continuous monthly payment basis for the duration of the Member's medical need throughout the Member's valid prescription period.

9.2 Reimbursement

The Contractor shall follow all state and federal laws, rules, and regulations regarding reimbursement.

To the extent a Provider has the capability, the Contractor shall submit electronic payments and remittance advices to Providers. Remittance advices must be provided within one (1) to five (5) business days of when payment is made.

9.2.1 Network Providers

The Contractor shall reimburse all Network Providers at a rate no less than the amount that the Division reimburses Fee-for-Service providers with the exception of the following:

1. Capitation and other incentive arrangements under Section 9.2.8, Physician Incentive Plans, of this Contract;

2. Directed Payments as defined under Section 11.2 of this Contract; and

3. Any Value-Based Payment arrangements created through the Mississippi Division of Medicaid Value-Based Payment Work Plan as described in Section 8.8 of this Contract and any other innovative payment models authorized under Miss. Code Ann. § 43-13-117 (H).

If the Contractor enters a contract with a FQHC or a RHC, the Contractor shall provide payment that is no less than the level and amount of payment that the Contractor would make for the services if the services were furnished by a provider that is not a FQHC or RHC. The Contractor shall follow the Mississippi State Plan related to enhanced payment for primary care services.

The Contractor shall reimburse Out-of-Network Providers for the covered services and specialty care for which the Contractor has referred the Member to an Out-of-Network Provider and out-of-area services provided to a Member in accordance with the Contractor's approved plan for Out-of-Network services.

9.2.2 I/T/U Providers

Contractor shall also pay I/T/U providers, whether participating in the network or not, for covered managed care services provided to Indian Members who are eligible to receive services

from the I/T/U either at a negotiated rate between the Contractor and the I/T/U provider or, if there is no negotiated rate, at a rate no less than the level and amount of payment that would be made if the provider were not an I/T/U provider.

9.2.3 Out-of-Network Providers

The Contractor shall be responsible for full payment for services received by Members from Out-of-Network Providers should the Contractor's services not be available from Network Providers as required, pursuant to the terms of this Contract.

9.2.4 Explanation of Benefits

The Contractor shall generate Explanations of Benefits, in a format approved by the Division, and submit the policy and procedures for sampling for Explanations of Benefits for Division approval sixty (60) calendar days prior to use. The Contractor must send the Explanation of Benefits to Members within thirty (30) calendar days of adjudication.

The Contractor shall be responsible for generating and mailing a random sample of EOBs to MississippiCAN and CHIP members in accordance with the guidelines described by DOM.

The Contractor shall at a minimum, ensure that EOBs are designed to address requirements found in 42 CFR 455.20 and 433.116 and shall include: claims for services with benefit limits, claims with enrollee cost sharing, denied claims with enrollee responsibility, and a sampling of paid claims (excluding anesthesia services).

The EOB must specify the following:

(i) The service furnished;
(ii) The name of the provider furnishing the service;
(iii) The date on which the service was furnished; and
(iv) The amount of the payment made under the plan for the service; and
(v) Shall omit any claims in the EOB file that are associated with sensitive services.

On a monthly basis, the Contractor shall sample a minimum of one hundred (100) claims and associated EOBs. The EOBs shall be examined for correctness based on how the associated claim was processed.

The Contractor shall ensure that the EOBs constitute a representative sample of EOBs from all types of services and provider types (excluding anesthesia services). DOM and/or the OPI may consider a particular type of service or provider warrants closer scrutiny and may require the Contractor to send out additional EOBs outside the sample size to address a closer examination, therefore, the Contractor shall oversample as needed.

The Contractor shall document and track any complaints received from enrollees and resolve the complaints according to the Contractors policies and procedures. In addition, any complaints

received should be used to detect any fraudulent activity that may indicate a need for further investigation/audit, referral and/or follow-up.

The Contractor shall use any complaints received to modify or enhance their EOB sampling methodology as indicated.

9.2.5 Authorization and Reimbursement for Member Transition between Contractors

9.2.5.1 Retrospective Reviews

When Retroactive Eligibility and Retrospective Reviews requests are necessitated for Members, the Contractor shall not deny payment for medically necessary covered services for lack of prior authorization or lack of referral. The Contractor shall not deny a claim on the basis of the provider's failure to file the claim within a specified time period after the date of service when the Provider could not have reasonably known which Contractor the Member was in during the timely filing period.

Additionally, upon receipt of notification that a Member is transferring from one (former) Contractor to a (new) Contractor, the former Contractor shall be responsible for contacting the new Contractor, the Member and the Member's Providers in order to transition existing care. A Prior Authorization (PA) shall be honored by the New Contractor for 90 days or until the recipient or Provider is contacted by the New Contractor regarding the PA. If the recipient and Provider are not contacted by the New Contractor, the existing PA shall be honored until expired.

9.2.5.2 Hospital Admission Prior to the Member Transition

If the Member is an inpatient in any facility at the time of transition, the Contractor responsible for the Member's care at the time of admission shall continue to provide coverage for the Member at that facility, including all Professional Services, until the Member is discharged from the facility for the current admission. An inpatient admission within fourteen (14) calendar days of discharge for the same diagnosis shall be considered a "current admission." The "same diagnosis" for an inpatient admission is defined as the primary APR-DRG assigned to that admission.

9.2.5.3 Outpatient Facility Services and Non-Facility Services

Effective on the Member's Transition date, the New Contractor will be responsible for outpatient services, both facility and non-facility.

9.2.5.4 Transplants

Follow up care for Members receiving a transplant provided on or after the Member's Transition, that is billed outside the Global Charges, will be the responsibility of the New Contractor.

9.2.5.5 Eligibility Issues

For a Member who loses eligibility during an inpatient stay, a Contractor is responsible for the care through discharge if the hospital is compensated under a DRG methodology, or through the day of ineligibility if the hospital is compensated under a per diem methodology.

9.2.6 Prohibitions

The Contractor is prohibited from paying for an item or services (other than an emergency item or service, not including items or services furnished in an emergency room of a hospital):

1. Furnished under the Contractor by an individual, entity, or Provider when that individual, entity, or Provider is excluded from participation;

2. Furnished at the medical direction or on the prescription of physician during the period when such physician is excluded from participation and the person furnishing such item or service know, or had reason to know of the exclusion (after a reasonable time period after reasonable notice has been furnished to the person);

3. Furnished by an individual or entity to whom the state has failed to suspend payments against the individual or entity, unless the state determines there is good cause not to suspend such payments;

4. With respect to any amount expended for which funds may not be used under the Assisted Suicide Funding Restriction Act of 1997 (42 U.S.C. § 14401, et seq.);.

5. With respect to any amount expended for roads, bridges, stadiums, or any other time or service not covered under the or any other item or service not covered under the Medicaid State Plan; and

6. For home health care services provided by an agency or organization, unless the agency provides the Contractor with a surety bond as specified in Section 1861(0)(7) of the Act.

9.2.6.1 No Supplemental Payments

The Contractor must assist the Division in ensuring that no payment is made to a Network Provider other than by the Contractor covered under this Contract, except when these payments are specifically required to be made by the Division in Title XIX of the Act, in 42 C.F.R. chapter IV.

9.2.6.2 Payments for Potentially Preventable Conditions

The Contractor may not make payments for Potentially Preventable Conditions as defined by the Federal regulations and the Mississippi State Plan in accordance with 42 C.F.R. § 438.3(g).

In accordance with the Mississippi State Plan, the Contractor shall identify and deny Never Events as defined in this Contract, which are a type of Potentially Preventable Condition. The Contractor shall track data and submit a report quarterly, in a format to be specified by the Division.

Section 2702(a) of the PPACA prohibits FFP payments to States for any amounts expended for providing medical assistance for health care-acquired conditions (HCACs) and other Potentially Preventable Conditions (PPCs). PPCs are, at a minimum, HCACs not present on admission to the healthcare facility, the wrong procedure performed on a patient, and procedures performed on a wrong patient or body part. The Contractor may not make payments for HCACs or PPCs as defined by the federal regulations in accordance with 42 C.F.R. § 438.3(g). The Contractor must require Providers to report on HCACs and PPCs associated with claims for payment or Member treatment for which payment would otherwise be made. The Contractor will track HCAC and PPC data and make it available to the Division upon request.

9.2.6.3 Payments from Members

Members utilizing medical services that are not medically necessary or who obtain covered services from Out-of-Network Providers without Prior Authorization and referral by the Contractor shall be responsible for payment in full of all costs associated with such services.

The Contractor shall not require any co-payments, deductibles, or other cost sharing by Members for covered services under this Contract unless co-payments, deductibles, or other cost sharing are allowable under federal law or regulation and subject to the review and approval by the Division prior to implementation. Co-payments are allowed as stated under Section 4.2.11, CHIP Member Financial Liability, of this Contract.

The Contractor shall not charge Members for missed appointments. Members with coverage from Third Party Liability/Resources shall not be required to pay any portion of the medical fees for covered services under this Contract, even during the deductible periods of these other health plans.

If applicable, any cost sharing imposed on Medicaid enrollees will be in accordance with Medicaid Fee-for-Service requirements at 42 C.F.R. § 447.50 through 42 C.F.R. § 447.90 for MississippiCAN Members or CHIP (as applicable). Additionally, the Contractor must exempt from premiums and cost-sharing any American Indian who is eligible to receive, is currently receiving, or has received an item or service furnished by an Indian health care provider or through referral under contract health services, if applicable.

The Member may be responsible for non-covered item(s) and/or service(s) only if the Provider ensures that written documentation in compliance with the Advance Beneficiary Notification

(ABN) is received by the Member stating that an item(s) or service(s) rendered is a non-covered item and/or service(s) and that the Member will be financially responsible for the item(s) and/or service(s).

9.2.7 Payment for Psychiatric Hospital Services

The Contractor shall reimburse for services provided by a licensed freestanding psychiatric hospital, defined by Miss. Code Ann. § 41-7-173 (h)(ii), to eligible members age twenty-one (21) to sixty-four (64) with a mental health or substance use disorder as an "in lieu of" service as authorized by 42 C.F.R. § 438.3. Reimbursement shall not exceed fifteen (15) days per member per month. The Contractor shall submit monthly a utilization report of these services in a format to be specified by the Division and outlined in the Reporting Requirements Exhibit.

9.2.8 Physician Incentive Plans

The Contractor may operate a physician incentive plan only if no specific payment can be made directly or indirectly under a physician incentive plan to a physician or physician group as an inducement to reduce or limit Medically Necessary Services furnished to a Member. Contracts must comply with the requirements set forth in 42 C.F.R. §§ 422.208 and 422.210.

The Contractor shall provide to the Division of Medicaid the following disclosure annually or at the request of the Division of Medicaid:

1. Whether services not furnished by physician/group are covered by incentive plan. If the physician incentive plan does not cover services furnished by physician/group, no further disclosure is required;

2. The type of incentive arrangement (included but not limited to withhold, bonus, capitation, any other incentive arrangements that have the potential to hold a physician or a physician group liable for more than 25 percent (25%) of potential payments);

3. Percentage of withhold or bonus, if applicable;

4. Panel size, and if patients are pooled, the approved method used; and

5. If the physician/group is at substantial financial risk, the Contractor must report proof the physician/group has adequate stop-loss coverage, including amount and type of stop-loss.

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MISSISSIPPI DIVISION OF
MEDICAID

10. Fraud, Waste, and Abuse

10.1 General Requirements

The Division's Office of Program Integrity will oversee all Fraud, Waste, and Abuse activities conducted by the Contractor. The Contractor must comply with all federal and state requirements regarding fraud, waste, and abuse including but not limited to 42 C.F.R. Part 455, Section 1902 (a)(68) of the Social Security Act, and 42 C.F.R. § 438.608. The Contractor must comply with all written direction by the Office of Program Integrity regarding waste, fraud, and abuse investigations, overpayments, and any other program integrity related activities and reporting. The Contractor must use the most current version of the Program Integrity Fraud and Abuse Standard Operating Procedure for referrals and reporting to the Division of Medicaid, Office of Program Integrity.

The Contractor cannot be owned by, knowingly hire, or contract with an individual who has been debarred, suspended, or otherwise excluded from participating in federal procurement activities or has an employment, consulting, or other Agreement with a debarred individual for the provision of items and services that are related to the entity's contractual obligation with the State, in accordance with 42 C.F.R. § 438.610.

Pursuant to 42 C.F.R. § 438.608(d)(2), Contractor shall require and have a mechanism for a network provider to report to the Contractor when it has received an overpayment, to return the overpayment to the Contractor when it has received an overpayment, to return the overpayment to the Contractor within 60 calendar days after the date on which the overpayment was identified, and to notify the Contractor in writing of the reason for the overpayment.

10.1.1 Program Overview

The Contractor and any subcontractors delegated responsibility for coverage of services or payment of claims under this Contract, shall implement and maintain a compliance program, as described in 42 C.F.R. § 438.608 and the Division's policies and procedures, that includes, at a minimum:

1. Written policies, procedures, and standards of conduct that articulate the organization's commitment to comply with all applicable requirements and standards under the Contract, and all applicable Federal and State requirements.

2. The designation of a Compliance Officer who is responsible for developing and implementing policies, procedures, and practices designed to ensure compliance with the

requirements of the Contract and who reports directly to the Chief Executive Officer and the board of directors.

3. A system for training and education for the Compliance Officer, the organization's senior management, and the organization's employees for the Federal and State standards and requirements under the Contract.

4. Effective lines of communication between the Contractor's compliance officer and the organization's employees.

5. The establishment of a Regulatory Compliance Committee on the Board of Directors and at the senior management level charged with overseeing the compliance program and its compliance with the requirements under the Contract.

6. Enforcement of standards through well-publicized disciplinary guidelines.

7. A system with dedicated staff for routine internal monitoring and auditing of compliance risks, prompt response to compliance issues as they are raised, investigation of potential compliance problems as identified in the course of self-evaluation and audits, correction of such problems promptly and thoroughly (or coordination of suspected criminal acts with law enforcement agencies) to reduce the potential for recurrence, and ongoing compliance with the requirements under the Contract.

8. Assistance to the Division in any investigation or prosecution of fraud by providing the following:

   a. Access to and free copies of computerized data stored by the Contractor;

   b. Direct computer access to computerized data stored by the Contractor that is supplied without charge and in the form requested by the Division; and

   c. Access to any information possessed or maintained by any Provider of service(s) under the Medicaid State Plan to which the Division and the Contractor are authorized to access.

9. Provision for prompt reporting of all Overpayments identified or recovered, specifying the Overpayments due to potential fraud to the State.

10. Provisions for prompt notification to the State when it receives information about changes in a Member's circumstances that may affect the Member's eligibility including all of the following:

    a. Changes in the Member's residence;

    b. The death of a Member.

11. Provision for notification to the State when it receives information about a change in a Network Provider's circumstances that may affect the network provider's eligibility to participate in the managed care program, including the termination of the provider agreement with the Contractor.

12. Provision for a method to verify, by sampling or other methods, whether services that have been represented to have been delivered by Network Providers were received by Members and the application of such verification processes on a regular basis.

13. In the case of CCOs, PIHPs, or PAHPs that make or receive annual payments under the contract of at least $5,000,000, provision for written policies for all employees of the entity, and of any contractor or agent, that provide detailed information about the False Claims Act and other Federal and State laws described in section 1902(a)(68) of the Social Security Act, including information about rights of employees to be protected as whistleblowers.

14. Provision for the prompt referral of any potential fraud, waste, or abuse that the Contractor identifies to the Division of Medicaid's Office of Program Integrity.

15. Provision for the Contractor's suspension of payments to a Network Provider for which the State determines there is a credible allegation of fraud in accordance with 42 C.F.R. § 455.23.

10.1.2 Engagement with Division's Office of Program Integrity

Suspected Fraud and/or Abuse regarding a provider or Member should be addressed to the Division of Medicaid's Office of Program Integrity. The Division of Medicaid's Office of Program Integrity should be notified in writing within thirty (30) calendar days of the discovery of any overpayments or underpayments made for services provided to Medicaid beneficiaries by providers.

If the Contractor identifies a Subcontractor, Member, or Provider that the Contractor suspects of committing fraud and/or abuse, the Contractor must notify Office of Program Integrity in writing immediately upon discovery and investigate the Subcontractor, Member, or Provider.

The Division of Medicaid shall conduct investigations related to suspected provider fraud, waste, and abuse cases and reserves the right to pursue and retain recoveries for these investigations.

The Contractor shall be subject to onsite reviews and comply with requests from the Division of Medicaid to supply documentation and records.

The Contractor and the Office of Program Integrity shall meet at least quarterly, and more frequently as needed, via phone, teleconference, video conference, or in-person to discuss areas of interest for past, current, and future investigations and to improve the effectiveness of fraud, waste, and abuse oversight activities.

10.1.3 Compliance Staff

In addition to the Compliance Officer, the Contractor shall employ at least two (2) additional employees focused on fraud and abuse:

1. At least one (1) employee responsible for managing all fraud and abuse detection activities for the Contractor, including the Fraud and Abuse Compliance Plan, as set forth Section 10.3, Fraud and Abuse Compliance Plan, of this Contract.

2. At least one (1) employee to serve as an investigator who resides in and is designated to the State of Mississippi. The investigator(s) will have full knowledge of provider investigations related to MississippiCAN and CHIP respectively and will be the key staff handling day-to-day provider investigation-related inquiries from the Division's Office of Program Integrity.

10.1.4 Provider Site Audits

The Contractor shall complete a minimum of six (06) OPI acceptable provider on-site audits, excluding any re audits or follow-up audits, by the end of the third quarter of the SFY, but two (02) on-site audits must occur quarterly. If two (02) on-site audits are not completed quarterly by the third quarter of the SFY, then a minimum of eight (08) on-site audits must be completed.

10.1.5 Cooperation with Other Agencies

The Contractor must cooperate with all appropriate state and federal agencies, including the Mississippi Attorney General's Medicaid Fraud Control Unit, in investigating fraud, waste, and abuse.

10.2 Fraud and Abuse Compliance Plan

10.2.1 Submission

The Contractor must have a written Fraud and Abuse compliance plan for MississippiCAN and CHIP that meets the 2016 Federal Requirements related to the Compliance Plan. The plan, including fraud and abuse policies and procedures, must be provided to the Office of Program Integrity for written approval within ninety (90) calendar days of execution of this Contract and annually thereafter. The Division will provide notice of approval, denial, or modification to the Contractor within sixty (60) calendar days of receipt. Revisions to an approved compliance plan or fraud and abuse policies and procedures must be submitted to the Office of Program Integrity for written approval at least sixty (60) calendar days prior to the planned implementation of those revisions.

The Contractor shall annually review and submit an updated Fraud and Abuse compliance plan to the Division for approval.

10.2.2 Plan Requirements

The Contractor's fraud, waste, and abuse compliance plan must:

1. Require reporting of fraud, waste, and abuse comply with the requirements of this Contract;

2. Include a risk assessment of the Contractor's various fraud, waste, and abuse and program integrity processes;

    a. A risk assessment must also be submitted when requested by the Division and immediately after a program integrity related action, including financial-related actions (such as overpayment, repayment, and fines), is issued on a provider with concerns of fraud, waste, and abuse. The Contractor must inform the Division of such action and provide details of such financial action. The assessment shall also include a listing of the Contractor top three vulnerable areas and shall outline action plans in mitigating such risks;

3. Outline unique policy and procedures, including specific instruments to be used;

4. Include procedures designed to prevent and detect abuse and fraud in the administration of delivery of services under this Contract;

5. Describe of the specific controls in place for prevention and detection of potential or suspected fraud, waste, and abuse, including but not limited to:

    a. A list of automated pre-payment claims edits;

    b. A list of automated post-payment claims edits;

    c. A list of desk audits on post-processing review of claims;

    d. A list of surveillance and/or utilization management protocols used to safeguard against unnecessary or inappropriate use of Medicaid services;

6. Include a list of provisions for the investigation and follow-up of any suspected or confirmed fraud, waste, and abuse, even if already reported, and/or compliance plan reports;

7. Ensure that the identities of individuals reporting violations of the Contractor are protected and that there is no retaliation against such persons;

8. Contain specific and detailed internal procedures for officers, directors, managers, and employees for detecting, reporting, and investigating fraud, waste, and abuse compliance plan violations;

9. Contain specific and detailed internal procedures on how information received from the State regarding providers already under investigation or review is disseminated internally to the appropriate group(s). Specifically, outline the steps that are in place to ensure providers under review or investigation are not contacted or investigated unless approval has been received from the Office of Program Integrity;

10. Require any confirmed or suspected provider fraud, waste, and abuse under state or federal law be reported to the Division's Office of Program Integrity;

11. Include work plans for conducting both announced and unannounced site visits and field audits to providers defined as high risk (providers with cycle/auto billing activities, providers offering DME, home health, mental health, and transportation services) to ensure services are rendered and billed correctly;

12. Include provisions about conducting monthly comparison of the Contractor's provider files against the Social Security Master Death File, the General Services Administration (GSA) System for Award Management (SAM) and the HHS-OIG List of Excluded Individuals/Entities (LEIE) and provide a report of the result of comparison to the Division each month. The Contractor must establish an electronic database to capture identifiable information on the owners, agents and managing employees listed on providers' Disclosure information as provided by the Division;

13. Include provisions about performing a monthly check for exclusions of their owners, agents and managing employees. The Contractor must establish an electronic database to capture identifiable information on its owners, agents and managing employees and perform monthly exclusion checking. The Contractor must provide the Division with such database and a monthly report of the exclusion check; and

14. Include details regarding prompt terminations of inactive providers due to inactivity in the past twelve (12) months, unless the Division provides prior approval for a provider type to remain contracted or as otherwise required by the Division.

10.3 Investigation and Reporting of Fraud, Waste, and Abuse

10.3.1 Duty to Report to the Division

The Contractor must report Subcontractor, Member, or Provider fraud and/or abuse that it has reasonable cause to suspect, or should have had reasonable cause to suspect, immediately to the Division. The Contractor must cooperate with the Division regarding the investigation. Failure to report and/or cooperate with the Division to investigate fraud could result in criminal and/or civil penalties for the Contractor.

The Contractor must report Member or Provider Fraud or Abuse in a format to be specified by the Division. The Contractor must use the most current version of the Program Integrity Fraud and Abuse Standard Operating Procedure for referrals and reporting to the Division of Medicaid, Office of Program Integrity

10.3.2 Division Authorization Required

10.3.2.1 Fraud Reported to the Division

The Contractor must not take any of the following actions once the suspected fraud is substantiated and reported to the Division without prior written approval from the Division:

1. Contact the subject of the investigation about any matters related to suspected and/or confirmed fraud or abuse;

2. Enter into or attempt to negotiate any settlement or agreement regarding incidents of suspected or confirmed fraud or abuse; or

3. Accept any monetary or other thing of valuable consideration offered by the subject(s) of the investigation in connection with incidents of suspected or confirmed fraud or abuse

Upon a finding by the Contractor of fraud and/or abuse, the Contractor may disenroll a network provider and request actions to be taken by the Division. However, the Contractor cannot indicate to the Provider or Member that they will be disenrolled from Medicaid or CHIP.

10.3.2.2 Retrospective Reviews

All retrospective reviews must be pre-approved by the Office of Program Integrity. This includes investigations of claims initiated by the Contractor and/or its Subcontractor. The Contractor is allowed a look-back period of a minimum of eighteen (18) months and a maximum of thirty-six (36) months based on the date of service of the claim.

The Contractor must submit a written request to the Office of Program Integrity to retrospectively audit a provider.

10.3.2.3 Prepayment Reviews

All prepayment reviews must be pre-approved by the Office of Program Integrity. This includes the Contractor and/or its Subcontractor. The Contractor must submit a written request to the Office of Program Integrity to place providers on prepayment review.

All prepayment reviews must be completed within twelve (12) months of case initiation. The Contractor must re-evaluate the case after the twelve (12) months to determine if the provider's billing practices have changed and a continuation of the prepayment review is necessary to prevent future improper payments or refer the case as a credible allegation of fraud. The Contractor must submit a new written request to the Office of Program Integrity for the new prepayment review.

The Contractor cannot use prepayment review to hold claims for an indefinite period.

10.3.2.4 Overpayments

The Contractor must implement and maintain procedures that are designed to detect and prevent fraud, waste, and abuse. The procedures must include a provision for reporting to the State, of all overpayments identified or recovered, within 30 calendar days, specifying the overpayments due to potential fraud. (See §§ 42 C.F.R. 438.608(a)(2) and(d)(3); and 457.1285).

When recovering funds on behalf of the Division, the Contractor will retain any overpayments identified and collected because of the audit if the Division approves the investigation. The Contractor will be responsible for collecting the overpayment for any provider audited.

If it is determined that the Office of Program Integrity will conduct an investigation, the Division will be responsible for collecting the overpayments of providers audited.

The Contractor will be required to report to the Office of Program Integrity within thirty (30) calendar days all overpayments identified or recovered, specifying the overpayment due to potential fraud to the State and annually all Overpayments recovered from providers. This information, along with Office of Program Integrity overpayments, will be reported to the entity that is responsible for rate setting according to 42 C.F.R. § 438.608(a)(2) effective May 2024.

10.3.2.5 Recoupment

The Contractor is prohibited from taking any action to recoup improperly paid funds already paid or withhold funds potentially due to a provider when the issues, services, or claims upon which the recoupment or withhold are based meet one or more of the following criteria:

1. The improperly paid funds have already been recovered by the State of Mississippi, either directly by the Division or as part of a resolution of a state or federal investigation and/or lawsuit, including but not limited to False Claims Act cases; or

2. The improperly paid funds have already been identified by the State's Recovery Audit Contractor (RAC); or

3. When the issues, services, or claims that are the basis of the recoupment or withhold are currently being investigated by the State of Mississippi, are the subject of pending Federal or State litigation or investigation, or are being audited by the Mississippi RAC.

This prohibition is limited to a specific provider, for specific dates, and for specific issues, services, or claims. The Contractor must confer with the Office of Program Integrity before initiating any recoupment or withhold of any program integrity related funds to ensure that the recovery recoupment or withhold is permissible.

If the Contractor obtains funds in cases where recovery or withhold is prohibited under this section, the Contractor will return the funds to the Division of Medicaid.

10.3.2.6 Suspension of Payment

The rules governing payment suspensions based upon pending investigations of credible allegations of fraud apply to Mississippi Coordinated Care Organizations. Each Contractor must cooperate with the Division when the Office of Program Integrity imposes payment suspensions or lifts a payment suspension. In accordance with 42 C.F.R. § 455.23, the Contractor must also suspend payments to the Provider within twenty-four (24) hours of receipt of notification from the Division that payments to a provider have been suspended and immediately inform the Division of that action. Such suspension shall include any claims that may be ready for payment, unless otherwise stated by the Division. The Contractor must lift a payment suspension within twenty-four (24) hours of receipt of notification from the Division of a payment suspension lift and immediately inform the Division of that action.

The Contractor shall require its Subcontractors, when applicable, to suspend payments to Providers for all claims the Subcontractor has or may have against any entity that directly or indirectly receives funds under this Contract. The Contractor is responsible for the return of any money paid in error for services provided to a suspended Provider. If the Contractor does not suspend payments to the Provider, or if the Contractor does not correctly report the amount of adjudicated payments on hold, the Division may impose contractual or other remedies.

10.3.2.7 Credible Allegation of Fraud

The state Medicaid Fraud Control Unit (MFCU) has statewide authority to prosecute individuals and entities for violations of laws with respect to fraud in the provision or administration of medical assistance under the Medicaid program. In accordance with federal regulations, the Office of Program Integrity must refer any and all cases of credible allegations of fraud to MFCU. The Contractor must report cases of fraud after due diligence and investigation reveals a credible allegation of fraud to the Office of Program Integrity immediately. The Office of Program Integrity will determine if a referral is made to MFCU.

10.3.2.8 Provider Terminations

The Division will not reimburse the Contractor for services rendered by any provider that is excluded or debarred from participation by Medicare, Medicaid, including any other state's Medicaid or CHIP program, except Emergency Services. The Contractor must terminate and/or exclude from participation the enrollment of any provider that is terminated under Medicaid, Medicare or CHIP programs of any other state.

The Office of Program Integrity maintains a list of providers whose Medicaid provider agreements have been terminated due to sanction or conviction of fraud. The Contractor must review the Mississippi Sanctioned Provider List at least monthly.

10.4 Pharmacy Lock-In Program

Beneficiary Health Management Program (BHMP)

The Contractor shall administer and monitor a health and safety program (BHMP) in which beneficiaries who may over utilize medical and/or pharmacy benefits may be assigned to either a prescriber(s) or a pharmacy(ies), or both, for a reasonable period of time 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, b

sed upon whether the member has utilized Medicaid medical and/or pharmacy services at a frequency or amount that is not medically necessary. The continued need for lock-in shall be re-evaluated at the end of the lock-in period by the Contractor for each member in the program.

Components of existing policies are as follows:

1. Beneficiaries 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 beneficiary 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 beneficiary. 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 phar

acy does not immediately have the medication.

4. Beneficiaries must be permitted to choose or change providers for good cause. Good cause is defined as:

a. Death, retirement, or closing of the specified provider,

b. Change in geographical location of the beneficiary or provider,

c. Provider discontinues participation in the Medicaid Program, or

d. Provider is terminated from participation in the Medicaid Program.

5. Care management and education reinforcement of appropriate medication/provider use shall be provided to the Division, which shall include reporting of over-prescribing providers. A Plan for an education program for beneficiaries shall be developed and submitted for review and approval by the Division's Office of Program Integrity.

7. When finalizing member BMHP decisions, the Contractor shall take into consideration the beneficiaries prior BMHP experiences with the Medicaid-Fee-For- Service Program and

hose of other Medicaid-participating CCOs, utilizing BMHP data made available by the Division. The contractor may be required to BMHP members at the request of DOM.

8. At a minimum, the Contractor will provide Medium to High-Risk Care Management services to all lock-in beneficiaries, specifically members with substance use disorders, as outlined Section 4.1.4 MississippiCAN Behavioral Health/Substance Abuse Disorder.

9. The Contractor must utilize the same criteria for members whether enrolled in managed care or fee-for-service. Applicable criteria found in Administrative Code Title 23 Medicaid Part 305, Program Integrity, Chapter 2, Beneficiary Health Management.

The Contractor shall utilize uniform criteria between beneficiaries in managed care and fee-for-service in order to ensure continuity of care between members.

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

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MISSISSIPPI DIVISION OF MEDICAID

11. Financial Requirements

11.1 Capitation Payments

11.1.1 Monthly Payments

On or before the tenth (10^{th}) business day of each month during the term of this Contract, the Division shall remit to the Contractor the capitation rate specified for each Member listed on the Member Listing Report issued for that month. Payment is contingent upon satisfactory performance by the Contractor of its duties and responsibilities as set forth in this Contract. As a condition for receiving payment under a Medicaid managed care program, a Contractor entity must comply with the requirements in 42 C.F.R. §§ 438.604, 438.606, 438.608, and 438.610, as applicable. All payments shall be made by electronic funds transfers, the cost of which shall be borne by the Contractor.

11.1.1.1 Bank Accounts

The Contractor shall set up the necessary bank accounts and provide written authorization to the Division's Agent to generate and process monthly payments through the Division's internal billing procedures.

11.1.1.2 Capitation Payment Calculation

The Division will pay the Contractor monthly Capitation Payments based on the number of eligible and enrolled Members. The Division will calculate the monthly Capitation Payments by multiplying the number of Member Months times the applicable monthly capitation rate by Member Rate Cell in Exhibit A, Capitation Rates. The Division will risk adjust the Non-Newborn SSI/Disabled, MA Adult, MA Children and Quasi-CHIP Rate Cells. These four Rate Cells have a Risk Adjustment factor, calculated using the CDPS+RX applied to each rate re-calculated based on each Contractor's actual risk scores. The Foster Care Rate Cell will also be risk adjusted using a Member's eligibility for either state or federal financial assistance to assign a risk score; however, the risk adjustment will not apply to newborns in Foster Care. The Division may adjust the Rate Cells needing Risk Adjustment or methodology from time to time as needed based on changes in eligibility criteria.

Please see Exhibit A for the capitation rates.

11.1.1.3 Capitation Payment Rate Development

Capitation Payments will be developed in accordance with the requirements of 42 C.F.R. § 438.4(b). The Contractor must provide the Services and Deliverables, including covered services to Members, described in the Contract for monthly Capitation Payments to be paid by the Division. Members are entitled to receive all Covered Services for the entire period for which the Division has made payment.

Please see Exhibit A for the capitation rates.

11.1.1.4 Incentive Arrangements

The Division reserves the right to institute incentive arrangements pursuant to 42 C.F.R. § 438.6(b)(2) with the Contractor through payments in excess of the approved Capitation Payments to support program initiatives. If such an arrangement is made, the Division will not provide payment in excess of five (5) percent above the approved Capitation Payments attributable to the enrollees or services covered by the incentive arrangement. For all such incentive arrangements, the arrangement will be for a fixed period of time, with performance measured during the rating period under the contract in which the incentive arrangement is applied. Pursuant to 42 C.F.R. § 438.6(b)(2)(ii), arrangements will not be renewed automatically.

11.1.1.5 Quality Withhold

The Division withholds two-percent (2%) of the monthly MSCAN Capitation Payment as an incentive to promote a core set of quality and health outcomes as determined by the Division. Each year, the Division will establish quality withhold measures and targets, with each measure being assigned a percentage of the withhold amount. For each measure, the Contractor must meet or exceed the established target to earn back the percentage of the withhold associated with that measure. The Contractor can only earn back the entirety of the withhold by meeting targets for all withhold measures.

If Contractor does not have sufficient data to consider its HEDIS scores credible, the Division will not hold the Contractor liable for not meeting the measurement. In this case, the portion of the incentive withheld related to that measurement will be returned to the Contractor.

Withhold measures will be revised on a yearly basis. HEDIS-associated measures will be measured on a calendar year period. Non-HEDIS-associated measures may be measured on a calendar year or the Mississippi state fiscal year period, at the discretion of the Division.

The withhold amount will correlate with state fiscal year capitation rates and will be withheld on a state fiscal year basis.

The reporting timeframes and due dates for each year are as follows:

1. January 1 – December 31 – Preliminary report due by July 15 after the close of the state fiscal year.
2. January 1 – December 31 – Final rates reported by January 15 after the close of the state fiscal year.

Incentive payments earned back by the Contractor will be paid to the Contractor by the Division within thirty (30) calendar days after each reporting period due date. The payment will equate to fifty percent (50%) of the total amount of incentive earned for the reporting date.

11.1.1.5.1 Quality Withhold Measurements and Targets

The quality withhold measurements and targets are also included in the capitation rate letter referenced in Exhibit A.

CCO MSCAN SFY 2026 Incentive/Withhold Targets		
Quality Measure	**Sub Measure**	**Target**
Developmental Screening in the First Three Years of Life (DEV-CH) †		**5.56%**
Immunizations for Adolescents (IMA)	***Combination 1***	**54.96%**
Anti-Depressant Management (AMM-AD)	***Effective Acute Phase Treatment***	**54.23%**
Follow up After Hospitalization for Mental Illness (FUH)	***30 Days - Ages 6 to 17***	**71.36%**

Prenatal and Postpartum Care: Postpartum Care (PPC-AD)		**78.15%**
Postpartum Depression Screening and Follow-up (PDS-E)		**5.00%**
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)		**28.43%**
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB-CH)	***Ages 3 Months to 17 Years***	**55.57%**
Adults: Pharmacotherapy Management of COPD Exacerbation (PCE)	***Systemic Corticosteroid***	**53.84%**
QIPP PPHR A/E Ratio		**2% improvement over Baseline Years of CY 2021 and 2022 (If a/e ratio >1.0) ††**

Each measure will be used to allow the Contractor to earn back one tenth (10%) of the quality withhold across all measures if the Contractor meets the target improvement compared to the benchmarks set by the Division. Measures with an asterisk represent a new measure, which a floor will be implemented to allow the Contractor to earn back a prorated amount. This floor will be calculated at 75% of the increase between the baseline and target.

11.1.1.6 Assumption of Risk

The Contractor must understand and expressly assume the risks associated with the performance of the duties and responsibilities under the Contract, including the failure, termination, or suspension of funding to the Division, delays or denials of required approvals, cost of claims incorrectly paid by the funding to Division, and cost overruns not reasonably attributable to the Division. The Contractor must further agree that no other charges for tasks, functions, or activities that are incidental or ancillary to the delivery of the Services and Deliverables will be sought from the Division or any other state agency, nor will the failure of the Division or any other party to pay for such incidental or ancillary services entitle the Contractor to withhold services or Deliverables due under the Contract.

11.1.2 Payment in Full

The Contractor shall accept the Capitation Payment paid each month by the Division as payment in full for all services to be provided pursuant to this Contract and all administrative costs associated therewith. Members shall be entitled to receive all covered services for the entire period for which payment has been made by the Division.

Because this is a comprehensive risk contract as defined under 42 C.F.R. § 438.3, the Contractor understands that any and all costs incurred by the Contractor in excess of the Capitation Payment shall be borne in full by the Contractor. Interest generated through investment of funds paid to the Contractor pursuant to this Contract shall be the property of the Contractor to use for eligible expenditures under this Contract.

Failure to enroll the Members identified in Section 7.4.3.3.1, Care Management: Assignment of Risk Levels: Mandatory Assignments into the Contractor will result in Capitation Payment reduction.

Failure to provide Care Management services as required under Section 7, Care Management will result in Capitation Payment reduction.

11.1.3 Rate Adjustments

The Contractor and the Division acknowledge that the capitation rates are subject to approval by the Federal government. Adjustments to the rates may be required to reflect legislatively or congressionally mandated changes in Medicaid services, program changes, changes in the scope of mandatory services, or when capitation rate calculations are determined to have been in error. In such events, funds previously paid may be adjusted as well. Within thirty (30) calendar days following written notice by the Division, the Contractor agrees to refund any overpayment to the Division, and the Division agrees to pay any underpayment to the Contractor.

In addition, the Division will review rates annually and adjust rates as deemed necessary, and in accordance with state and federal laws and regulations, subject to approval from the Federal government.

For the purposes of capitation rate setting and other financial reporting purposes, Contractor compensation shall be capped in accordance with Section 702 of the Bipartisan Budget Act of 2013. The BBA established a cap on reimbursement of compensation costs for Contractor employees, which is adjusted annually to reflect the change in the Employment Cost Index for all workers as calculated by the Bureau of Labor Statistics (BLS). See 10 U.S.C. § 2324(e)(1)(P) and 41 U.S.C. §4304(a)(16).

11.1.4 Application of CMS Sanctions

Payments provided for under this Contract will be denied for new Members when, and for as long as, payment for those Members is denied by CMS pursuant to 42 C.F.R. § 438.730.

11.1.5 Refund and Recoupment

The Division may request and obtain a refund of, or it may recoup from subsequent payments, any payment previously made to the Contractor for a Member who is determined to have been ineligible for Enrollment for any month. Upon notice by the Division of a Member who is ineligible, the Contractor may recoup from any Providers previously paid the amounts for any provided covered services. The Contractor must recoup these amounts within one hundred twenty (120) days of notification that the Member is ineligible.

11.1.6 Reserve Account

The Contractor shall establish and maintain an insured bank account or a secured investment that complies with the Mississippi Insurance Department regulations referenced in Miss. Code Ann. § 83-41-325 (1972, as amended).

11.1.7 Reinsurance

The Contractor must supply a guarantee of coverage letter, with annual updates, for any outstanding claims.

The Contractor must insure any portion of the risk under the provision of the Contract based upon the Contractor's ability (size and financial reserves included) to survive a series of adverse experiences, including but not limited to withholding of payment by the Division, or imposition of liquidated damages or other remedies by the Division. These arrangements must be approved by the Division.

11.1.8 Capitation Rates

The Contractor will be required to serve eligible Medicaid beneficiaries across the entire state. The Contractor will receive a prepaid capitated monthly payment and will provide services through a full-risk arrangement. Once the Division notifies the Contractor that the capitation rates and risk adjustment developed by the Division and its actuary are final and not subject to further negotiation, the Contractor must accept capitation rates and risk adjustment methodology within fifteen (15) business days of such rates being presented to the Contractor by the Division. Acceptance of such capitation rates and risk adjustment methodology shall be indicated by execution of any amendment to this Contract incorporating such rates or methodology. Any capitation rates and risk adjustment methodology subsequently disapproved by CMS shall be deemed null and void immediately upon notification by CMS to the Division of the disapproval. The Division shall notify the Contractor of CMS approval or disapproval of any capitation rates or risk adjustment methodology within two (2) business days of receipt of such approval or disapproval. Should CMS disapprove, the Division will submit a revised rate request to CMS.

Current Capitation Rates will be incorporated under Exhibit A: Capitation Rates, of this Contract, and any amendments thereto. Exhibit A includes the capitation rates per member per month (PMPM) varying by Rate Cell. Each Contractor will be paid based on the distribution of Members they have in each Rate Cell.

Capitation Rates will be adjusted as needed based on the most current actuarial information. The contractor and Division acknowledge that contracts for Medicaid capitated rates and services are subject to approval by CMS. Should the Division choose to use another vendor for any service(s) contemplated under this Contract, at no point will the Division pay duplicate payments to both the Contractor and the chosen vendor(s) for the service(s), and Capitation Rates will be adjusted accordingly. All Capitation Rates will follow the Rating Period and will be reviewed and adjusted no less than annually.

The Capitation Rate is established in accordance with 42 C.F.R. § 438. Prospective adjustments to rates may be required if there are mandated changes in Medicaid services to the MississippiCAN and CHIP populations through this Contract as a result of legislative, executive, regulatory, or judicial action. Changes applicable to this Contract mandated by state or federal legislation, or executive, regulatory, or judicial mandates, shall take effect on the dates specified in the legislation or mandate. In the event of such changes, any rate adjustments shall be made through the Contract amendment process.

11.1.9 Loss of Program Authority

Should any part of the scope of work under this contract relate to a state program that is no longer authorized by law (e.g., which has been vacated by a court of law, or for which CMS has

withdrawn federal authority, or which is the subject of a legislative repeal), the Contractor must do no work on that part after the effective date of the loss of program authority. The state must adjust capitation rates to remove costs that are specific to any program or activity that is no longer authorized by law. If the Contractor works on a program or activity no longer authorized by law after the date the legal authority for the work ends, the Contractor will not be paid for that work. If the state paid the Contractor in advance to work on a no-longer-authorized program or activity and under the terms of this Contract the work was to be performed after the date the legal authority ended, the payment for that work should be returned to the state. However, if the Contractor worked on a program or activity prior to the date legal authority ended for that program or activity, and the state included the cost of performing that work in its payments to the Contractor, the Contractor may keep the payment for that work even if the payment was made after the date the program or activity lost legal authority.

11.1.10 Capitation Payments During Implementation Period

During the implementation period, the Division will not make monthly Capitation Payments to any contracted entities under this contract. The Division will end the implementation period and begin the operational period at its discretion. The Division will make capitation payments to any contracted entities under this contract after the beginning of the operational period and no sooner. Thus, the Division will not submit a capitation rate letter regarding this contract to CMS for approval for the implementation period.

11.1.11 Risk Corridor

Risk Corridor for Pharmacy High - Cost Drugs – State Fiscal Year (SFY) 2026

For State Fiscal Year (SFY) 2026, some Medicaid members have conditions requiring very expensive drug treatments. These members are infrequent and not evenly distributed among the CCOs. To help mitigate the CCO's risk, the Division has incorporated a pharmacy high-cost drug risk corridor for SFY 2026, subject to CMS approval. The pharmacy high-cost drug risk corridor is applicable to total drug spend and related costs due to administration and monitoring for specified products of $250,000 or more per year at a member level. The capitation rates include a PMPM estimate of the costs that will be covered in the pharmacy high-cost drug risk corridor specific to each Rate Cell. The actual costs from the CCOs will be compared to these estimated costs for the final settlement calculation.

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

Mississippi Division of Medicaid Risk Corridor Parameters for Pharmacy High-Cost Drugs SFY 2026		
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 drugs billed as medical claims with a HCPCS code that starts with the letter "J."

(b) Inpatient stays for the administration and monitoring 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 2026.

i) Lyfgenia
ii) Casgevy
iii) Zynteglo

(3) The timing of the initial and final pharmacy high-cost drug risk corridor settlements are outlined below.

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

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

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

11.1.12 Pharmacy Payment Through Division PBA

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 the 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.

11.2 State Directed Payments

State Directed Payments (SDP) are financial arrangements authorized and approved by CMS that allow the Contractor to make specific directed payments to providers under certain guidelines as defined in 42 C.F.R. § 438.6. These payments are developed and reviewed annually by the Division and pertain only to the MSCAN population.

11.2.1 Mississippi Hospital Access Program

The Mississippi Hospital Access Program (MHAP) includes a directed payment provision as defined in 42 C.F.R. § 438.6 for hospitals estimated using the total pool of funds and the expected enrollment for each Rating Period. The Division will annually distribute to the Contractors the MHAP directed payments in the amount of the annual limit as approved by CMS. The Contractor shall receive separate monthly payments from the Division for MHAP. Within five (5) business days of receipt of monthly MHAP payments, the Contractor shall distribute the MHAP funds with no amount withheld for administrative cost. Annual settlement payments, recoupments or capitation rate adjustments will be issued by the Division to ensure the MHAP pool is distributed but not exceeded, due to fluctuations in member enrollment and the distribution of enrollment between Contractors. Within five (5) business days of receipt of any annual settlement payments, the Contractor shall distribute the MHAP funds with no amount withheld for administrative cost. The Division will notify the Contractor fifteen (15) calendar days in advance of a settlement recoupment.

The Division will reconcile the total amount paid to the Contractor for MHAP on an annual basis after a period of time for which Member Month runout has occurred.

The Contractor shall ensure all MHAP payments are distributed for the purpose of protecting patient access to hospital care at all in-state hospitals of all classes.

Contractor shall ensure all MHAP payments are distributed pursuant to the requirements and conditions as outlined in Miss. Code Ann. §43-13-117, et. seq (1972, as amended) for the purpose of protecting patient access to hospital care at the following out-of-state hospital that is

authorized by federal law to submit intergovernmental transfers (IGT's) to the State of Mississippi and classified as a Level I trauma center located in a county contiguous to the state line at least at a level of access available as of November 30, 2015.

The Division will administer any and all programs related to MHAP payments, with the Contractor only acting as a payor, withholding no administrative costs or fees. The Contractor shall participate in stakeholder meetings and otherwise cooperate with the Division in distribution of these payments to maintain hospital funding and/or comply with Federal requirements. The Division reserves the right to modify these payments to comply with state and federal regulations.

11.2.2 Mississippi Medicaid Access to Physician Services

The Mississippi Medicaid Access to Physician Services (MAPS) is a directed payment arrangement that is a uniform percentage increase applied to utilization during the payment arrangement period. MAPS has been established by the state for eligible physicians and professional practitioners as defined in the preprint including the payment arrangement and approval, which is pursuant to 42 C.F.R. § 438.6. State-owned academic health science centers with a Level 1 trauma center, Level 4 neonatal intensive care nursery, organ transplant program and more than a four hundred physician multispecialty practice group are eligible for MAPS.

MAPS payments are made quarterly plus a final reconciliation for the year. When the Contractor receives payment of MAPS, it shall be paid within five (5) business days of receipt, and the Contractor shall distribute the MAPS funds with no amount withheld for administrative cost.

11.2.3 Transforming Reimbursement for Emergency Ambulance Transportation (TREAT) Directed Payments

The Transforming Reimbursement for Emergency Ambulance Transportation (TREAT) ambulance directed payment arrangement will reimburse emergency ambulance services providers based on actual emergency ambulance services provided to members in the MississippiCAN program. The payment arrangement is intended to improve access to care by providing funding needed to maintain adequate emergency services and/or attracting new ambulance service providers to serve the MississippiCAN membership. The payment methodology, which is included in the preprint, must be approved by CMS annually and is pursuant to 42 C.F.R. § 438.6(c).

Contractor will receive payments for TREAT outside of the monthly capitation payments. Within five (5) business days of receipt of TREAT payments, the Contractor shall distribute the TREAT funds to emergency service ambulance providers with no amount withheld for administrative cost.

Contractor will be required to report to the Division, in accordance with the Division's reporting requirements, all payments made to TREAT providers.

11.2.4 Mississippi Outcomes for Maternal Safety (MOMS) Initiative

The Mississippi Outcomes for Maternal Safety (MOMS) directed payment arrangement will reimburse hospitals and perinatal outpatient providers based on their completion of required metrics included in the preprint approved by CMS in the MississippiCAN program. The payment arrangement is intended to improve access to care and improvements in maternal care by reducing Severe Maternal Morbidity (SMM) in the MississippiCAN membership. The payment methodology, which is included in the preprint, must be approved by CMS annually and is pursuant to 42 C.F.R. § 438.6(c).

Contractor will receive payments for MOMS outside of the monthly capitation payments. Within five (5) business days of receipt of MOMS payments, the Contractor shall distribute the MOMS funds to hospitals and perinatal outpatient providers with no amount withheld for administrative cost.

Contractor will be required to report to the Division, in accordance with the Division's reporting requirements, all payments made to MOMS providers.

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

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

Rural APC Opt-Out payments shall be made annually upon the completion of DOM's review of the hospital cost report and calculation of any reimbursement due under the directed payment arrangement. When the Contractor receives payment of Rural APC Opt-Out payments, it shall be paid to the provider within five (5) business days of receipt. The Contractor shall distribute the Rural APC Opt-Out funds with no amount withheld for administrative cost

11.3 Federal, State and Local Taxes

The Contractor shall pay taxes lawfully imposed upon it with respect to this Contract or any product delivered in accordance herewith. The Division makes no representation whatsoever as to the exemption from liability to any tax imposed by any governmental entity on the Contractor.

In no event will the Division be responsible for the payment of taxes for which the Contractor may be liable as a result of the Contract.

The Division incorporates the full three percent (3%) Premium Tax, as required by Miss. Code Ann. § 27-15-103, into the Capitation Payment. The Contractor is expected to remit to the Mississippi Department of Revenue the full three percent (3%) Premium Tax. If Contractor does not remit the full three percent (3%) Premium Tax to the Mississippi Department of Revenue through any available credits, reductions, deductions, or any other permissible offsets allowed under State law, then Contractor shall remit the total amount of credits, reductions, deductions or other permissible offsets allowed under state law, as applicable to Capitation Payments, to the Division within ten (10) business days of filing its annual insurance premium tax return with the State.

On an annual basis, within ten (10) business days of filing with the State, the Contractor will provide sufficient documentation of such payments to the Division, including but not limited to proof of calculations used to arrive at the payment amounts, the Mississippi income tax return (Corporate Income and Franchise Tax Return or Insurance Company Income Tax Return), Mississippi insurance premium tax return and proof of remittance of such taxes to the Mississippi Department of Revenue.

11.4 Medical Loss Ratio

The Contractor shall provide quarterly and annual Medical Loss Ratio (MLR) reports as specified by the Division and in accordance with Exhibit C, Medical Loss Ratio (MLR) Requirements, of this Contract. The Division reserves the right to make such reports available to the public in their entirety. If the MLR (cost for health care benefits and services and specified quality expenditures) is less than ninety-one-and-three-tenths (91.3%) for MSCAN or less than eighty-five percent (85.0%) for CHIP, the Contractor shall refund the Division the difference no later than the tenth (10^{th}) business day of May following the end of the MLR Reporting Year. Any unpaid balances after the tenth (10^{th}) business day of May shall be subject to interest of ten percent (10%) per annum. If funding levels for state directed payments (MHAP, MAPS, TREAT, MOMS, or Rural APC Opt-Out) change materially in future contract periods, the 91.3% MLR minimum for MSCAN will be recalibrated to account for this change in the directed payment programs.

See Exhibit C of this Contract for MLR calculation methodology and classification of costs.

11.5 Value Based Payments

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

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

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

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

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

DOM will promulgate a MSDOM VBP Work Plan on a State Fiscal Year basis, which is incorporated via reference to this contract. The Work Plan will include metrics, performance periods, payment processes, requirements, and any other information relevant to the Contractor and providers for the implementation and operationalization of the MSDOM VBP. The Contractor will be required to comply with the final Work Plan promulgated by the Division, as

well as produce and disseminate reports as outlined within that Work Plan. The Work Plan will comply with all applicable provisions of state law and 42 C.F.R. §438.6(c). DOM has the right to alter the MSDOM VPB Program and Work Plan at any time, at its discretion. Contractor will have sixty (60) calendar days' notice prior to the required implementation date of any ad hoc changes made by DOM. Changes made for each new State Fiscal Year are to be expected by the Contractor.

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MISSISSIPPI DIVISION OF
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12. Third Party Liability

12.1 General Requirements

The Contractor shall pursue payments from liable third parties in accordance with the State Plan and applicable federal and state laws and regulations. If the Contractor desires to Subcontract with any individual, firm, corporation, or any other entity, the Contractor shall abide by the requirements of Section 13, Subcontractual Relationships and Delegation, of this Contract.

Medicaid is the payer of last resort and pays for covered services only after any liable third-party sources have paid. Federal law requires Mississippi to have in place processes and procedures to identify third parties liable for payment of services under the Mississippi State Plan for Medical Assistance and for payment of claims involving third parties.

Federal law considers the program outlined in the Mississippi statute and the federal regulations to be the Third Party Liability (TPL) program. This involves identification of other payers, including but not limited to group health and other health insurers, Medicare, liability insurance, and workers' compensation insurance.

In accordance with federal law, Mississippi state law provides that all Medicaid beneficiaries to assign to the Division their rights to payment or recovery from a third party or private insurer. State law also requires that Medicaid beneficiaries cooperate with the Division in the enforcement of these assigned rights. Failure to cooperate with the Division violates the conditions for eligibility and may result in the recipient's loss of Medicaid eligibility. Mississippi law also subrogates the Division to the Medicaid beneficiaries' right to recover from a third party.

12.2 Division Responsibilities

The Division will be responsible for maintaining the contract(s) needed for insurance verification services or to identify third party coverage for all Medicaid beneficiaries, regardless of the health care service delivery system.

The Division will provide data to the Contractor regarding any third-party insurance coverage for any covered Member in the Contractor's Health Plan.

While the Division will make reasonable efforts to ensure accuracy of shared data, the Division cannot guarantee the accuracy of the data.

12.3 Contractor Responsibilities

The Contractor is responsible for administering the TPL program requirements in accordance with Section 1902(a)(25) of the Social Security Act and 42 C.F.R. § 433 Subpart D, as they apply to services provided under this Contract to Members. The Contractor:

1. Shall coordinate benefits in accordance with 42 C.F.R. § 433.135 and Division requirements;

2. Must implement cost avoidance and post-payment recovery procedures in accordance with federal and State requirements;

3. Must take reasonable measures to identify any legally liable third party insurance coverage for its Members;

4. Must make all reasonable efforts to obtain member cooperation in pursuit of liable third parties, and if those efforts fail, the Contractor will consult with the Division;

5. Must adjudicate the claim and use post-payment recovery if the probable existence of Third Party Liability was not established by either the Contractor or the Division prior to submission of the claim;

6. Must utilize the state TPL daily file; and

7. Must send the Division any TPL resources identified from all available sources not included in the TPL daily file on a daily basis.

Periodic meetings may be required with the Contractor's compliance personnel and the Division.

12.3.1 Cost Avoidance

Cost avoidance is the method of denying claims (avoiding payment) when other insurance resources are liable for payment. In accordance with Division requirements, the Contractor must have processes, methods, and resources necessary to receive the state TPL daily file from the Division and to identify third-party coverage for its members. The TPL file must be uploaded to the Contractor's claims system upon receipt. This information will be used in managing provider payment at the front end before the claim is paid.

Any TPL discrepancies with the TPL information supplied by the Division in the state TPL daily file should be identified and reported to the Division in a daily return file sent to the Office of Third Party Recovery.

The Contractor maintains ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of this Contract. Any Subcontract into which the Contractor enters with respect to performance under the Subcontract shall in no way relieve the Contractor of its legal responsibility to carry out the terms of this Contract.

The Contractor must share the TPL daily file with their Subcontractors responsible for tracking and pursuing recoveries. The Contractor must also share any additional TPL resources identified by the Subcontractors in a daily file exchange.

The Contractor must monitor the TPL functions assigned to delegated vendors and also share the TPL file information with all delegated vendors (vision, dental, behavioral health, non-emergency transportation, any other covered benefits and/or services delegated to vendors, etc.).

The Contractor must submit to the Division all TPL resources identified for its Members from all available sources including all delegated vendors (vision, dental, behavioral health, non-emergency transportation, any other covered benefits and/or services delegated to vendors, etc.).

The Contractor must have appropriate edits in the claims system to ensure that claims are properly coordinated when other insurance is identified.

If the probable existence of TPL has been established at the time the claim is filed, the Contractor and all of its Subcontractors must reject the claim and return it to the provider for a determination of the amount of any TPL.

The Contractor shall bill or inform the provider to bill the third-party coverage within thirty (30) calendar days of identification.

For EPSDT and Title IV-D services, the Contractor should not cost-avoid claims and will pursue recovery under a policy known as “Pay & Chase.” In accordance with the Division’s billing manual, the Contractor should reimburse for EPSDT and Title IV-D services prior to billing of the third-party source, and then pursue recovery of Medicaid payment, for practitioner services.

12.3.2 Post-Payment Recovery

Post-payment recovery is necessary in cases where the Contractor has not established the probable existence of a liable third party at the time services were rendered or paid for or in situations when the Contractor was unable to cost-avoid.

The Contractor must have procedures in place to ensure that a provider who has been paid by the Contractor and subsequently receives reimbursement from a third party repays the Contractor.

After Payment Recovery, the Contractor must have established procedures for recouping post-payment and shall report all third-party cost-avoidance and recoveries for its Members in accordance with the format specified by the Division.

The capitation rates set forth in this Contract have been adjusted to account for the primary liability of third parties to pay such expenses. The Contractor shall be responsible for making every reasonable effort to determine the legal liability of third parties to pay for services rendered to Members pursuant to this Contract. All funds recovered by the Contractor from Third Party Resources shall be treated as income to the Contractor. The Contractor shall coordinate with the Division on all aspects of Third Party Resources.

The Contractor must comply with all applicable state and federal rules and regulations regarding recovery.

12.3.3 Contractor Provider Audits (TPL) Overpayments

The Contractor must submit to the Division a schedule of all provider TPL audits (desk or on-site) prior to any audits being conducted.

The Contractor must submit a monthly report of all findings and recoveries to the Division in a format established by the Division.

12.3.4 Casualty and Subrogation

The Contractor shall pursue payments from liable third parties in accordance with the State Plan, CHIP State Health Plan, and applicable Federal and state laws and regulations. If the Contractor desires to Subcontract with any individual, firm, corporation, or any other entity, the Contractor shall abide by the requirements of Section 13, Subcontractual Relationships and Delegation, in regard to any such Subcontract.

When handling a subrogation case, all initial letters sent to third parties (i.e., attorneys or insurance companies) must be approved by the Division prior to use by the Contractor and Subcontractors. The Contractor shall submit a copy of all form letter templates and form document templates to the Division for written approval and as part of the Readiness Review process.

The Contractor shall prepare a standard subrogation release of claim that relates only to the claims the Contractor may have. The Contractor shall not execute releases sent in by third parties.

The Contractor shall place a third party on notice that the Division may have a separate lien for services not covered by the Contractor and provide contact information for the Division's designated third party staff member.

In the event the Division has a claim related to the accident, the Contractor will not be able to negotiate its claim without first notifying the Division. The Division subrogation claim takes priority over the Contractor's subrogation claim. In cases where the Division and Contractor both have claims related to the accident and the settlement or verdict amount is insufficient to satisfy both claims, at the sole discretion of the Division, the Division and Contractor may divide the proceeds.

Under no circumstances may the Contractor or any Subcontractor imply that they are an Agent of the State or Division, and the Contractor must educate Subcontractors not to make this implication in the pursuit of recovery from liable third parties. Education must clarify that at no point may an insurer or attorney imply that they are representing Medicaid, acting as an Agent of the State, or imply they are settling on behalf of the State or the Division of Medicaid. However, it is appropriate to state that the Contractor provides services for the Division of Medicaid. The Division will provide language that must be included in all of the form letters issued by the Contractor and/or any Subcontractors.

12.4 Third Party Liability Recoveries by the Division

After one hundred and eighty (180) days from the date of payment of a claim subject to recovery, the Contractor must cease all recovery activity. The Division reserves the right to attempt recovery independent of any action by the Contractor for those claims that do not indicate recovery amounts in the Contractor's reported encounter data.

The Division will retain all funds received as a result of any state-initiated recovery.

12.5 Third Party Liability Audit

The Division or its designated Agent shall periodically, at the Division's discretion, conduct a Third Party Liability audit of the Contractor. The Contractor shall make available specific data as requested to complete the audit. The Contractor must maintain documentation supporting claims that were denied or recovered during its coordination of benefits (COB) process and be able to provide this documentation upon audit request.

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13. Subcontractual Relationships and Delegation

13.1 Right to Enter into Other Contracts

The Division and the Contractor agree that each may contract for the provision or purchase of services for the execution of this Contract from parties not related to this Contract, subject to Division approval.

The Division may undertake or award other contracts for services related to the services described in this Contract or any portion herein. Such other contracts include but are not limited to consultants and/or agents retained by the Division to perform functions related in whole or in part to Contractor services. The Contractor shall fully cooperate with such other contractors and the Division in all such cases.

13.2 Requirements

The Contractor has the right to Subcontract to provide services specified under this Contract, subject to Division approval. The Contractor maintains ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of its Contract with the Division. Any Subcontract into which the Contractor enters with respect to performance under the Contract shall in no way relieve the Contractor of the legal responsibility to carry out the terms of this Contract. The Division will consider the Contractor to be the sole point of contact regarding contractual matters, including payment of any and all charges resulting from the Contract. Nothing contained in the Subcontract shall be construed as creating any contractual responsibility between the Subcontractor(s) and the Division. The Contractor is solely responsible for fulfillment of the Contract terms with the Division and for the performance of any Subcontractor under such Subcontract approved by the Division. The Division will make Contract payments only to the Contractor.

13.2.1 Subcontracting Conditions

If the Contractor delegates any activities or obligations under this Contract to a Subcontractor, the following conditions must be met:

1. The delegated activities or obligations, and related reporting responsibilities, are specified in the Contract or written agreement with the Subcontractor;

2. The Subcontractor agrees to perform the delegated activities and reporting responsibilities specified in compliance with the Contractor's obligations under this Contract; and

3. The contract or written agreement between the Contractor and Subcontractor must either provide for revocation of the delegation of activities or obligations or specify other remedies in instances where the Division or Contractor determine that the Subcontractor has not performed satisfactorily.

4. The Subcontractor agrees that the Division, CMS, the HHS Inspector General, the Comptroller General, or their designees have the right to audit, evaluate, and inspect any books, records, contracts, computer, or other electronic systems of the Subcontractor, or of the Subcontractor's contractor, that pertain to any aspect of services and activities performed, or determination of amounts payable under this Contract.

5. The Subcontractor will make available, for the purposes of an audit, evaluation, or inspection under 42 C.F.R. § 438.230(c)(3)(i), its premises, physical facilities, equipment, books, records, contracts, computer, or other electronic systems relating to its Medicaid enrollees or Members.

6. The right to audit under 42 C.F.R. § 438.230(c)(3)(i) will exist through ten (10) years from the final date of the Contract period or from the date of completion of any audit, whichever is later.

7. In the event that the Contractor terminates the Subcontractor or the Subcontractor ends its relationship with the Contractor, the Contractor will give notice to the Division within one (1) business day of termination and include information about the Contractor's plan to ensure continuity of services affected by the loss of the Subcontractor.

8. Subcontracts must include information about a Member's Grievance and Appeal rights, as well as information explaining a MississippiCAN Member's State Fair Hearing rights, CHIP Member's Independent External Review Rights, and right to request continuation of benefits during a pending appeal.

9. Subcontracts must include provisions protecting Members against balance billing by Subcontractors, as required by Section 1123B(d)(1) of the Balanced Budget Act of 1997.

10. The Contractor must include a provision in each of its Subcontracts similar to that stated in Section 15.3, Offer of Gratuities, of this Contract, and shall enforce this provision against a Subcontractor who has offered or given anything of value to any of the persons or entities described in this Section 15.3, whether or not the offer or gift was on the Contractor's behalf.

13.2.2 Subject to Audit

If the Division, CMS, or the HHS Inspector General determines that there is a reasonable possibility of fraud or similar risk, the Division, CMS, or the HHS Inspector General may inspect, evaluate, and audit the Subcontractor at any time.

13.2.3 Division Approval Process

The Contractor shall not Subcontract any portion of the services to be performed under this Contract without the prior written approval of the Division. All Subcontracts and relevant documentation must be submitted to the Division for approval no later than ninety (90) calendar days prior to the implementation of the Subcontract. All Subcontracts may be subject to review and approval by the Division and must include all Division-required terms and conditions. At award of this Contract, the Division will provide a checklist of specific requirements that the Contractor must include in every Subcontract supporting the services under this Contract. When submitting a Subcontract to the Division for approval, the Contractor must provide the completed checklist to indicate where within the Subcontract the requirement is addressed.

Subcontracts and revisions to Subcontracts must be maintained and available for review at one (1) central office in Mississippi designated by the Contractor and approved by the Division.

The Division reserves the right to change or alter this process in any way during the term of this Contract.

13.2.3.1 All Subcontracts Subject to Division Approval

Any Subcontract between the Contractor and a third party, including the Contractor's parent company or any subsidiary corporation owned by the Contractor's parent company, or between the third party and a fourth party, or between any subsequent parties, to perform part or all of the selected Contractor's responsibilities under this Contract must be submitted to the Division for advance written approval. This provision includes, but is not limited to, Subcontracts for Behavioral Health/Substance Use Disorder Services, vision services, dental services, claims processing, third party services, Member services, and any other benefits and/or services that are subcontracted to other vendors. This provision does not include, for example, purchase orders. The Contract language for Subcontractors must be standardized, as approved by the Division.

13.2.3.2 Documentation to Be Submitted

Subcontract approval submissions must be made in a manner and method defined by the Division. Submissions must and include the following, at a minimum:

1. The subcontractor's name;

2. The reimbursement methodology and/or amount being paid to the subcontractor per the agreement;

3. A detailed explanation of the services/duties the subcontractor will be providing,

4. The population that will be affected by the agreement and/or received communications from the Subcontractor (e.g., providers and/or members);

5. The term of the agreement;

6. The annotated subcontractor checklist as described in Section 13.2.3, Subcontractual Relationships and Delegation: Division Approval Process; and

7. Confirm all associated documents including, but not limited to, original contractual agreement (even if it does not apply to or directly refer to the Mississippi market), the master service agreement, business associate agreements, and all active amendments with the downstream contractor (i.e., amendments that have been implemented prior to the downstream contractor working with the Mississippi market) have been submitted to the Division.

13.2.3.2 Amendments to Subcontracts

If such Subcontract is approved, the Contractor shall notify the Division not less than sixty (60) calendar days in advance of its desire to amend or terminate such Subcontract. The Contractor shall include a copy of the proposed Subcontract amendment with notification of and information about the proposed amendment. The proposed amendment must receive written approval from the Division prior to its effective date.

13.3 Contractor Held Accountable

The Contractor must oversee and will be held accountable for any functions and responsibilities that it delegates to any Subcontractor or subsidiary. All Subcontracts and agreements must be in writing, must specify the activities and report responsibilities delegated to the Subcontractor, and provide for revoking delegation or imposing other sanctions and/or remedies if the Division or Contractor determines that the Subcontractor's performance is inadequate, and shall contain provisions such that it is consistent with the Contractor's obligations pursuant to this Contract.

All Subcontractors must agree to comply with all applicable Medicaid laws, regulations, including applicable sub-regulatory guidance and contract provisions.

13.4 Division Has No Obligation to Subcontractor

Approval of any Subcontract shall neither obligate the Division nor the State of Mississippi as a party to that Subcontract nor create any right, claim, or interest for the Subcontractor against the State of Mississippi or the Division, their Agents, their employees, their representatives, or successors. The Division shall be indemnified by the Contractor for all claims that arise against the Subcontractor.

13.5 Contractor Obligated to Monitor Subcontractor

The Contractor must monitor each Subcontractor's performance on an ongoing basis, subject it to formal review at least once a year, and include the results of this review in its Quality Management Program Evaluation, conducted annually, the details of which are contained in the Reporting Requirements (Exhibit H), which is incorporated into this Contract via reference. If the Contractor identifies deficiencies or areas for improvement in the performance of any of its Subcontractors that is providing services under this Contract, the Contractor must take corrective action. The Subcontract must comply with the provisions of this Contract and must include any general requirements of this Contract that are appropriate to the service or activity identified. It is not required that Subcontractors be enrolled as a Medicaid Provider, unless the Subcontractor renders medical services to Members or Fee-for-Services beneficiaries. If so, the Subcontractor must be enrolled as a Medicaid Provider.

13.6 Division's Right of Refusal

The Division may refuse to enter into or renew an agreement with a Contractor if any Subcontractor entity has any person who has an ownership or control interest in the Subcontract entity; or who is an agent or managing employee of the Subcontractor; or has been convicted of a criminal offense related to that person's involvement in any program established under Medicare, Medicaid, or the Title XIX Services Program.

The Division may refuse to enter into or may terminate this Contract if it determines that the Contractor did not fully and accurately make any disclosure of any Subcontractor entity required under 42 C.F.R. § 455.106.

Disclosure by Providers and State Medicaid agencies must be in accordance with 42 C.F.R. §1002.3. Before the Division enters into or renews a Contract, or at any time upon written request by the Division, the Contractor must disclose to the Division the identity of any person described in 42 C.F.R. §§ 1001.1001(a)(1) and 1002.3 related to any Subcontractor entities.

The Division may refuse to enter into or renew this Contract if any person who has ownership or control interest in any Subcontractor entity, or who is an agent or managing employee of the Subcontractor entity, has been convicted of a criminal offense related to that person's involvement in any program established under Medicare, Medicaid, CHIP, or the Title XIX or Title XXI Services Programs.

The Division may refuse to enter into, or terminate, this Contract if it determines that the Subcontractor entity did not fully and accurately make any disclosure required under 42 C.F.R. § 1002.3(a).

The Contractor shall give the Division immediate written notice by certified mail, facsimile, or any other carrier that requires signature upon receipt of any action or suit filed and prompt notice of any claim made against the Contractor or Subcontractor that in the opinion of the Contractor may result in litigation related in any way to the Contract with the Division.

13.7 Division's Remedy Rights Regarding the Subcontractor

The Division shall have the right to invoke against any Subcontractor any remedy set forth in this Contract, including the right to revoke delegated activities or obligations or require the termination of any Subcontract, for each and every reason for which it may invoke such a remedy against the Contractor or require the termination of this Contract. Suspected Fraud and Abuse by any Subcontractor may be investigated by the Division at investigatory agency and/or its contractors.

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14. Remedies

The Contractor is expected to meet or exceed all Division objectives and standards as described in this Contract. All areas of responsibility and all Contract requirements are subject to performance evaluation by the Division. Performance reviews may be conducted by the Division at any time and relate to any responsibility and/or requirement of this Contract.

Any and all instances of noncompliance by the Contractor may be subject to remedies as set forth in this Section.

14.1 Remedies

14.1.1 Understanding of the Parties

The Contractor agrees and understands that the Division, at its sole discretion, may pursue contractual remedies for noncompliance with any provision of the Contract. At any time and at its discretion, the Division may impose or pursue one or more of the remedies for each item of noncompliance and will determine remedies on a case-by-case basis.

The Division's pursuit or non-pursuit of a remedy does not constitute a waiver of any other remedy that the Division may have at law or equity, nor is there a precedent established if the Division pursues or does not pursue a remedy in multiple factually similar circumstances.

14.1.2 Notice and Opportunity to Cure

1. The Division will notify the Contractor in writing of specific areas of the Contractor's performance that fail to meet performance expectation, standards, or schedules set forth in this Contract, but that, in the determination of the Division, do not result in a material deficiency or delay in the implementation or operation of services.

2. The Contractor will, within five (5) business days (or another date, if approved by the Division) of receipt of written notice of a non-material deficiency, provide the Division a written response that:

    a. Explains the reasons for the deficiency, the Contractor's plans to address or cure the deficiency, and the date and time by which the deficiency will be cured; or

    b. If the Contractor disagrees with the Division's findings, its reasons for that disagreement.

3. The Contractor's proposed cure of deficiency is subject to the approval of the Division. The Contractor's repeated commission of deficiencies or repeated failure to resolve any

such deficiencies may itself rise to the level of a breach of this Contract and entitle the Division to pursue any other remedy provided in the Contract or any other appropriate remedy the Division may have at law or equity.

14.1.3 Corrective Action Plan

The Division may require the Contractor to submit to the Division a Corrective Action Plan (CAP), in writing, to correct and resolve any failure to meet Contractual requirements and/or standards, as determined by the Division.

14.1.3.1 Corrective Action Plan Process

1. The CAP must include the Contractor's assessment or diagnosis of the root cause of such deficiency and any additional explanation of the reasons for the cited deficiency, and a specific and detailed proposal to cure or resolve the deficiency including a timeline.

2. The CAP must be submitted by the deadline set by the Division in its request for the CAP. The CAP is subject to approval by the Division.

3. The Division will notify the Contractor in writing as to whether the Division accepts the Contractor's proposed CAP, and the Division may:

    a. Condition approval on completion of tasks in the order/priority that the Division may reasonably prescribe,

    b. Disapprove portions of the Contractor's CAP, and/or

    c. Require additional or different corrective action(s).

4. The Division's acceptance of a CAP under this section does not:

    a. Excuse the Contractor's prior substandard performance,

    b. Relieve the Contractor of its duty to comply with all Contractual performance standards, or

    c. Prohibit the Division from pursuing any and all other appropriate remedies for continued substandard performance.

14.1.4 Administrative Remedies

At its discretion, the Division may impose one or more of the following remedies for each instance of noncompliance and will determine the scope and severity of the remedy on a case-by-case basis:

1. Assess liquidated damages in accordance with Exhibit G, Liquidated Damages;

2. Conduct accelerated monitoring of the Contractor, which may or may not be unannounced, including more frequent or more extensive monitoring by the Division or its agent;

3. Require additional, more detailed, financial, programmatic, and/or other reports to be submitted at the discretion of the Division;

4. Decline to renew or extend the Contract;

5. Appoint temporary management under the circumstances described in 42 C.F.R. § 438.706;

6. Initiate disenrollment of a Member or Members;

7. Suspend enrollment of Members;

8. Withhold or recoup payment to the Contractor;

9. Terminate the Contract, as described in Subsection 14.3, below;

10. Reduce or eliminate marketing and/or community event participation;

11. Refuse to allow participation in Contractor pay for performance programs;

12. In the case of marketing activities, refer the Contractor to the Mississippi Insurance Department for review and appropriate action;

13. At the Contractor's expense, require special training or retraining of marketing representatives including but not limited to business ethics, marketing policies, effective sales practices, and/or state marketing policies and regulations;

14. Refer any matter to the applicable federal agencies for civil money penalties;

15. Refer any matter to the state and/or federal agencies responsible for investigating or addressing civil rights matters;

16. Exclude the Contractor from participation in the Medicaid program;

17. Refer any matter to the state or federal agencies responsible for investigating or addressing Consumer Affairs matters,

18. Refer any matter to the state or federal agencies responsible for investigating or addressing Members' rights to privacy and confidentiality,

19. Refuse to consider for future contracting any Contractor that fails to submit Member Encounter data on a timely and accurate basis; and

20. Impose any other sanction as provided by 42 C.F.R. § 438.700, et seq.

The Division retains authority to impose additional sanctions under State statutes or State regulations that address areas of noncompliance specified in 42 C.F.R. § 438.700, as well as additional areas of noncompliance. Nothing in this section shall prevent the Division from exercising that authority.

The Division will give CMS written notice whenever it imposes or lifts a sanction for one of the violations listed in 42 C.F.R. § 438.700, et seq. The notice will be given no later than thirty (30) calendar days after the Division imposes or lifts the sanction, and will specify the type of sanction, and the reason for the Division's decision to impose or lift the sanction.

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14.1.5 Liquidated Damages

The Division will be entitled to actual and consequential damages resulting from the Contractor's failure to comply with any of the terms of the Contract. In some cases, the actual damage to the Division or the State of Mississippi as a result of the Contractor's failure to meet any aspect of the responsibilities of the Contract and/or to meet specific performance standards set forth in the Contract are difficult or impossible to determine with precise accuracy. Therefore, liquidated damages will be assessed in writing against the Contractor in accordance with and for failure to meet any aspect of the responsibilities of the Contract and/or to meet the specific performance standards identified by the Division in Exhibit G, Liquidated Damages. Liquidated damages will be assessed if the Division determines such failure is the fault of the Contractor, including the Contractor's Subcontractor(s) and/or consultant(s), the Division reserves the right

to waive all or part of the liquidated damages on a case-by-case basis. All such waivers must be in writing, contain the reason for the waiver, and be signed by the Executive Director. Waiver in one instance does not set any precedent for waiver in another, no matter if the circumstances are factually similar.

The liquidated damages prescribed in this section and Exhibit G are not intended to be punitive, but are intended to be reasonable estimates of the Division's projected financial loss and damage resulting from the Contractor's nonperformance, including financial loss as a result of project delays. Accordingly, in the event the Contractor fails to perform in accordance with the Contract, it is agreed by the Division and the Contractor that damage will be sustained by the Division, and that the actual damages that will be sustain are uncertain and extremely difficult and impractical to ascertain and determine. Therefore, the Division may assess liquidated damages as provided in this section and in Exhibit G, Liquidated Damages.

If the Contractor fails to perform any of the services described in the Contract, the Division may assess liquidated damages for each occurrence of a liquidated damages event.

The Division may collect liquidated damages:

1. Through direct assessment and demand for payment delivery to the Contractor, or

2. By deduction of amounts assessed as liquidated damages as set-off against payment then due to the Contractor or that become due at any time after assessment for the liquidated damages. The Contractor will make deductions until the full amount payable by the Contractor is received by the Division.

With the exception of Member Encounter Data submissions, the Division will utilize the following guidelines to determine whether a report is correct and complete for the purposes of liquidated damages: (a) The report must contain one hundred percent (100%) of the Contractor's data; (b) ninety-nine percent (99%) of the required items for the report must be completed; and (c) ninety-nine point five percent (99.5%) of the data for the report must be accurate as determined by edit specifications/review guidelines set forth by the Division.

Liquidated damages for late Deliverables shall begin on the first day the Deliverable is late. Liquidated damages for incorrect or deficient Deliverables shall begin on the sixteenth (16th) calendar day after the date on the notice provided by the Division to the Contractor that the Deliverable remains incorrect or deficient.

Any liquidated damages assessed by the Division shall be due and payable to the Division within thirty (30) calendar days after the Contractor's receipt of their notice of assessment. If payment is not made by the due date, said liquidated damages shall be withheld from future Capitation Payments by the Division without further notice. The collection of liquidated damages by the Division shall be made without regard to any Appeal rights the Contractor may have pursuant to this Contract. However, in the

event an Appeal by the Contractor results in a decision in favor of the Contractor, any such funds withheld by the Division will be returned to the Contractor.

14.1.6 Equitable Remedies

The Contractor acknowledges that if the Contractor breaches, attempts to breach, or threatens to breach its obligation(s) under this Contract, the Division may be irreparably harmed, and the Division may proceed directly to court to pursue equitable remedies.

If a court of proper jurisdiction finds that the Contractor breached, attempted to breach, or threatened to breach any material provision of this Contract, the Contractor agrees that it will not oppose the entry of an appropriate order compelling performance of the Contractor and restraining it from any further breaches, attempts to breach, or threats breaches without any other additional findings of irreparable injury or other conditions to injunctive relief.

14.1.7 Stop Work Order

1. Order to Stop Work: The Executive Director or the Executive Director's designee, may, by written order to Contractor at any time, and without notice to any surety, require Contractor to stop all or any part of the work called for by this contract. This order shall be for a specified period not exceeding 90 days after the order is delivered to Contractor, unless the parties agree to any further period. Any such order shall be identified specifically as a stop work order issued pursuant to this clause. Upon receipt of such an order, Contractor shall forthwith comply with its terms and take all reasonable steps to minimize the occurrence of costs allocable to the work covered by the order during the period of work stoppage. Before the stop work order expires, or within any further period to which the parties shall have agreed, the Executive Director or the Executive Director's designee shall either:

    a. Cancel the stop work order; or

    b. Terminate the work covered by such order as provided in the Termination for Default clause or the Termination for Convenience clause of this contract.

2. Cancellation or Expiration of the Order: If a stop work order issued under this clause is canceled at any time during the period specified in the order, or if the period of the order or any extension thereof expires, the Contractor shall have the right to resume work. An appropriate adjustment shall be made in the delivery schedule or Contractor price, or both, and the contract shall be modified in writing accordingly, if:

    a. The stop work order results in an increase in the time required for, or in Contractor's cost properly allocable to, the performance of any part of this contract; and

b. The Contractor asserts a claim for such an adjustment within 30 days after the end of the period of work stoppage; provided that, if the Executive Director or the Executive Director's designee decides that the facts justify such action, any such claim asserted may be received and acted upon at any time prior to final payment under this Contract.

3. Termination of Stopped Work: If a stop work order is not canceled and the work covered by such order is terminated for default or convenience, the reasonable costs resulting from the stop work order shall be allowed by adjustment or otherwise.

14.2 Termination by the Division

The Contractor acknowledges and agrees that the Division has incurred substantial expense in connection with the preparation and entry into this Contract, including expenses related to training of staff, data collection and processing, actuarial determination of capitation rates for the initial term and each renewal term, and ongoing changes to the Medicaid Enterprise Systems (MES)/Management Information System (MMIS) operated by the Division. The Contractor further acknowledges and agrees that in the event this Contract is terminated prior to the end of the initial term or any renewal term due to the actions of the Contractor or due to the Contractor's failure to fully comply with the terms and conditions of this Contract, the Division will incur substantial additional expense in processing the disenrollment of all Members and mass MES/MMIS changes, in effectuating additional staffing changes, in procuring alternate health care arrangements for Members, and in modifying any Member service materials identifying the Contractor, among other expenses; and that these expenses are difficult or impossible to accurately estimate.

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Prior to the completion of the Contract, all or a part of the Contract may be terminated for any of the following reasons.

14.2.1 Termination for Convenience

1. Termination. The Executive Director or designee may, when the interests of the State so require, terminate this contract in whole or in part, for the convenience of the State. The Executive Director or designee shall give written notice of the termination to Contractor specifying the part of the contract terminated and when termination becomes effective.

2. Contractor's Obligations. The Contractor shall incur no further obligations in connection with the terminated work and on the date set in the notice of termination Contractor will

stop work to the extent specified. The Contractor shall also terminate outstanding orders and subcontracts as they relate to the terminated work. The Contractor shall settle the liabilities and claims arising out of the termination of subcontracts and orders connected with the terminated work. The Executive Director or designee may direct the Contractor to assign the Contractor's right, title, and interest under terminated orders or Subcontracts to the State. The Contractor must still complete the work not terminated by the notice of termination and may incur obligations as are necessary to do so.

14.2.2 Termination Upon Bankruptcy

This Contract may be terminated in whole or in part by the Division upon written notice to Contractor, if Contractor should become the subject of bankruptcy or receivership proceedings, whether voluntary or involuntary, or upon the execution by Contractor of an assignment for the benefit of its creditors. In the event of such termination, Contractor shall be entitled to recover just and equitable compensation for satisfactory work performed under this contract, but in no case shall said compensation exceed the total contract price.

14.2.3 Termination for Default

1. Default. If the Contractor refuses or fails to perform any of the provisions of this Contract with such diligence as will ensure its completion within the time specified in this contract or any extension thereof, or otherwise fails to timely satisfy the contract provisions, or commits any other substantial breach of this contract, the Executive Director or designee may notify the Contractor in writing of the delay or nonperformance and if not cured in ten (10) days or any longer time specified in writing by the Executive Director or designee, such officer may terminate the Contractor's right to proceed with the contract or such part of the contract as to which there has been delay or a failure to properly perform. In the event of termination in whole or in part, the Executive Director or designee may procure similar supplies or services in a manner and upon terms deemed appropriate by the Executive Director or designee. The Contractor shall continue performance of the contract to the extent it is not terminated and shall be liable for excess costs incurred in procuring similar goods or services.

2. Contractor's Duties. Notwithstanding termination of the contract and subject to any directions from the Executive Director or the Executive Director's designee, the Contractor shall take timely, reasonable, and necessary action to protect and preserve property in the possession of Contractor in which the State has an interest.

3. Compensation. Payment for completed services delivered and accepted by the State shall be at the contract price. The State may withhold from amounts due the Contractor such sums as the Executive Director or designee deems to be necessary to protect the State

against loss because of outstanding liens or claims of former lien holders and to reimburse the State for the excess costs incurred in procuring similar goods and services.

4. Excuse for Nonperformance or Delayed Performance. Except with respect to defaults of subcontractors, the Contractor shall not be in default by reason of any failure in performance of this Contract in accordance with its terms (including any failure by the Contractor to make progress in the prosecution of the work hereunder which endangers such performance) if the Contractor has notified the Executive Director or designee within 15 days after the cause of the delay and the failure arises out of causes such as: acts of God; acts of the public enemy; acts of the State and any other governmental entity in its sovereign or contractual capacity; fires; floods; epidemics; quarantine restrictions; strikes or other labor disputes; freight embargoes; or unusually severe weather. If the failure to perform is caused by the failure of a subcontractor to perform or to make progress, and if such failure arises out of causes similar to those set forth above, the Contractor shall not be deemed to be in default, unless the services to be furnished by the subcontractor were reasonably obtainable from other sources in sufficient time to permit the Contractor to meet the contract requirements. Upon request of Contractor, the Executive Director or designee shall ascertain the facts and extent of such failure, and, if such officer determines that any failure to perform was occasioned by any one or more of the excusable causes, and that, but for the excusable cause, the Contractor's progress and performance would have met the terms of the contract, the delivery schedule shall be revised accordingly, subject to the rights of the State under the clause entitled (in fixed-price contracts, "Termination for Convenience," in cost-reimbursement contracts, "Termination"). (As used in this Paragraph of this clause, the term "subcontractor" means subcontractor at any tier).

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5. Erroneous Termination for Default. If, after notice of termination of the Contractor's right to proceed under the provisions of this clause, it is determined for any reason that the Contract was not in default under the provisions of this clause, or that the delay was excusable under the provisions of Paragraph (4) (Excuse for Nonperformance or Delayed Performance) of this clause, the rights and obligations of the parties shall, if the contract contains a clause providing for termination for convenience of the State, be the same as if the notice of termination had been issued pursuant to a termination for convenience.

6. Additional Rights and Remedies. The rights and remedies provided in this clause are in addition to any other rights and remedies provided by law or under this contract.

14.2.4 Availability of Funds

It is expressly understood and agreed that the obligation of the State to proceed under this agreement is conditioned upon the appropriation of funds by the Mississippi State Legislature and the receipt of State and/or Federal funds. If the funds anticipated for the continuing fulfillment of the agreement are, at any time, not forthcoming or insufficient, either through the failure of the Federal government to provide or the State of Mississippi to appropriate funds, or the discontinuance, or material alteration of the program under which the funds were provided or if funds are not otherwise available to the State, the State shall have the right upon ten (10) working days written notice to the Contractor to terminate this agreement without damage, penalty, cost, or expense to the State and the Division of any kind whatsoever. The effective date of termination shall be as specified in the notice of termination.

14.2.5 Termination for Cause

The Division may terminate the Contract in whole or in part upon the following conditions:

14.2.5.1 Failure to Adhere to Laws, Rules, Ordinances, or Order

The Division may terminate the Contract if a court of proper jurisdiction, administrative court, CMS, the State Auditor, or other authority finds that the Contractor failed to adhere to any laws, ordinances, rules, regulations, or orders of any public authority having jurisdiction and such violation prevents or substantially impairs performance of the Contractor's duties under the Contract. The Division will provide at least thirty (30) calendar days' advance written notice of such termination.

14.2.5.2 Breach of Confidentiality

The Division may terminate the Contract at any time if the Contractor Division breaches confidentiality laws with respect to the services and deliverables provided under the Contract.

14.2.5.3 Failure to Maintain Adequate Personnel Resources

The Division may terminate the Contract if after providing notice and an opportunity to correct the Division determines that the Contractor has failed to supply personnel or resources and that failure results in the Contractor's inability to fulfill its duties under the Contract. The Division will provide at least thirty (30) calendar days' advance written notice of such termination.

14.2.5.4 Termination for Offer of Gratuities

1. This Contract will be terminated by the Division should the Contractor violate Section 15.3, Offer of Gratuities, of this Contract.

2. Termination of a Subcontract by the Contractor pursuant to Section 13.2.1, Subcontracting Provisions, of this Contract, which requires application of Section

15.3 of this Contract to all Subcontractors, will not be cause for termination of this Contract unless:

a. The Contractor fails to replace the terminated Subcontractor within a reasonable time; and

b. This failure constitutes cause under Termination for Cause as defined by the Section.

14.2.5.5 Judgment and Execution

1. The Division may terminate the Contract at any time if judgement for the payment of money in excess of $500,000.00 that is not covered by insurance, is rendered by any court or government body against the Contractor, and the Contractor does not:
   a. Discharge the judgement or provide for its discharge in accordance with the terms of the judgment;
   b. Procure a stay of execution of the judgment within thirty (30) calendar days from the date of entry thereof; or
   c. Perfect an appeal of such judgement and cause the execution of such judgement to be stayed during the appeal, providing such financial reserves as may be required under generally accepted accounting principles.
2. If a writ or warrant of attachment or any similar process is issued by any court against all or any material portion of the property of the Contractor, and such writ or warrant of attachment or any similar process is not released or bonded within thirty (30) calendar days after its entry, the Division may terminate the Contract in accordance with this section.

14.2.5.6 Termination for Breach of Contract

The Division will have the right to terminate the Contract, in whole or in part, if the Division determines, at its sole discretion, that the Contractor has breached the contract.

14.2.5.7 Termination for Criminal Conviction

The Division will have the right to terminate the Contract, in whole or in part, or require the replacement of a Subcontractor, if the Contractor or a Subcontractor, or any personnel of Contractor or a Subcontractor, is convicted of a criminal offense in a state or federal court:

1. Related to the delivery of an item or service;

2. Related to the neglect or abuse of Members in connection with the delivery of an item or service;

3. Consisting of a felony related to fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct; or

4. Resulting in a penalty or fine in the amount of $500,000 or more in a state or federal administrative proceeding.

14.2.5.8 Termination for Continued Failure of Deliverable Requirements

The Division may terminate this Contract for continued violations of the Deliverable requirements of this Contract. More information about additional damages available to the Division for failure to abide by Deliverable requirements is provided in Exhibit G, Liquidated Damages, of this Contract.

14.2.5.9 Termination for Failure to Allow Access

Refusal by the Contractor to allow access to all records, documents, papers, letters, or other materials shall constitute a breach of Contract and serve as grounds for termination.

14.3 Notice of Termination

Upon termination of the Contract for any reason except as described in Section 14.4, Termination by Mutual Agreement, or Section 14.10, Action of the Mississippi Insurance Department, of this Contract, the Division will provide the Contractor with a pre-termination hearing, in accordance with 42 C.F.R. § 438.710. The Division will give the Contractor written notice of its intent to terminate, the reason for termination, and the time and place of the conference.

After the hearing, the Division will give the Contractor written notice of the decision. If the decision is to affirm the termination, the notice will provide the effective date of the termination. The Division is required to notify Members of the Division's intent to terminate the Contract and give Members the opportunity to disenroll immediately from the Contractor without cause with the option to enroll with another Contractor, as appropriate.

If the Contract is terminated because the Contractor is not in compliance with terms of this Contract and if directed by CMS, the Division cannot renew or otherwise extend this Contract for the Contractor unless CMS determines that compelling reasons exist for doing so.

14.4 Termination by Mutual Agreement

The Contract may be terminated by mutual agreement of the parties. Upon a mutual agreement of termination, the parties will set a date for the Termination to be effective. That date will be no fewer than ninety (90) calendar days from the date of the mutual agreement. The Contractor shall perform all obligation upon termination as defined in this Contract, and payment in full of any refunds, outstanding liquidated damages, or other sums due the Division pursuant to this Contract.

14.5 Procedure upon Termination

The following provisions apply to all terminations of the Contract, whether the termination is initiated by the Division or by mutual agreement.

Procedure on Termination

1. Notice of Termination

The Division will give the Contractor written notice of its intent to terminate, the reason for termination, and the time and place of the conference. After the conference, the Division will give the Contractor written notice of the decision. If the decision is to affirm the termination, the notice will provide the effective date of the termination. The Division is required to notify Members of the Division's intent to terminate the Contract and give Members the opportunity to disenroll immediately from the Contractor without cause with the option to enroll with another Contractor, as appropriate.

If the Contract is terminated because the Contractor is not in compliance with terms of this Contract and if directed by CMS, the Division cannot renew or otherwise extend this Contract for the Contractor unless CMS determines that compelling reasons exist for doing so.

14.5.1 Contractor Responsibilities

Upon delivery by certified mail, return receipt requested, or in person to the Contractor, if a Notice of Termination specifying the nature of the termination, the extent to which performance of work under the Contract is terminated, and the date upon which such termination becomes effective, the Contractor shall:

1. Stop work under the Contract on the date and to the extent specified in the Notice of Termination;

2. Place no further orders or Subcontracts for materials, services or facilities, and incur no further obligations except as may be necessary for completion of such portion of the work in progress under the Contract until the effective date of termination;

3. Terminate all orders and Subcontracts to the extent that they relate to the performance of work terminated by the Notice of Termination;

4. Incur no further obligations in connection with the terminated work and terminate outstanding orders and subcontracts as they relate to the terminated work;

5. Settle the liabilities and claims arising out of the termination of subcontracts and orders connected with the terminated work. The Executive Director or designee may direct the Contractor to assign the Contractor's right, title, and interest under terminated orders or subcontracts to the State.

6. Deliver to the Division within the time frame as specified by the Division in the Notice of Termination, copies of all data and documentation in the appropriate media and make available all records required to assure continued delivery of services to beneficiaries and Providers at no cost to the Division;

7. Complete the performance of the work not terminated by the Notice of Termination, including all items enumerated in Section 14.5.1.1, below;

8. Take such action as may be necessary, or as the Division may direct, for the protection and preservation of the property related to the Contract that is in the possession of the Contractor and in which the Division has or may acquire an interest;

9. Fully train the Division staff or other individuals at the direction of the Division in the operation and maintenance of the Contractor's obligations under this Contract;

10. Notify the Contractor's Provider Network of the planned termination;

11. Reimburse the Division for additional costs related to mailings to Members and other stakeholders, additional enrollment costs, additional costs to procure and implement similar services, attorney's fees, Member notification, and any other costs incurred by the Division as a result of the termination of this Contract;

12. Promptly transfer all information necessary for the reimbursement of any outstanding claims;

13. Promptly transfer all Member records, financial records, State and Federal data, such as encounter and quality data, and outstanding Provider and/or Member Complaints, Grievances, and Appeals; and

14. Complete each portion of the Contractor Responsibilities after receipt of the Notice of Termination. The Contractor shall proceed immediately with the performance of the above obligations notwithstanding any allowable delay in determining or adjusting the amount of any item of reimbursable price under this clause. The Contractor must still complete the work not terminated by the Notice of Termination and may incur obligations as are necessary to do so.

15. The Contractor has an absolute duty to cooperate and help with the orderly transition of the duties to the Division or its designated contractor following termination of the Contract for any reason.

14.5.1.1 Obligations not Terminated by Notice of Termination

Upon termination of this Contract, the Contractor shall be solely responsible for the provision and payment for all covered services for all Members for the remainder of any month for which the Division has paid the monthly capitation rate. Upon final Notice of Termination, on the date, and to the extent specified in the Notice of Termination, the Contractor shall:

1. Continue providing covered services to all Members until midnight on the last day of the calendar month for which a capitation rate payment has been made by the Division;

2. Continue providing all covered services to all infants of female Members who have not been discharged from the hospital following birth, until each infant is discharged;

3. Continue providing covered services to any Members who are hospitalized on the termination date, until each Member is discharged;

4. Arrange for the transfer of patients and Medical Records to other appropriate Providers as directed by the Division;

5. Supply to the Division such information as it may request respecting any unpaid claims submitted by Out-of-Network Providers and arrange for the payment of such claims within the time periods provided herein;

6. Take such action as may be necessary, or as the Division may direct, for the protection of property related to this Contract, which is in the possession of the Contractor and in which the Division has or may acquire an interest; and,

7. Provide for the maintenance of all records for audit and inspection by the Division or its Agents, CMS, the Office of the Inspector General, Comptroller General, and other authorized government officials; the transfer of all data and records to the Division or its

Agents as may be requested by the Division; and the preparation and delivery of any reports, forms or other documents to the Division as may be required pursuant to this Contract or any applicable policies and procedures of the Division.

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8. The Contractor shall submit a Work Plan that details the obligations and timeline to the Division within a reasonable time set by the Division. This Work Plan will be used to help ensure that the Contractor and the Division agrees to what is set forth and obligated by the Contractor in this contract and also to help ensure no harm to and a smooth transition for the Contractor's members out of the Contractor's plan.

The covenants set forth in this section shall survive the termination of this Contract and shall remain fully enforceable by the Division against the Contractor. In the event that the Contractor fails to fulfill each covenant set forth in this section, the Division shall have the right, but not the obligation, to arrange for the provision of such services and the fulfillment of such covenants, all at the sole cost and expense of the Contractor and the Contractor shall refund to the Division all sums expendd by the Division in so doing.

14.5.2 Division Responsibilities

1. Except for Termination for Default or Cause, the Division will make payment to the Contractor on termination and at the Capitation Payment rate for the number of Members enrolled on the first day of the last month of operations.

2. In the event of the failure of the Contractor and the Division to agree in whole or in part as to the amounts to be paid to the Contractor in connection with any termination described in this Contract, the Division shall determine on the basis of information available the amount, if any, due to the Contractor by reason of termination and shall pay to the Contractor the amount so determined.

3. The Contractor shall have the right of Appeal, as stated under Section 17.10, Disputes, of this Contract from any such determination made by the Division.

14.6 Effective Date of Termination

Except as otherwise provided in the Contract, terminations will be effective as of the date specified in the Notice of Termination. The parties may extend the effective date of termination one or more times by mutual written agreement. Contractor Responsibilities, as referenced in Section 14.4.1, above, will still be effective after the termination date until the Contractor Responsibilities are concluded and the obligations of the Contractor to the Division are complete.

14.7 Terms Survive Termination

The terms set forth in this Contract shall survive the termination of this Contract and shall remain fully enforceable by the Division against the Contractor. In the event that the Contractor fails to fulfill each term set forth in this Contract, the Division shall have the right, but not the obligation, to arrange for the provision of such services and the fulfillment of such terms, all at the sole cost and expense of the Contractor, and the Contractor shall refund to the Division all sums expended by the Division in so doing.

14.8 Temporary Management

The Division can require the appointment of temporary management upon the finding by the Division that there is continued egregious behavior or substantial risk to the health of Members or to assure the health of Members during a time or for an orderly termination or reorganization of the Contractor or until improvements are made to remedy Contract violations. Temporary management cannot be terminated until the Contractor has the capability to ensure violations will not recur. If the Contractor repeatedly fails to comply with Contract provisions, the Division may impose the sanction of temporary management and give Members the right to terminate enrollment with the Contractor.

14.9 Disputes of Remedies

In order to appeal the Division's imposition of any remedies, sanctions, or damages, the Contractor shall request review in accordance with the Disputes provisions provided in Section 15.10. of this Contract. The imposition of sanctions and liquidated damages is not stayed pending appeal. Pending final determination of any dispute under this Contract, the Contractor shall proceed diligently with the performance of this Contract and in accordance with the Division's direction.

14.10 Action by the Mississippi Insurance Department

1. Upon receipt of official notice that the Mississippi Insurance Department has taken action that resulted in the Contractor being placed under administrative supervision, the Division will suspend further enrollment of Medicaid beneficiaries until notice is received from the Department of Insurance that administration supervision is no longer needed.

2. Upon receipt of official notice that the Mississippi Insurance Department has taken action that resulted in the Contractor being placed in rehabilitation, the Division will immediately disenroll all Members of the Contractor and suspend further enrollment of Members until notice is received from the Department of Insurance that the Contractor has been rehabilitated. If the Division disenrolls Members before the end of the month,

the rehabilitator will be notified of the prorated amount of payment due to the Division for the days of the month not covered by the Contractor for each Member, and the Division shall be entitled to reimbursement for those amounts.

3. Violation of this section may result in termination of the Contract by the Division.

14.11 Nonperformance or Delayed Performance of a Subcontractor

If the failure to perform is caused by the failure of a subcontractor to perform or to make progress, and if such failure arises out of causes similar to those set forth in Section 14 of this Contract, the Contractor shall be deemed to be in breach when the Contractor fails to make reasonable effort to obtain the goods or services to be furnished by the subcontractor from other sources in order to timely meet the Contract requirements. The Contractor shall not be deemed to be in breach only where the services to be furnished by the subcontractor were not reasonably obtainable from other sources in a sufficient time to permit the Contractor to meet the Contract requirements.

14.12 Excuse for Nonperformance or Delayed Performance

Except with respect to defaults of subcontractors, the Contractor shall not be in breach by reason of any failure in performance of this Contract in accordance with its terms if the Contractor has notified the Executive Director or designee as soon as practicable, but in no case longer than seven (7) calendar days, after the cause of the delay, and the failure arises out of causes such as: acts of God; acts of the public enemy; acts of the State, and any other governmental entity in its sovereign or contractual capacity; fires; floods; strikes or other labor disputes; freight embargoes; or unusually severe weather.

Upon request of the Contractor, the Executive Director or designee shall ascertain the facts and extent of such failure, and, if such officer determines that any failure to perform was occasioned by any one or more of the excusable causes, and that, but for the excusable cause, the Contractor's progress and performance would have met the terms of the Contract, the delivery schedule shall be revised accordingly in consultation with and with the approval of the Division.

If an event not enumerated in this subsection but equivalent in nature and/or effect occurs that is outside of the control of the Contractor that also may be cause for failure of Contract performance, the Contractor should notify the Executive Director or designee as soon as practicable, but in no case longer than seven (7) calendar days, after the cause of the delay. The Executive Director or designee shall ascertain the facts and extent of such failure, and, if such officer determines that any failure to perform was occasioned by the event, the Division may, at its discretion, deem the failure not to be a breach, and the delivery schedule may be revised accordingly in consultation with and with the approval of the Division.

14.13 Retainage

If the Contractor's failure to perform satisfactorily exposes the Division to the likelihood of contracting with another person or entity to perform services required of the Contractor under this Contract, upon notice setting forth the services and retainage, the Division may withhold from the Contractor payments in an amount commensurate with the costs anticipated to be incurred. If costs are incurred, the Division shall account to the Contractor and return any excess to the Contractor. If the retainage is not sufficient, the Contractor shall immediately reimburse the Division the difference, or the Division may offset from any payments due the Contractor. The Contractor will cooperate fully with the retained Contractor and provide any assistance it needs to implement the terms of its agreement for services for retainage.

The Contractor shall cooperate with the Division or those procured resources in allowing access to facilities, equipment, data, or any other Contractor resources to which access is required to correct the failure. The Contractor shall remain liable for ensuring that all operational performance standards remain satisfied.

14.14 Recoupment of Costs

If the Contractor's failure to perform satisfactorily exposes the Division to the likelihood of costs related to the failure to perform satisfactorily, the Division may offset from the Contractor payments in the amount commensurate with the costs incurred. The Division shall account to the Contractor the costs incurred.

14.15 Rework

If the Contractor's failure to satisfactorily perform necessitates Rework by the Division, the Division may offset the Contractor payments in the amount commensurate with the costs incurred by the Division and/or is Agent for Rework. The Division shall account to the Contractor all costs incurred. The need for Rework will be determined at the Division's sole discretion.

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15. Federal, State, and General Requirements

The Contractor agrees that all work performed as part of this Contract will comply fully with administrative and other requirements established by federal and state laws, regulations and guidelines, and assumes responsibility for full compliance with all such laws, regulations and guidelines, and agrees to fully reimburse the Division for any loss of funds, resources, Overpayments, duplicate payments or incorrect payments resulting from noncompliance by the Contractor, its staff, or agents, as revealed in any audit.

15.1 HIPAA Compliance

The Contractor shall abide by the Administrative Simplification Provisions of HIPAA, as may be applicable to the services under this Contract, including EDI, code sets, identifiers, security, and privacy provisions.

To the extent that the Contractor uses one or more Subcontractors or agents to provide services under this Contract, and such Subcontractors or agents receive or have access to protected health information (PHI), each such Subcontractor or agent shall sign an agreement with the Contractor that complies with HIPAA.

The Contractor shall ensure that any agents and Subcontractors to whom it provides PHI received from the Division (or created or received by the Contractor on behalf of the Division) agree in writing to the same restrictions, terms, and conditions relating to PHI that apply to the Contractor in this Contract. The Division shall have the option to review and approve all such written agreements between the Contractor and its agents and Subcontractors prior to their effectiveness.

The Contractor acknowledges that it is a covered entity as defined in 45 C.F.R. §160.103 and is therefore legally required to comply with the HIPAA's requirements. The Contractor explicitly agrees to indemnify, defend, and hold harmless the Division, without limitation, for any civil money penalties, assessments, damages, and/or all other costs incurred by the Division which result from noncompliance with any provision of HIPAA by Contractor or any of its subcontractors and/or Business Associates.

15.2 Conflict of Interest

The Contractor shall comply with the conflict of interest safeguards described in 42 C.F.R. §§ 438.58 and 457.1214 and with the prohibitions described in section 1902(a)(4)(C) of the Act applicable to Contract Officers, employees, or independent contractors, as well as any other applicable state or federal laws concerning conflict of interest.

In accordance with 1902(a)(4)(C) and 1932(d)(3) of the Social Security Act, the Contractor shall comply with conflict of interest safeguards with respect to officers, Contract Officers, employees, and

independent contractors of the Division having responsibilities relating to this Contract. The Division shall comply with conflict of interest safeguards on the part of Division officers, employees, and agents who have responsibilities relating to this Contract or the enrollment processes specified in 42 C.F.R. § 438.54(b). Such safeguards shall be at least as effective as described in section 27 of the Federal Procurement Policy Act (41 U.S.C. § 423).

The Contractor shall have no interest and shall not acquire any interest, direct or indirect, that would conflict in any manner or degree with the performance of its services under this Contract. The Contractor shall not employ any individual or entity having any such known interests, including subsidiaries or entities that could be misconstrued as having a joint relationship. No public official of the State of Mississippi and no official or employee of the Division, Department of Health and Human Services (HHS), CMS, or any other State or Federal agency that exercises any functions or responsibilities in the review or approval of this Contract or its performance shall voluntarily acquire any personal interest, direct or indirect, in this Contract or any Subcontract entered into by the Contractor. The Contractor certifies that no officer, director, employee, or agent of the Contractor; any Subcontractor; or supplier and person with an ownership or control interest in the Contractor; any Subcontractor; or supplier is also employed by the State of Mississippi or any of its agencies; Division's Agent; HHS; CMS; or any agents of HHS or CMS; or is a public official of the State of Mississippi.

The Contractor shall disclose all actual, apparent, or potential conflicts of interest, including employing immediate family members of Medicaid Providers, to the Division within two (2) business days of having knowledge of them.

The Contractor shall develop a mitigation plan as requested by the Division that must be approved and accepted by the Division. Any changes to the approved mitigation plan must be approved in advance by the Division. The Contractor must maintain one hundred percent (100%) compliance with this item at all times throughout the term of the contract.

Such violation will be reported to the State Ethics Commission, Attorney General, and appropriate federal law enforcement officers for review. This Contract may be terminated by the Division if it is determined that a conflict of interest exists.

15.3 Offer of Gratuities

The Contractor certifies that no Member of Congress, nor any elected or appointed official, employee or Agent of the State of Mississippi, HHS, CMS, or any other Federal agency, has or will benefit financially or materially from this Contract. This Contract will be terminated by the Division if it is determined that gratuities of any kind were offered to or received by any of the aforementioned officials or employees from the Contractor, its agents, employees, Subcontractors, or suppliers.

15.4 Contractor Status

15.4.1 Independent Contractor

It is expressly agreed that the Contractor is an independent Contractor performing professional services for the Division and is not an officer or employee of the State of Mississippi or the Division. It is further expressly agreed that the Contract shall not be construed as a partnership or joint venture between the Contractor and the Division.

The Contractor shall be solely responsible for all applicable taxes, insurance, licensing, and other costs of doing business. Should the Contractor default on these or other responsibilities jeopardizing the Contractor's ability to perform services effectively, the Division, in its sole discretion, may terminate this Contract.

The Contractor shall not purport to bind the Division, its officers, or employees, nor the State of Mississippi to any obligation not expressly authorized herein unless the Division has expressly given the Contractor the authority to do so in writing.

The Contractor shall give the Division immediate notice in writing of any action or suit filed, or of any claim made by any party that might reasonably be expected to result in litigation related in any manner to this Contract or that may impact the Contractor's ability to perform.

No other agreements of any kind may be made by the Contractor with any other party for furnishing any information or data accumulated by the Contractor under this Contract or used in the operation of this program without the written approval of the Division. Specifically, the Division reserves the right to review any data released from reports, histories, data files, or other means that were created pursuant to this Contract.

In no way shall the Contractor represent itself directly or by inference as a representative of the State of Mississippi or the Division of Medicaid except within the confines of its role as a Contractor for the Division of Medicaid. The Division's approval must be received in all instances in which the Contractor distributes publications, presents seminars or workshops, or performs any other outreach.

The Contractor shall not use the Division's name or refer to the Contract, and the services provided therein, directly or indirectly in any advertisement, news release, professional trade or business presentation without prior written approval from the Division.

15.4.2 Employment of Division Employees

The Contractor shall not knowingly engage on a full-time, part-time, or other basis during the period of the Contract, any professional or technical personnel who are or have been at any time during the period of the Contract in the employ of the Division without the written consent of the Division. Further, the Contractor shall not knowingly engage in this project, on a full-time, part-time, or other basis during the

period of the Contract, any former employee of the Division who has not been separated from the Division for at least one (1) year, without the prior written consent of the Division.

The Contractor shall give priority consideration to hiring interested and qualified adversely affected State employees at such times as requested by the Division to the extent permitted by this Contract or State Law.

15.4.3 Personnel Practices

All employees of the Contractor involved in the Medicaid function will be paid as any other employee of the Contractor who works in another area of their organization in a similar position. The Contractor shall develop any and all methods to encourage longevity in Contractor's staff assigned to this Contract.

Employees of the Contractor shall receive all benefits afforded to other similarly situated employees of the Contractor.

At the Division's direction, the Contractor shall be required to provide employment data to the Division that allows the Division to monitor the requirements of this section.

15.4.4 Property Rights

No property rights inure to the Contractor except for compensation for work that has already been performed.

15.5 Provider Exclusions

The Division will not reimburse the Contractor for services rendered by any Provider that is excluded or debarred from participation by Medicare, Medicaid, or OIG, including any other states' Medicaid program, or CHIP program, except for Emergency Services.

The Contractor must ensure that all their Providers and Subcontractor entities screen their employees for excluded persons. The Contractor must communicate this obligation to all Providers and Subcontractors upon renewal of any Subcontracts.

The Contractor must comply with 42 C.F.R. § 455.436 requiring performance of the following:

1. Confirm the identity and determine the exclusion status of providers and subcontractors and any person with an ownership or control interest or who is an agent or managing employee of the provider, Contractor, or subcontractor through routine checks of Federal databases;

2. Check the Social Security Administration's Death Master File, the National Plan and Provider Enumeration System (NPPES), the List of Excluded Individuals/Entities (LEIE), the Excluded Parties List System (EPLS), and any such other databases as the Secretary may prescribe;

3. Consult appropriate databases to confirm identity upon enrollment and reenrollment; and

4. Check the LEIE and EPLS no less frequently than monthly.

At the direction of the Division, the Contractor shall be required to provide information to the Division to allow the Division to monitor compliance with these terms by the Contractor, its Providers, and its Subcontractors.

15.6 Compliance with Laws

The Contractor and its Subcontractors shall comply with all applicable standards, orders, or requirements issued under Section 306 for the Clean Air Act (42 U.S.C. § 1857(h)), Section 508 of the Clean Water Act (33 U.S.C. § 1368), Executive Order 11738, and Environmental Protection Agency regulations (Title 40 of the Code of Federal Regulations) that prohibit the use under non-exempt federal contracts, grants, or loans of facilities included on the EPA list of Violating Facilities. The Contractor shall report violations to the applicable grantor federal agency and the U. S. EPA Assistant Administrator for Enforcement.

The Contractor and its Subcontractors shall abide by mandatory standards and policies relating to energy efficiency, which are contained in the State Energy Conversation Contractor issued in compliance with the Energy Policy and Conservation Act (Pub. L.94-165).

The Contractor shall comply with all applicable Federal and State laws, regulations, policies, or reporting requirements needed to comply with the policies and regulations set forth in Title VI of the Civil Rights Act of 1964, Title IX of the Education Amendments of 1972 (regarding education programs and activities), the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, the Americans with Disabilities Act of 1990, as amended, the Patient Protection and Affordable Care Act, the Health Care and Education Reconciliation Act of 2010, and the Health Insurance Portability and Accountability Act of 1996.

The Contractor understands that the State of Mississippi is an equal opportunity employer and therefore, maintains a policy which prohibits unlawful discrimination based on race, color, creed, sex, age, national origin, physical handicap, disability, genetic information, or any other consideration made unlawful by federal, state, or local laws. All such discrimination is unlawful and the Contractor agrees during the term of the agreement that the Contractor will strictly adhere to this policy in its employment practices and provision of services. The Contractor shall comply with, and all activities under this agreement shall be subject to, all applicable federal, State of Mississippi, and local laws and regulations, as now existing and as may be amended or modified.

15.7 Assignment

This Contract and any payments that may become due hereunder shall not be assignable by the Contractor except with the prior written approval of the Division. The transfer of five percent (5%) or more of the beneficial ownership in the Contractor at any time during the term of this Contract shall be deemed an assignment of this Contract.

The Division is entitled to assign this Contract to any other agency of the State, which may assume the duties or responsibilities of the Division relating to this Contract. The Division shall provide written notice of any such assignment to the Contractor, whereupon the Division shall be discharged from any further obligation or liability under this Contract arising on or after the date of such assignment.

15.8 No Waiver

15.8.1 No Waiver of Breach

No assent, expressed or implied, by the parties to the breach of the provision or conditions of this Contract shall be deemed or taken to be a waiver of any succeeding breach of the same or any other provision or condition and shall not be construed as a modification of the terms of this Contract.

15.8.2 No Waiver of Other Rights, Powers, and Remedies

No covenant, condition, duty, obligation, or undertaking contained in or made a part of this Contract will be waived except by the written agreement of the parties, and forbearance or indulgence in any other form or manner by either party in any regard whatsoever shall not constitute a waiver of the covenant, condition, duty, obligation, or undertaking to be kept, performed, or discharged by the party to which the same may apply; and until complete performance or satisfaction of all such covenants, conditions, duties, obligations, and undertakings, the other party shall have the right to invoke any remedy available under law or equity, notwithstanding any such forbearance or indulgence. No waiver of or modification to any term or condition of the Contract will void, waive, or change any other term or condition. No waiver by one party to this agreement of a default by the other party will imply, be construed as, or require waiver of further or other defaults.

15.9 Severability

In the event that any provision of this Contract (including items incorporated by reference) is declared to be illegal, unlawful, void, or unenforceable, or in conflict with any law of the State of Mississippi or any federal law, then both the Division and the Contractor shall be relieved of all obligations arising under such provision. The remaining portions or provisions of this Contract shall not be affected, and the obligations of the parties shall continue in full force and effect, and all remaining provisions shall be

binding upon each party to this Contract and be fully performed as if the Contract did not contain the particular part, term, or provision held to be invalid.

If the laws or regulations governing this Contract should be amended or judicially interpreted so as to render the fulfillment of this Contract impossible or economically infeasible, as determined jointly by the Division and the Contractor, then both the Division and the Contractor shall be discharged from any further obligations created under the terms of this Contract after the Contractor fulfills its obligations in closing out this Contract.

15.10 Disputes

Any disputes regarding the terms and conditions of this Contract which cannot be disposed of by agreement between the parties shall be decided by the Executive Director, or the Executive Director's designee. Such decision shall be in writing and mailed or otherwise furnished to the Contractor. Any assessment of liquidated or actual damages shall be considered a decision of the Executive Director or their designee. The decision of the Executive Director, or their designee, shall be final and conclusive, unless within ten (10) calendar days following the date of such decision the Contractor mails or otherwise furnishes a written Appeal to the Division's Executive Director.

The Contractor shall be afforded an opportunity to offer evidence in support of its Appeal. The Contractor shall proceed diligently with the performance of this Contract in accordance with the decision rendered by the Executive Director, or their designee, until a final decision is rendered by the Executive Director or his or her representative. This does not impair Contractor's right to any available judicial remedies upon exhaustion of internal dispute process as outlined in this section.

15.10.1 Cost of Litigation

In the event that the Division deems it necessary to take legal action to enforce any provision of the contract, the Contractor shall bear the cost of such litigation as assessed by the court in which the Division prevails. Neither the State of Mississippi nor the Division shall bear any of the Contractor's cost of litigation for any legal actions initiated by the Contractor against the Division regarding the provisions of the Contract. Legal action shall include administrative proceedings.

15.10.2 Attorney Fees

The Contractor agrees to pay reasonable attorney fees incurred by the State and the Division in enforcing this agreement or otherwise reasonably related thereto.

15.11 Proprietary Rights

The Division shall own all work products developed or furnished in connection with the Contract by the Contractor or any subcontractor ("Work Product"). All such Work Product shall be considered a work made for hire. If any Work Product is not considered a work made for hire under applicable law, the

Contractor must make an exclusive, perpetual, royalty-free assignment of all of the Contractor's rights, title, and interest in such Work Product, including U.S. and foreign patents, copyrights, and trade secrets.

With regard to work performed by the Contractor's subcontractors, the Contractor will require that all agreements with subcontractors provide for the irrevocable assignment of rights to the Division, without additional consideration of all Work Products of the subcontractors. The Contractor must give the Division, and any person or Agent designated by the Division, all assistance reasonably requested by the Division to perfect the Division's ownership of all Work Product, including the execution and delivery of documents assigning title to such Work Product to the Division. The Contractor must not publish or attempt to transfer to third parties any Work Product without the Division's prior written approval.

15.11.1 Ownership of Documents

Where activities supported by this Contract produce original writing, sound recordings, pictorial reproductions, drawings, or other graphic representation and works of any similar nature, the Division shall have the right to use, duplicate, and disclose such materials in whole or in part, in any manner, for any purpose whatsoever and to have others do so. If the material is qualified for copyright, the Contractor may copyright such material, with approval of the Division, but the Division shall reserve a royalty-free, non-exclusive, and irrevocable license to reproduce, publish, and use such materials, in whole or in part, and to authorize others to do so.

15.11.2 Ownership of Information and Data

The Division, the Department of Health and Human Services (HHS), The Centers for Medicare and Medicaid Services (CMS), the State of Mississippi, and/or their agents shall have unlimited rights to use, disclose, or duplicate, for any purpose whatsoever, all information and data developed, derived, documented, or furnished by the Contractor under this Contract.

The Contractor agrees to grant on its own behalf and on behalf of its agents, employees, representatives, assignees, and Subcontractors to the Division, HHS, CMS and the State of Mississippi and to their officers, agents, and employees acting in their official capacities a royalty-free, non-exclusive, and irrevocable license throughout the world to publish, reproduce, translate, deliver, and dispose of all such information now covered by copyright of the proposed Contractor.

Excluded from the foregoing provisions in this subsection, however, are any pre-existing, proprietary tools owned, developed, or otherwise obtained by Contractor independent of this Contract. Contractor is and shall remain the owner of all rights, title, and interest in and to the Proprietary Tools, including all copyright, patent, trademark, trade secret and all other proprietary rights thereto arising under Federal and State law, and no license or other right to the Proprietary Tools is granted or otherwise implied. Any right that the Division may have with respect to the Proprietary Tools shall arise only pursuant to a separate written agreement between the parties.

15.11.3 Licenses, Patents, and Royalties

The Division does not tolerate the possession or use of unlicensed copies of proprietary software. The Contractor shall be responsible for any liquidated damages or fines imposed as a result of unlicensed or otherwise defectively titled software.

The Contractor, without exception, shall indemnify, save, and hold harmless the Division and its employees from liability of any nature or kind, including cost and expenses for or on account of any copyrighted, patented, or non-patented invention, process, or article manufactured by the Contractor. The Division will provide prompt written notification of a claim of copyright or patent infringement.

Further, if such a claim is made or is pending, the Contractor may, at its option and expense, procure for the Division the right to continue use of, replace, or modify the article to render it non-infringing. If none of the alternatives are reasonably available, the Contractor agrees to take back the article and refund the total amount the Division has paid the Contractor under this Contract for use of the article.

If the Contractor uses any design, device, or materials covered by letters, patent or copyright, it is mutually agreed and understood without exception that the proposed prices shall include all royalties or costs arising from the use of such design, device, or materials in any way involved in the work.

15.12 Omissions

In the event that either party discovers any material omission in the provisions in this Contract that the party believes is essential to the successful performance of this Contract, both parties shall negotiate in good faith with respect to those matters for the purpose of making such adjustments as may be necessary to reasonably perform the objectives of this Contract, provided that such adjustments do not adversely affect the interests of either party. Any such adjustments shall be uniformly applied to all Contractors performing services for the Division under this Contract.

15.13 Entire Agreement

This Contract, together with all attachments, represents the entire agreement between the Contractor and the Division with respect to the subject matter stated herein and supersedes all other contracts and agreements between the parties.

15.13.1 Change Orders and/or Amendments

No modification or change to any provision of this Contract shall be effective unless it is in writing and is signed by a duly authorized representative of the Contractor and the Division as an amendment to this Contract. This Contract shall be amended whenever and to the extent required by changes in Federal or State law or regulations. Any amendments shall be executed by the Parties and submitted to PPRB and CMS for approval. The Contractor shall proceed diligently with the Contract as amended. The Parties mutually agree that any amendment subsequently disapproved by CMS shall be deemed null and void immediately upon notification by CMS to the Division of the disapproval. The Division shall notify the

Contractor of CMS approval or disapproval of any contract amendment within two (2) business days of receipt of such CMS approval or disapproval.

The Executive Director of the Division or designated representative may, at any time, by written order delivered to the Contractor at least thirty (30) calendar days prior to the commencement date of such change, make administrative changes within the general scope of the Contract. If any such change causes an increase or decrease in the cost of the performance of any part of the work under the Contract, an adjustment commensurate with the costs of performance under this Contract shall be made in the Capitation Payment rate, delivery schedule or both. Any claim by the Contractor for equitable adjustment under this clause must be asserted in writing to the Division within thirty (30) calendar days from the date of receipt by the Contractor of the notification of change. Failure to agree to any adjustment shall be a dispute within the meaning of the Disputes clause, 15.10, of this Contract. Nothing in this clause, however, shall in any manner excuse the Contractor from proceeding diligently with the Contract as changed.

Any provision of this Contract that conflicts with Federal and State statutes, regulations, other laws, or CMS policy guidance shall be automatically amended to conform to the provisions of those laws, regulations, and policies. Such amendment of the Contract will be effective on the effective date of the statutes or regulations necessitating it and will be binding on the parties even though such amendment may not have been reduced to writing and formally agreed upon and executed by the parties.

15.14 E-Verification

The Contractor represents and warrants that it will ensure its compliance with the Mississippi Employment Protection Act of 2008 and will register and participate in the status verification system for all newly hired employees. Mississippi Code Annotated §§ 71-11-1 *et seq*. The term "employee" as used herein means any person that is hired to perform work within the State of Mississippi. As used herein, "status verification system" means the Illegal Immigration Reform and Immigration Responsibility Act of 1996 that is operated by the United States Department of Homeland Security, also known as the E-Verify Program, or any other successor electronic verification system replacing the E-Verify Program. The Contractor agrees to maintain records of such compliance. Upon request of the State and after approval of the Social Security Administration or Department of Homeland Security, where required, the Contractor agrees to provide a copy of each such verification. The Contractor further represents and warrants that any person assigned to perform services hereafter meets the employment eligibility requirements of all immigration laws. The breach of this agreement may subject the Contractor to the following:

1. Termination of this Contract for services and ineligibility for any state or public contract in Mississippi for up to three (3) years with notice of such cancellation/termination being made public;

2. The loss of any license, permit, certification or other document granted to the Contractor by an agency, department or governmental entity for the right to do business in Mississippi for up to one (1) year; or
3. Both. In the event of such termination/cancellation, the Contractor would also be liable for any additional costs incurred by the State due to contract cancellation or loss of license or permit to do business in the State.

15.15 Employment Practices

The Contractor shall not discriminate against any employee or applicant for employment because of race, color, religion, sex, gender identity, sexual orientation, national origin, age, marital status, political affiliations, disability, genetic information, or any other consideration made unlawful by federal, State or local laws. The Contractor must act affirmatively to ensure that employees, as well as applicants for employment, are treated without discrimination because of their race, color, religion, gender, sexual orientation, national origin, age, marital status, political affiliation, genetic information, or disability.

Such action shall include, but is not limited to the following: employment, promotion, demotion or transfer, recruitment or recruitment advertising, layoff or termination, rates of pay or other forms of compensation, and selection for training, including apprenticeship. The Contractor agrees to post employment notices setting forth the provisions of this clause in conspicuous places available to employees and applicants.

The Contractor shall, in all solicitations or advertisements for employees placed by or on behalf of the Contractor, state that all qualified applicants will receive consideration for employment without regard to race, color, religion, sex, gender identity, sexual orientation, national origin, age, marital status, political affiliation, genetic information, or disability, except where it relates to a bona fide occupational qualification or requirement.

The Contractor shall comply with the non-discrimination clause contained in Federal Executive Order 11246, as amended by Federal Executive Order 11375, relative to Equal Employment Opportunity for all persons without regard to race, color, religion, sex, or national origin, and the implementing rules and regulations prescribed by the Secretary of Labor and with Title 41, Code of Federal Regulations, Chapter 60. The Contractor shall comply with related state laws and regulations, if any.

The Contractor shall comply with the Civil Rights Act of 1964, and any amendments thereto, and the rules and regulations thereunder, and Section 504 of Title V of the Rehabilitation Act of 1973, as amended, and the Mississippi Human Rights Act of 1977.

If the Division finds that the Contractor is not in compliance with any of these requirements at any time during the term of this Contract, the Division reserves the right to terminate this Contract or take such other steps as it deems appropriate, in its sole discretion, considering the interests and welfare of the State.

15.16 Lobbying

The Contractor certifies, to the best of its knowledge and belief, that no federal appropriated funds have been paid or will be paid by or on behalf of the Contractor to any person for the purposes of influencing or attempting to influence an officer or employee of any agency, a member of Congress, or an employee of a member of Congress in connection with the awarding of any federal contract, the making of any federal grant, the making of any federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan, or cooperative agreement.

If any funds other than federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, member of Congress, an officer or employee of Congress or an employee of a member of Congress in connection with this federal contract, grant, loan, or cooperative agreement, the Contractor shall complete and submit "Disclosure Form to Report Lobbying," in accordance with its instructions.

This certification is a material representation of fact upon which reliance is placed when entering into this Contract. Submission of this certification is a prerequisite for making or entering into this Contract imposed under Title 31, Section 1352, and U. S. Code. Failure to file the required certification shall be subject to civil penalties for such failure.

The Contractor shall abide by lobbying laws of the State of Mississippi.

15.17 Bribes, Gratuities, and Kickbacks

The receipt or solicitation of bribes, gratuities, and kickbacks is strictly prohibited.

No elected or appointed officer or other employee of the Federal Government or of the State of Mississippi shall benefit financially or materially from this Contract. No individual employed by the State of Mississippi shall be permitted any share or part of this Contract or any benefit that might arise from it.

The bidder, offeror, or Contractor represents that it has not violated, is not violating, and promises that it will not violate the prohibition against gratuities set forth in Section 6-204 PPRB OPSCR Rules and Regulations Effective Date 1/18/2020 (Gratuities) of the Mississippi Public Procurement Review Board Office of Personal Service Contract Review Rules and Regulations.

15.18 Trade Secrets, Commercial and Financial Information

It is expressly understood that Mississippi law requires that the provisions of this Contract which contain the commodities purchased or the personal or professional services provided, the price to be paid, and the term of the contract shall not be deemed to be a trade secret or confidential commercial or financial information and shall be available for examination, copying, or reproduction.

15.19 Transparency

This contract, including any accompanying exhibits, attachments, and appendices, is subject to the "Mississippi Public Records Act of 1983," and its exceptions. See Mississippi Code Annotated §§ 25-61-1 et seq. and Mississippi Code Annotated § 79-23-1. In addition, this contract is subject to the provisions of the Mississippi Accountability and Transparency Act of 2008. Mississippi Code Annotated §§ 27-104-151 et seq. Unless exempted from disclosure due to a court-issued protective order, a copy of this executed contract is required to be posted to the Mississippi Department of Finance and Administration's independent agency contract website for public access at http://www.transparency.mississippi.gov. Information identified by Contractor as trade secrets, or other proprietary information, including confidential vendor information or any other information which is required confidential by state or federal law or outside the applicable freedom of information statutes, will be redacted.

15.20 E-Payment

The Contractor agrees to accept all payments in United States currency via the State of Mississippi's electronic payment and remittance vehicle. The agency agrees to make payment in accordance with Mississippi law on "Timely Payments for Purchases by Public Bodies," Mississippi Code Annotated § 31-7-301 et seq., which generally provides for payment of undisputed amounts by the agency within forty-five (45) days of receipt of invoice.

15.21 Paymode

Payments by state agencies using the State's accounting system shall be made and remittance information provided electronically as directed by the State. These payments shall be deposited into the bank account of Contractor's choice. The State may, at its sole discretion, require the Contractor to electronically submit invoices and supporting documentation at any time during the term of this Agreement. The Contractor understands and agrees that the State is exempt from the payment of taxes. All payments shall be in United States currency.

15.22 Procurement Regulations

The Contract shall be governed by the applicable provisions of the Mississippi Public Procurement Review Board Office of Personal Service Contract Review Rules and Regulations, a copy of which is available at 501 North West Street, Suite 701E, Jackson, Mississippi 39201 for inspection, or downloadable at http://www.DFA.ms.gov.

15.23 Representation Regarding Contingent Fees

The Contractor represents that it has not retained a person to solicit or secure a state contract upon an agreement or understanding for a commission, percentage, brokerage, or contingent fee, except as disclosed in the Contractor's bid or proposal.

15.24 State Approval

It is understood that if this Contract requires approval by the Public Procurement Review Board and/or the Mississippi Department of Finance and Administration Office of Personal Service Contract Review, and this Contract is not approved by the PPRB and/or OPSCR, it is void and no payment shall be made hereunder.

15.25 CMS Review and Approval

This Contract is subject to review and approval by the Centers for Medicare and Medicaid Services (CMS) and may be modified as required and/or suggested by CMS. The Contractor is required to accept and agree to CMS suggestions and/or modifications in order to be a Contractor under this Contract. Any modifications to this Contract may be enacted pursuant to the provisions described in the RFQ and this Contract.

15.26 Monitoring Requirements

The Division is responsible for monitoring and oversight of the Contractor for compliance with the provisions of this Contract and applicable federal and State laws and regulations. The Division and its representatives will conduct ongoing monitoring and oversight through activities including but not limited to the following:

1. Tracking and/or auditing or reviewing Contractor activities, materials, and records developed under the Contract, which may include periodic medical audits and audits or review of Appeals, enrollments, disenrollments, termination of providers, utilization and financial records;
2. Reviewing management systems and procedures developed under this Contract;
3. Conducting periodic reviews of the Contractor's Provider Network to confirm adequacy and to ensure that providers excluded from Medicaid participation are excluded from the Contractors Provider Network;
4. Reviewing Contractor reports for progress, successes, trends, and challenges or problems;
5. Conducting random inspections of Contractor and Subcontractor facilities, including but not limited to service locations, health care facilities, and equipment;
6. Reviewing any other areas of materials relevant to or pertaining to this Contract; and
7. Providing feedback to the Contractor about findings, and requiring corrective actions, as determined necessary by the Department. The Contractor shall fully cooperate with monitoring and oversight activities. The Contractor shall participate in scheduled meetings, respond to Division inquiries and findings from monitoring and oversight activities, respond to requests for corrective action plans, provide reports on the timeline required by and as requested by the Division, among other activities as deemed necessary by the Division.

See Section 16, Reporting Requirements, of this Contract, and the Reporting Requirements (Exhibit H), which is incorporated into this Contract via reference, for more information.

Cooperation in Contract monitoring and provision of documents during Contract monitoring shall be at no additional cost to the Division.

15.28 Inspection and Monitoring

Pursuant to the requirements of 42 C.F.R. § 438.3, the Division, the Division's Office of Program Integrity, the State Medicaid Fraud Control Unit, the Mississippi Office of the State Auditor, the U.S. Department of Health and Human Services (HHS), CMS, OIG, the Comptroller General, the Government Accountability Office, and any other governmental auditing agency preapproved by the Division, or authorized representatives or designees of the aforementioned parties, shall at any time have the right to enter onto the Contractor's or Subcontractor's premises, or such other places where duties under this Contract or Medicaid-related activities are being performed, with or without notice, to inspect, audit, monitor, or otherwise evaluate (including periodic systems testing) the work being performed by the Contractor, Subcontractor, Subcontractor's contractor, or supplier.

The right to audit exists for ten (10) years from the final date of the Contract period or from the date of completion of any audit, whichever is later (42 C.F.R. § 438.3(h)). All inspections and evaluations shall be performed in such a manner as will not unduly delay work. Refusal by the Contractor to allow access to all records, documents, papers, letters, or other materials shall constitute a material breach of contract. All audits performed by persons other than Division staff will be coordinated through the Division and its staff.

Because of the importance of having accurate service utilization data for program management, utilization review and evaluation purposes, emphasis will be placed on case record validation during periodic monitoring visits to project sites. The Division shall prepare a report of its findings and recommendations and require the Contractor to develop a Corrective Action Plan or Plans to address any deficiencies. If the Division, CMS, or OIG determines that there is a reasonable possibility of fraud or similar risk, the Division, CMS, or OIG may inspect, evaluate, and audit the Subcontractor at any time.

15.29 Readiness Reviews

The Contractor shall comply with all requirements related to the assessment of the Contractor's performance prior to the Special Open Enrollment and operational start date of this Contract, as required by the Request for Qualifications and 42 C.F.R. § 438.66. The Division will complete readiness reviews of the Contractor prior to implementation of the Contract expansions and Contract renewals at its discretion, initiating the process no later than three (3) months prior to the implementation of this Contract. This includes evaluation of all program components including but not limited to information technology; operations and administrative services; service delivery components including but not limited to care management, quality improvement, and utilization review; financial management components including but not limited to financial reporting, monitoring, and solvency; systems

management including but not limited to claims management, encounter data, and enrollment information management; Provider Network management; medical and behavioral health management.; and Contractor staffing. The readiness reviews will include desk reviews of materials the Contractor must develop and onsite visits at the Contractor's administrative offices. The Division may also require similar information from Subcontractors and conduct onsite visits to the offices of any Subcontractor.

15.30 Privacy/Security Compliance

The Contractor shall execute the Division's Business Associate Agreement (BAA) and Data Use Agreement (DUA) before contract execution. The BAA and DUA can be found on the Procurement Website at http://www.medicaid.ms.gov/resources/procurement/. Moreover, all activities under this contract shall be performed in accordance with all applicable Federal and/or State laws, rules and/or regulations including the Administrative Simplification provisions of HIPAA, as amended by the Genetic Information Nondiscrimination Act (GINA) of 2008 and the Health Information Technology for Economic and Clinical Health Act (HITECH Act), Title XIII of Division A, and Title IV of Division B of the American Recovery and Reinvestment Act (ARRA) of 2009, and their implementing regulations at 45 C.F.R. Parts 160, 162, and 164, involving electronic data interchange, code sets, identifiers, and the security and privacy of protected health information (PHI), as may be applicable to the services under this Contract. Each party to this contract shall treat all data and information to which it has access under this contract as confidential information to the extent that confidential treatment of same is required under Federal and State law and shall not disclose same to a third party without specific written consent of the other party. In the event that either party receives notice that a third party requested divulgence of the confidential or otherwise protected information and/or has served upon it a subpoena or other validly issued administrative or judicial process ordering divulgence of the confidential or otherwise protected information, the party shall promptly inform the other party and thereafter respond in conformity with such subpoena as required by applicable State and/or Federal law, rules, and regulations. The provision herein shall survive the termination of the contract for any reason and shall continue in full force and effect and shall be binding upon both parties and their agents, employees, successors, assigns, subcontractors, or any party claiming an interest in the contract on behalf of, or under, the rights of the parties following termination.

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16. Reporting Requirements

This section provides requirements for reports to be provided to the Division under the terms of this Contract. The Division reserves the right to make operational reports, data, and information submitted by the Contractor public. The Division also reserves the right to perform audits, as appropriate, to verify and validate operational reports, data, and information submitted by the Contractor.

Additionally, the Division will provide the Contractor with the MississippiCAN and CHIP Reporting Requirements in Exhibit ___ and templates for each required item unless noted in the Exhibit. The Reporting Requirements Exhibit includes reporting requirements and naming conventions for reports to be provided to the Division. The templates for the required reports are not exhaustive documents, and it is the Contractor's responsibility to be aware of reports required in this Contract that do not appear in Exhibit ____, and vice versa, as well as any other reports requested by the Division. If a reporting requirement enumerated in this Contract conflicts with the most current version of the template provided by the Division, the instructions contained in the template will control. The Division reserves the right to request additional information or reports, outside of those identified in the Reporting Requirements Exhibit, from the Contractor to assist in the determination of Contract compliance, appropriate utilization of public funds, health outcomes of Members, and/or review of any other areas the Division wishes to evaluate. Ad hoc reports requested by the Division, outside of those identified in the Reporting Requirements Exhibit, shall be formatted, named, and submitted to the Division by the requested timeline as instructed by the Division.

The Contractor shall be given a minimum of sixty (60) calendar days' written notice of any new edits or changes to any reporting requirement templates provided by the Division. The Contractor shall, upon notice from the Division, communicate these same changes to Subcontractors. Minor modifications, such as to clarify an instruction, add additional lines to a template, or correcting a formatting issue, are not considered substantive and will be promulgated as needed by the Division and are effective immediately. Other exceptions to the sixty (60) calendar day notice may be determined by the Division as needed and will be communicated to the Contractor.

Additional reporting requirements will be provided to the Contractor in the Mississippi Division of Medicaid Value-Based Purchasing Work Plan and the Mississippi Division of Medicaid Performance Measures Manual, both of which are incorporated into this Contract via reference. The Contractor must also supply any and all reporting and information necessary for the preparation of the Division's Managed Care Program Annual Report (MCPAR) as defined under 42 C.F.R. §438.66(e).

All reports shall be submitted by the dates and timeframes enumerated in this Contract, the

MississippiCAN and CHIP Reporting Requirements (Exhibit H), the Value-Based Purchasing Work Plan, and the Performance Measures Manual. If a requested report is not in the aforementioned documents, then it must be submitted by the dates and timeframes and in the formats enumerated by the Division.

For the purposes of this contract, "timely" submission means that the subject Deliverable is submitted to the Division at the time and in the manner and format specified by the Division. If a Deliverable is submitted after the specified time or in a manner or format not specified by the Division, then it is "untimely," and the Division may impose liquidated damages as described in Section 14, Remedies, and Exhibit G, Liquidated Damages, of this Contract.

16.1 Record System Requirements

The Contractor and any Subcontractor shall maintain detailed records for all lines of business covered by this Contract as required by 42 C.F.R. § 438.3(u) including but not limited to the following:

1. All medical and administrative expenses incurred pursuant to this Contract;
2. Member Enrollment status;
3. Provision of covered services;
4. Methodologies for allocation of expenses in adherence with 42 C.F.R. § 438.8;
5. Member grievance and appeal records in 42 C.F.R. § 438.416; base data in 42 C.F.R. § 438.5(c); MLR reports in 42 C.F.R. § 438.8(k); program integrity in 42 C.F.R. §§ 438.604, 438.606, 438.608, and 438.610; and
6. All relevant medical information relating to individual Members, for the purpose of audit and evaluation by the Division and other Federal or State agencies.

All records pertaining to the Contract, including training records and including records of any Subcontractors and Subcontractors' contractors, shall be maintained and available for review by authorized Federal and State agencies, including but not limited to the Division, CMS, OIG, the Comptroller General, and their designees during the entire term of this Contract and for a period of ten (10) years thereafter, unless an audit, litigation, or other legal action is in progress.

When an audit is in progress, audit findings are unresolved, or there is pending litigation or legal action that has not been completed, records shall be kept for a period of no less than ten (10) years or until all issues are finally resolved, whichever is later. All records shall be maintained at one central office in Mississippi designated by the Contractor and approved by the Division. If the Division, CMS, OIG, or Comptroller General determines that there is a reasonable possibility

of fraud or similar risk, the Division, CMS, OIG, or the Comptroller General may inspect, evaluate, and audit any Subcontractor at any time.

All records pertaining to the Contract, including training records, must be readily retrievable within three (3) business days for review at the request of the Division and its authorized representatives at no cost to the Division or its authorized representatives.

Related to QM activities, the Contractor shall maintain and make available to the Division, CMS, OIG, the State Medicaid Fraud Control Unit, and State and Federal Auditors all studies, reports, protocols, standards, work plans, work sheets, committee minutes, committee reports to the Board of Directors, Medical Records, and such further documentation as may be required by the Division concerning quality management activities and corrective actions.

16.2 Reporting Requirements

The Contractor is responsible for complying with the reporting requirements set forth in this Contract and for validating the accuracy, completeness, and timely submission of each report. The Contractor shall provide such additional data and reports as may be requested by the Division. The Division will furnish the Contractor with the appropriate reporting formats, instructions, and timetables for submission.

The Division will also provide technical assistance in filing reports and data as may be permitted by the Division's available resources. The Division reserves the right to modify the form, content, instructions, and timetables for the collection and reporting of data. The Division will provide the Contractor with written notice of all changes. Modifications by the Contractor will be completed and effective within sixty (60) calendar days from the date on the written notice provided to the Contractor, unless otherwise approved by the Division. Minor modifications, such as to clarify an instruction, add additional lines to a template, or correcting a formatting issue, are not considered substantive and will be promulgated as needed by the Division and are effective immediately.

The Contractor shall transmit and receive all transactions and code sets required by HIPAA regulations, as required by Section 15.1, HIPAA Compliance, of this Contract.

The Contractor agrees to furnish to the Division, at no cost to the Division, any records, documents, reports, or data generated or required in the performance of this Contract including but not limited to the reports specified in the MississippiCAN and CHIP Reporting Requirements (Exhibit H), which are incorporated via referenced into this Contract, and reports required under 42 C.F.R. § 438.604.

16.2.1 Provider Services Reports

The Contractor shall submit reports providing information on general Provider services operations, including but not limited to Provider enrollment, Provider services call center, staff training, Grievances, and Appeals.

16.2.2 EPSDT Reports

The Contractor shall comply with all requirements related to the submission of an EPSDT CMS-416 report as required by the Federal government. The Contractor will have in place a periodic notification system that will facilitate compliance with the EPSDT periodicity schedule.

16.2.3 Financial Reports

The Contractor shall file with the Division, within seven (7) calendar days after issuance, a true, correct, and complete copy of any report or notice issued in connection with a financial examination conducted by or on behalf of the Mississippi Insurance Department, State of Mississippi.

The Contractor shall submit to the Division a copy of all quarterly and annual filings submitted to the Mississippi Insurance Department. A copy of such filing shall be submitted to the Division on the same day on which it is submitted to the Mississippi Insurance Department. Any revisions to a quarterly and/or annual Mississippi Insurance Department financial statement shall be submitted to the Division on the same day on which it is submitted to the Mississippi Insurance Department.

Throughout the duration of the Contract term, the Contractor shall operate and maintain an accounting system that either (1) meets Generally Accepted Accounting Principles (GAAP) as established by the Financial Accounting Standards Board or (2) can be reconciled to meet GAAP. This accounting system shall have the capability to produce standard financial reports and ad hoc financial reports related to financial transactions and ongoing business activities, and the Contractor shall enhance or update it upon request. Throughout the term of the Contract, the Contractor must notify the Division prior to making any changes to its basis of accounting.

Contractor must submit to the Division audited financial statements specific to this Contract on an annual basis. The audit must be conducted in accordance with generally accepted accounting principles and generally accepted auditing standards. The Mississippi Insurance Department regulates the financial stability of all appropriately licensed Contractors in Mississippi. The Contractor agrees to comply with all DOI standards.

The Contractor shall file with the Division other financial reporting as required for the Capitation Payment development process, including but not limited to annual financial templates, which

include medical expenditures by rate cell, administrative expenses and other required supplemental expenditure data along with payroll and fringe benefit information for any staff or contractors wholly or partially dedicated to this Contract, capital improvement, real property acquisition and/or lease information, or any other data associated with delivery of services under this Contract.

16.2.4 Claims Denial Report

The Contractor shall submit to the Division a listing of the denials processed in a time and manner as specified in the Reporting Requirements (Exhibit H). The report will be prepared in accordance with the Division's format and include a breakdown of the denials by category to include, at a minimum:

1. Prior authorization,
2. Claims completion errors,
3. Duplicate claims,
4. Services not covered,
5. Services not rendered because the Member is not eligible,
6. Timely filing,
7. Coordination of benefits, and
8. Any other denial categories utilized by the Contractor.

The Contractor shall summarize the above denials, reported for the previous month, in a report as a percentage of total claims processed. A detailed explanation shall be provided for any percentage of denial in excess of two percent (2.0%) by individual denial category. Additionally, a detailed explanation shall be provided by the Contractor if the monthly aggregate denial rate exceeds six percent (6.0%). The Contractor may be placed on a Corrective Action Plan if a pattern of inappropriate denials or delays of provider payments is detected by the Division. The determination that a pattern of inappropriate denials or delays of provider payments exists is at the sole discretion of the Division.

16.2.5 Provider Statistical Summary Report

The Contractor shall follow all guidelines related to Provider Statistical and Summary Report (PS&R) production for Providers, as requested on an ad hoc basis by Providers and/or the Division. The Division will provide guidelines to the Contractor describing the reporting formats

and Contractor report delivery deadlines. MississippiCAN and CHIP PS&Rs will be required separately for outpatient hospital and inpatient claims payment information. MississippiCAN and CHIP PS&Rs should be validated for accuracy each time the report is modified and prior to distribution to hospitals and/or the Division.

16.2.6 Hospice Reports

The Contractor shall provide a monthly report addressing utilization of hospice services for monitoring purposes in a time and manner required in the Reporting Requirements (Exhibit H). The report will be prepared in accordance with the Division's format and include, at a minimum, number of Members accessing hospice services, the length time spent in hospice, total Member discharges, Member discharge status, the total number of hospice prior authorization requests, and outcomes of hospice prior authorization requests.

16.2.7 Third Party Liability Reporting

The Contractor shall provide a monthly report of Third-Party Subrogation to the Division that includes claims for services relating to the date of accident each month in a Division-defined format outlined in the Reporting Requirements (Exhibit H). In such cases, the Contractor will work closely with the Division to coordinate efforts. This report will be reviewed to ensure that the Contractor is in compliance. For cases identified by the Division as having a separate claim for medical services, the Division has the right to request the Contractor submit related information for the Division's review within three (3) business days of the request.

The Contractor shall submit monthly the following reports of Third-Party Resources in the Division's required format:

1. All newly identified health insurance leads. The TPL leads shall be verified prior to submission to the Division.

2. A report showing the total amount of all claims that were denied (cost avoided) due to the existence of having a TPL on file. The Contractor must report denials on all claim types, including those from their delegated vendor/subcontractors. Any claims adjusted shall be reported annually.

3. A report showing the total amount of all monies recovered from other insurance companies after the Contractor had initially paid the claim as primary. The Contractor must report recoveries on all claim types, including those from their delegated vendors/subcontractors. This also includes all retroactive coverages that are identified after the claim has already been processed, but before the timely filing of the coverage has lapsed.

4. A report showing the total amount of all monies recovered from Providers due to audits, reviews, and/or disallowances after the Contractor had initially paid the claim as primary.

The Contractor shall maintain documentation supporting claims that were denied by other carriers during their coordination of benefits (COB) process and be able to provide this documentation upon audit request.

If recoveries are not reported, the Contractor shall provide an explanation as to the reason these recoveries were not reported to the Division. All recovery amounts received by the Contractor and their delegated vendors/subcontractors must be included within the monthly recovery reports submitted to the Division.

Additionally, the Contractor shall submit an annual report reconciling recovery amounts.

16.2.8 Internal Audit Reporting

The Contractor shall submit a report to the Division, detailing the annual review, completed activities and corrective actions that are recommended or in progress, and the results of all clinical, administrative and Member satisfaction surveys conducted during the immediately preceding year. The report shall set forth any proposed modifications to the quality management system or policies and procedures. Any such modifications shall be approved in writing by the Division prior to implementation.

16.2.9 Contractor Reporting of Grievances and Appeals

The Contractor shall maintain a health information system to track the receipt and resolution of verbal, in-person, and written Grievances and Appeals. The Contractor shall submit logs for Grievances and Appeals to the Division as dictated in the Reporting Requirements (Exhibit H). The Contractor shall regularly review the grievances and appeals for any trends or commonalities that need to be addressed globally. A summary of any such trends or commonalities and the action taken by the Contractor to address those issues shall be submitted with the quarterly logs. The logs shall contain all information required in the Reporting Requirements Exhibit and reporting template instructions.

The Contractor shall submit to the Division within thirty (30) calendar days of filing a copy of any report regarding specific Grievances or Appeals or its system for tracking Grievances and Appeals required to be filed with the Mississippi Insurance Department.

16.2.10 Mississippi Insurance Department Reports

The Contractor shall submit to the Division copies of all reports submitted to the Mississippi Insurance Department.

16.2.11 Program Integrity Reports

The Contract shall submit the following reports related to FWA Compliance Plan and FWA activities:

a. Annual FWA Compliance Plan, which is due January 30th for the current calendar year
b. Fraud, Waste and Abuse Activity report, which is due 15th business day after the close of the quarter
c. Annual Provider Report of Investigations/Audits/Complaints, which is due 30th calendar day following the year in which the cases/complaints were reported
d. Annual Member Report of Investigation/Audits/Complaints, which is due 30th calendar day following the year in which the cases/complaints were reported
e. Pharmacy Lock-In Report, which is due the 5th business day of the month following reporting period.

16.3 Confidentiality of Records

The Contractor shall treat all information, including that relating to Members and Providers, that is obtained by the Contractor through its performance under this Contract as confidential information and shall not use any information so obtained in any manner except as necessary for the proper discharge of its obligations and securement of its rights hereunder.

All information as to personal facts and circumstances concerning Members obtained by the Contractor shall be treated as privileged communications, shall be held confidential, and shall not be divulged without the written consent of the Division and the written consent of the Member, the Member's attorney, or the Member's responsible parent or guardian, except as may be required by the Division. The use or disclosure of information concerning Members shall be limited to purposes directly connected with the administration of the Contract. All protected health information (PHI) and personally identifiable information (PII) shall be protected in compliance with HIPAA and any other applicable state and federal laws. All of the Contractor officers and employees performing any work for or on the Contract shall be instructed in writing of this confidentiality requirement and receive training regarding the confidentiality requirements under this Contract and all applicable laws annually thereafter.

Any vendors or subcontractors of the Contractor shall be required to sign a Business Associate Agreement (BAA) in compliance with HIPAA and all other relevant laws.

The Contractor shall immediately notify the Division of any unauthorized possession, use, knowledge or attempt thereof, of the Division's data files or other confidential information. by

the Contractor, its officers, employees, subcontractors, or agents. The Contractor shall immediately furnish to the Division full details of the attempted unauthorized possession, use or knowledge, and assist in investigating or preventing the recurrence thereof.

The Division, the State Attorney General, authorized Federal or State personnel or the authorized representatives of these parties, including, without limitation, any employee, Agent, or Contractor of the Division, CMS, and the Division's Agent, shall have access to all confidential information in accordance with the requirements of this Contract and State and Federal law and regulations pertaining to such access. The Division shall have authority to determine if and when any other party has properly obtained the right to have access to such information in accordance with applicable State and Federal laws and regulations. The Contractor shall adhere to 42 C.F.R., Part 431, Subpart F and 45 C.F.R. Parts 160 and 164 to the extent these requirements are applicable to the obligations under this Contract.

16.4 Access to Records

Pursuant to the requirements of Title XIX, Section 1902(a)(27) of the Social Security Act, 42 C.F.R. § 434.6(a)(5) and 42 C.F.R. § 438.3(h), Section 1128A [42 U.S.C. 1320a-7a] and Miss. Code Ann. §§ 43-13-118, 43-13-121, and 43-13-229 (1972, as amended), the Contractor and each of its Providers and Subcontractors shall make all of its books, documents, papers, Provider records, Medical Records, financial records, data, surveys and computer databases (collectively referred to as records) available for examination and audit by the Division, the State Attorney General, authorized Federal or State personnel or the authorized representatives of these parties including, without limitation, any employee, Agent, or Contractor of the Division, CMS, and the Division's Agent. Financial records may include financial statements, support for costs reported, allocations of costs from a parent company and allocation methods. Access will be at the discretion of the requesting authority and will be either through review of records or by submission of records to the office of the requester. Any records requested hereunder shall be produced immediately for onsite reviews or sent to the requesting authority by mail within fourteen (14) calendar days following a request, for desk audits. Requests may be written or verbal. All records shall be provided at the sole cost and expense of the Contractor including, without limitation, any costs associated with making excerpts or transcripts, copying, reproducing, shipping and/or mailing of records. The Division shall have unlimited rights to use, disclose, and duplicate, all information and data developed, derived, documented, or furnished by the Contractor and in any way relating to this Contract in accordance with applicable State and Federal laws and regulations.

In accordance with 45 C.F.R. § 74.48, the Contract awarded to the Contractor and their Subcontractors shall make available to the HHS awarding agency, the U. S. Comptroller General, or any representatives, access to any books, documents, papers, and records of the Contractor that are directly pertinent to a specific program for the purpose of making audits,

examinations, excerpts, and transcriptions. HHS awarding agencies, the HHS Inspector General, the U.S. Comptroller General, or any of their duly authorized representatives have the right of timely and unrestricted access to any books, documents, papers, or other records of Contractor that are pertinent to the awards in order to make audits, examinations, excerpts, transcripts and copies of such documents. This right also includes timely and reasonable access to a recipient's personnel for the purpose of interview and discussion related to such documents. The rights of access in this paragraph are not limited to the required retention period but shall last as long as records are retained.

There will be no restrictions on the right of the State or Federal government to conduct whatever inspections and audits are necessary to assure quality, appropriateness or timeliness of services and reasonableness of their costs. Under the False Claims Act at 31 U.S.C. § 3731(b)(2), claims may be brought up to ten (10) years after the date on which a violation is committed. The right to audit exists for ten (10) years from the final date of the Contract period or from the date of completion of any audit, whichever is later (42 C.F.R. § 438.3(h)).

Any person (including an organization, agency, or other entity, but excluding a Member) that fails to grant timely access upon reasonable request (as defined by the Secretary in regulations) to the Inspector General of the Department of Health and Human Services for the purpose of audits, investigations, evaluations or other statutory functions of the Inspector General of the Department of Health and Human Services, the Division, or any other duly authorized representative, shall be subject, in addition to any other penalties that may be prescribed by law or this Contract, as referenced in Section 14, Remedies, and Exhibit G, Liquidated Damages.

16.5 Health Information System

The Contractor shall maintain a health information system that collects, analyzes, integrates, and reports data. The system must provide information on areas including, but not limited to, utilization, claims, Grievances and Appeals, and Disenrollment for other than loss of Medicaid eligibility. The Contractor must collect data on Member and Provider characteristics (e.g., trimester of Enrollment, tracking of appointments kept and not kept, place of service, Provider type), and make all collected data available to the Division, to CMS, to the Mississippi Insurance Department, and to any other oversight agency of the Division.

It is a Division requirement that the Contractor send clinical, encounter, and care management data to the Division in formats adhering to the standards required by the state and federal government including, but not limited to, Health Level 7 Fast Healthcare Interoperability Resources (HL7 – FHIR), Application Programming Interface (API) and United States Core Data for Interoperability (USCDI) on a regular basis. A regular basis shall be further defined by the Division; however, it should be assumed that regular basis will be at a minimum of once per day depending on data type and source. The Contractor is required to maintain data transmission

and formatting compliance based on state and federal regulations which may be updated by the state and/or federal government during the contract period.

It is a Division requirement that the Contractor integrates with any future Division Government-to-Constituent (G2C) CIAM with Federation.

16.5.1 Clinical Data

The clinical data that is aggregated by the Contractor in the management of the Division's beneficiaries should include the following information specific to the Medicaid beneficiary:

1. Patient Identification Data;
2. Patient Demographic Data;
3. Smoking Status;
4. Encounter Data;
5. Medications;
6. Diagnosis(es);
7. Procedure(s);
8. Immunizations;
9. Allergy;
10. Plan of Care Data;
11. Gaps in Care Data;
12. Laboratory Orders and Results;
13. Radiology Orders and Reports;
14. Pathology Orders and Reports;
15. Transcription Data;

16. Vital Signs;

17. Height, Weight, and BMI;

18. Problems; and

19. Data from Care Management Programs, as defined by the Division.

Per 42 C.F.R. § 438.242, the Contractor shall comply with Section 6504(a) of the PPACA, which requires that the State claims processing and retrieval systems are able to collect data elements necessary to enable the mechanized claims processing and information retrieval systems in operation by the State to meet the requirements of section 1903(r)(1)(F) of the Social Security Act.

The Contractor shall ensure that its data concepts and systems are capable of reporting multiple detailed data sets including, but not limited to, clinical, care management plans, and encounter data with the Division, in structured and unstructured formats. The Contractor shall ensure all data is accurate and complete.

The Contractor shall work with the Systems Work Group to define a mutual statement of work and schedule to implement software and hardware routing solutions required for the successful delivery of all available data (including, but not limited to: Laboratory reports, Radiology reports, Admission/Discharge/Transfer data, United States Core Data for Interoperability (USCDI), and Pathology reports) from the Contractor's systems to the Division in accordance with state and federal standards which currently include: the Health Level 7 Fast Healthcare Interoperability Resources (HL7 – FHIR), Application Programming Interface (API) and United States Core Data for Interoperability (USCDI) standards.

The Contractor shall work with the IT/Data Systems Work Group of the Mississippi Community Behavioral Health Clinic (CCBHC) Planning Grant Steering Committee to define a mutual statement of work and schedule to implement software and hardware routing solutions required for the successful implementation of CCBHCs.

To facilitate improved interoperability, the Contractor shall participate in a statewide and a regional Health Information Exchange (HIE) at no additional cost to the Division.

16.5.2 Population Health Data

The Contractor shall ensure that the health information system possesses the collection and analytic capacity to execute a Population Health Management program to:

1. Support Providers in the optimal delivery of care;
2. Guide and support Members in managing their health needs and risks;
3. Support the Division in its goals to modernize and execute data analytic strategies;
4. Improve health outcomes; and
5. Reduce the total cost of care for Coordinated Care Members.

More information about Population Health Management can be found in Section 5, Member Services, of this Contract.

16.6 Population Health Management Reporting

The Contractor must report to the Division and network Primary Care Providers/Patient-Centered Medical Homes, at intervals designated by the Division, on the efficacy of its Population Health Management programs for MississippiCAN and CHIP. Each program's report will be designed collaboratively by the Division and the Contractor and will include, but is not limited to, measures to identify changes in:

1. Health disparities among subpopulations;
2. Targeted health outcomes;
3. Member participation in health promotion and disease prevention initiatives;
4. Percent of members in each risk stratification level; and
5. Member utilization of inpatient and emergency department services.

16.7 Member Encounter Data

In accordance with 42 C.F.R. § 438.242 and 42 C.F.R. § 438.818, the Contractor must collect and submit complete, accurate, and timely Member Encounter Data to the Division that meets Federal requirements and allows the Division to monitor the program at least monthly following the month in which the claims were adjudicated (paid, amended, or denied status). Member Encounter Data consists of a separate record each time a Member has an Encounter with a health care Provider, including Member Encounter Records reflecting a zero dollar ($0) amount as well as Member Encounter Records where the Contractor has a capitation and/or VBP arrangement with the provider. For any services that the Contractor has entered into capitation and/or VBP reimbursement arrangement with providers, the Contractor shall comply with all Member

Encounter Data submission requirements in this section. The Contractor shall require timely submissions from its providers as a condition of the capitation payment. A service rendered under this Agreement is considered an Encounter regardless of whether it has an associated Claim. The Contractor shall only submit Member Encounter Data for Members enrolled with the Contractor on date of service and not submit any duplicate records. The Provider's National Provider Identifier (NPI) shall be used when submitting required Encounter Data. Adjustments necessitated by administrative payments or recoupments, program integrity recoupments, lump sum payments, and payment errors processed during that payment cycle are not considered duplicate records.

All Member Encounter Data must be submitted to the Division's Agent by the Contractor using established protocols. The Division will not accept any Member Encounter Data submissions or correspondence directly from any Subcontractors, and the Division will not forward any electronic media reports or correspondence directly to a Subcontractor. The Contractor will be required to receive all electronic files and hardcopy material from the Division, or its Agent, and distribute them within its organization or to its Subcontractors as needed.

The Contractor must maintain appropriate systems and mechanisms to obtain all necessary data from its Providers or Subcontractors to ensure its ability to comply with the Member Encounter Data reporting requirements. The failure of a Provider or Subcontractor to provide the Contractor with necessary Member Encounter Data shall not excuse the Contractor's non-compliance with this requirement. The Contractor shall not submit duplicate Member Encounter Data.

16.7.1 Data Format

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, VBP innovation, program oversight, and reporting requirements. The Contractor must submit Member Encounter Data to the Division's Agent using protocols established by the Division and its Agent(s). 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 PBA.

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

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

1. ASC X12N 837P Professional Claim/Encounter Transaction;
2. ASC X12N 837I Institutional Claim/Encounter Transaction;
3. ASC X12N 837D Dental Claim/Encounter Transaction;
4. ASC X12N 834 Benefit Enrollment and Maintenance;
5. ASC X12N 835 Claims Payment Remittance Advice Transaction;
6. ASC X12N 277 Claims Status Response; and
7. NCPDP Version D.0 Pharmacy as directed by the Division.

16.7.2 Provider Claims

The Contractor shall encourage Providers to submit claims as soon as possible after the dates of service., but no more than one-hundred eighty (180) calendar days following the date of service. For the purpose of timely filing, the Through Date shall be used for determining claims filing. Claims filed within the appropriate time frame but denied may be resubmitted for reconsideration to the Contractor within ninety (90) calendar days from the date of denial. The Contractor will be responsible for processing claims in accordance with 42 C.F.R. § 447.46, as specified in Section 9.1, Claims Management, of this Contract.

Claims adjudicated by a third-party vendor must be provided to the Contractor by the end of the month following the month of adjudication.

16.7.3 Member Encounter Data Provision, Submissions, and Processing Requirements

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 associated with encounters from providers with whom the Contractor has a capitation arrangement or value-based purchasing arrangement shall be equivalent to the level of detail associated with encounters for which the Contractor received and settled a Fee-for-Service claim. 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 data the Division is required to report to CMS under 42 C.F.R.§ 438.818 including but not limited to:

1. Accurate enrollee and provider identifying information;
2. Date of service;
3. Procedure and diagnosis codes;
4. Allowed amount and Paid amount;
5. Third party liability amounts;
6. Claim received date;
7. Claim adjudication date; and
8. Claim payment dates.

The Contractor must submit complete and accurate Member Encounter Data that includes:

a. All Member Encounter data,
b. Member Encounter Data adjustments,
c. Encounters reflecting a zero-dollar amount ($0.00),
d. Encounters reflecting claim voids,
e. Encounter claims reflecting denied claims, and
f. Encounters in which the Contractor has a capitation arrangement with a provider.

The 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,
(d) payment errors.

Submissions shall be comprised of encounter records or adjustments to previously submitted records that 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 managed by the Contractor as directed by the Division, the Contractor shall submit complete and accurate Member Encounter Data processed by the Contractor's Subcontractor within five (5) business days following adjudication.

The Contractor shall receive Member Pharmacy Claim Data from the Division PBA that meets established Division data quality standards. The Contractor shall make changes or corrections to any systems, processes or data transmission formats received or submitted as needed to comply with the Division's data quality standards as originally defined or subsequently amended.The Contractor will receive Member Pharmacy Claim Data and Prior Authorization Data daily as incrementally received. The Contractor must utilize Member Pharmacy Claim Data and Prior Authorization Data in all aspects of Care Management for all Members.

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

For adjustments of pharmacy encounters processed by Contractor's PBM prior to live operations of the Division's PBA, failure of Contractor's PBM to submit Member Pharmacy Encounter Data timely shall not excuse Contractor's noncompliance with this requirement, and the Division may impose liquidated damages or other available remedies under this Contract for non-compliance.

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 Subcontractors more than 30 calendar days after the date of adjudication.

The Contractor shall submit Member Encounter Data according to HIPAA X12 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 that contains fatal errors that prevent processing or that does not satisfy defined threshold error rates will be rejected and returned to the Contractor for immediate correction. When the Division or its Agent rejects a file of encounter claims, the rejected files must be resubmitted with all of the required data elements in the correct format by the Contractor within thirty (30) calendar days from the date the Contractor received the rejected file. The Division may impose liquidated damages or other available remedies under Section 14, Remedies, 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. Corrections and resubmissions must pass all edits before they are accepted by the Division's Agent.

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 Div
sion's Agent's edits are returned to the Contractor, and the Contractor must make the requested corrections.

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.

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

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

The Contractor shall correct and resubmit denied Encounter Records within the time frame referenced above. Corrections and resubmissions must pass all edits before they are accepted by the Division's Agent.

The Contractor shall ensure that the payment information on the Subcontractors' Member Encounter Data reflects the date and the amount paid to the provider by the Subcontractor.

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

16.7.4 Encounter File Specifications

The Contractor must adhere to the file size and format specifications provided by the Division. The Contractor must also adhere to the Encounter File submission schedule provided by the Division.

16.7.5 Data Completeness

The Contractor shall submit records each time a Member has an Encounter with a health care Provider. The Contractor must have a data completeness monitoring program in place that:

1. Demonstrates that all Claims and Encounters submitted to the Contractor by Providers and Subcontractors are submitted accurately and timely as Encounters to the Division's Agent. In addition, demonstrates that denied Encounters are resolved and/or resubmitted;

2. Evaluates Provider and Subcontractor compliance with contractual reporting requirements; and

3. Demonstrates the Contractor has processes in place to act on the information from the monitoring program and takes appropriate action to ensure full compliance with Member Encounter Data reporting to the Division.

The Contractor must submit an annual Data Completeness Plan for review and approval. This Data Completeness Plan must include the three (3) elements listed above. The Contractor must report findings from its annual Data Completeness internal audits on at least an annual basis, or at the request of the Division.

16.7.6 Accuracy of Data

The Contractor will assist the Division in reconciliation of the Cash Disbursement Journal to Contractor Paid Amount totals for submitted claims. The Contractor shall submit at least ninety-nine percent (99%) of all Member Encounter Data in a valid format, which will be deemed valid by the Division, including those of Subcontractors or delegated vendors as provided for in this Section, both for the original and any adjustment or void. The Division or its Agent will validate Member Encounter Data submissions according to the Cash Disbursement Journal of the Contractor and any of its applicable Subcontractors. The measurement report for this validation shall be the Encounter Claims to Cash Disbursements Journal for the twenty-four (24) month period ending in June of the current year. If twenty-four (24) months of data is not available due to the amount of time the Contract has been operational, the measurement report shall include all data available in June of the current year. This measurement period shall apply to Encounter Claims for the Contractor and all Subcontractors and shall be measured by the Entire Plan and separately for each Service category. The measurement report shall apply to Encounter Claims for the Contractor and all Subcontractors as measured by the Entire Plan and each Service category. If the Contractor fails to submit complete Member Encounter Data, as measured by a comparison of encounters to cash disbursements, Contractor may be subject to liquidated damages or other available remedies as outlined in Section 14, Remedies, of this Contract.

The data accuracy requirement also consists of assurance that the Encounter Data accurately reflects the information contained within the Contractor's or Subcontractor's Claims Systems, while the Claims System data should be an accurate representation of the information contained within the Medical Record(s) that substantiates the clinical service(s) provided. It is the Division's expectation that the individual data elements captured at each transactional stage of this process cycle are accurately transmitted and reconcilable with each other. The Division or its Agent may, at its discretion, determine to periodically test and evaluate the accuracy of the encounter data through sampling or through a more comprehensive EQR Protocol 5 review. If the Contractor fails to maintain accurate Encounter Data, as measured by a comparison of encounters to claims data and/or claims data to medical records, Contractor may be subject to liquidated damages or other available remedies as outline in Section 14, Remedies, of this Contract.

Ninety-nine percent (99%) of the records in the Contractor's encounter batch submission must pass X12 EDI compliance edits and the Mississippi Medicaid MES/MMIS threshold and repairable compliance edits. The X12 EDI compliance edits are established through Strategic National Implementation Process (SNIP) levels one (1) through four (4). MES/MMIS threshold and repairable edits that report exceptions are set forth in the Companion Guide.

16.7.7 Data Validation

Member Encounter Data quality will be validated by chart review of a sample of enrollees against monthly Member Encounter Data reported by the Contractor. The Contractor agrees to assist the Division in its validation of Member Encounter Data by making available Medical Records and claims data as requested. The validation may be completed by the Division staff and/or independent, external review organizations.

In addition, the Contractor will validate files sent to them when requested.

16.7.8 Secondary Release of Member Encounter Data

All Member Encounter Data documenting services rendered to Members under this Agreement are the property of the Division. Access to this data is provided to the Contractor and its agents for the sole purpose of operating the MississippiCAN Program under this Agreement. The Contractor and its agents are prohibited from releasing any data resulting from this Agreement to any third party without the advance written approval of the Division.

16.8 Drug Utilization Data

For any pharmacy and/or drug delivery services and/or benefits the Contractor is directed to deliver by the Division, the Contractor shall report drug (i.e., j-code) utilization data to the Division's Agent as authorized by the Omnibus Budget Reconciliation Act of 1990, Section 1927 of the Social Security Act, and as required by CMS per 42 C.F.R. § 438.5(c), for the purposes of accurate, timely collection of quarterly drug rebates. The Contractor must include national drug code (NDCs) numbers and corresponding quantities (i.e., HCPCS codes and units for Physician-Administered Drugs and Implantable Drug System Devices) in a format to be specified by the Division. The Contractor shall submit to the Division the drug utilization data necessary for the collection of drug rebates in formats to be specified by the Division weekly. The Contractor must resolve any disputes related to the data within thirty (30) calendar days from notification by the Division.

16.9 Cost or Pricing Data

If the Division determines that any price, including profit or fee, negotiated in connection with this Contract was increased because the Contractor furnished incomplete or inaccurate cost or pricing data not current as certified in the Contractor's certification of current cost or pricing data, then such price or cost shall be reduced accordingly and this Contract shall be modified in writing and acknowledged by the Contractor to reflect such reduction.

16.10 Data Certifications

Per 42 C.F.R. §§ 438.606 and 438.604, all data, reports, documents, records, Member Encounter Data, and any other information required to be submitted to the Division by the Contractor shall be certified by one of the following: The Contractor's Chief Executive Officer, the Contractor's Chief Financial Officer, or an individual who has delegated authority to sign for, and who reports to, the Contractor's Chief Executive Officer or Chief Financial Officer. The certification must attest, based on best knowledge, information, and belief, to the accuracy, completeness and truthfulness of the data and to the accuracy completeness and truthfulness of the documents. The Contractor must submit the certification in writing with the signature of the appropriate certifier, at the time the certified data, documents, reports, records, Member Encounter Data, or other information is submitted to the Division.

16.11 Claims Processing and Information Retrieval Systems

The Contractor's claims processing system must have the capability to process Claims consistent with timeliness and accuracy requirements identified in this Contract. The Contractor's information retrieval systems must have the capability to accept claims history data from the Division or its Agent.

16.12 Internal Contractor Reporting

The Contractor is responsible for reporting all suspected or confirmed instances of internal Fraud and Abuse relating to the provision of and payment for Medicaid services including, but not limited to Fraud and Abuse acts related to the Contract and/or the Division of Medicaid that is other than provider and enrollee Fraud and Abuse (e.g. internal to the health plan– employees/management, Subcontractors, vendors, delegated entities). This report shall include at a minimum:

1. The date reported ("Date reported" is the date the report was submitted to the Office of Coordinated Care);

2. The name of the Contractor reporting;

3. The name of the individual or entity;

4. The entity's tax identification number;

5. A description of the acts allegedly involving suspected Fraud or Abuse:

    a. Source of Complaint/detection tool utilized;

    b. Nature of Complaint;

    c. If applicable, case closed due to:

        i. Corrective action completed by provider;

        ii. Provider voluntarily left network;

        iii. Provider involuntarily terminated by Contractor;

        iv. Other (specify);

6. Potential exposure/loss identified;

7. If known, actual exposure/loss identified; and

8. If applicable, exposure/loss collected or recouped from individual or entity by the Contractor.

In accordance with the PPACA and the Mississippi Administrative Code Section 23, Part 305, the Contractor shall report Overpayments made by the Division of Medicaid to the Contractor as well as Overpayments made by the Contractor to a provider.

16.13 Subcontractor Disclosures

The Contractor must disclose all information in accordance with 42 C.F.R. § 455.104(b) and 42 C.F.R § 438.608(c) regarding Subcontractors. The Contractor is responsible for obtaining all disclosure information from all Subcontractors, managing employees, and agent's employees, and submitting to the Division.

The Contractor must disclose all information from their Subcontractors as related to persons convicted of crimes in accordance with 42 C.F.R. § 455.106.

16.14 Deliverables

The Contractor must obtain the Division's prior written approval of all Deliverables sixty (60) calendar days prior to the operational date of the Initial Term and throughout the duration of the Contract unless otherwise specified by the Division. Deliverables include but are not limited to operational policies and procedures, required materials, letters of agreement, Provider Agreements, Provider reimbursement methodology, reports, tracking systems, required files, and quality management program documents. Failure by the Division to respond to approval requests shall not be interpreted as approval of Deliverables.

The Contractor must meet the Division's required time frames for the submission of Deliverables.

16.15 Data, Information, and Documentation Requirements

In accordance with 42 C.F.R. § 438.604, the Contractor must submit to the State the following data:

1. Member Encounter Data in the form and manner described in 42 C.F.R. § 438.818.

2. Data as determined by the State to certify the actuarial soundness of capitation rates to the Contractor under 42 C.F.R. § 438.4, including base data described in 42 C.F.R. § 438.5 (c) that is generated by the Contractor.

3. Data as determined by the State to determine the compliance of the Contractor with the medical loss ratio requirement described in 42 C.F.R. § 438.8.

4. Data as determined by the State to determine that the Contractor has made adequate provision against the risk of insolvency as required under 42 C.F.R. § 438.116.

5. Documentation described in 42 C.F.R. § 438.207(b) on which the State bases its certification that the Contractor has complied with the State's requirements for availability and accessibility of services, including the adequacy of the provider network, as set forth in 42 C.F.R. § 438.206.

6. Information on ownership and control described in 42 C.F.R. § 455.104 from the Contractor and Subcontractors as governed by 42 C.F.R. § 438.230.

7. The annual report of overpayment recoveries as required in 42 C.F.R. § 438.608(d)(3).

8. In addition to the data, documentation, or information listed above, the Contractor must submit any other data, documentation, or information relating to the performance of the entity's obligations under this part required by the State of Mississippi or the Secretary for Health and Human Services.

The Contractor must provide a website for MississippiCAN that includes the information required in 438.10(g)-(i) and a website for CHIP that includes information required in 42 C.F.R.§ 457.1207, cross-referencing 42 C.F.R. § (g)-(i), and the Contractor must provide the Division with the specific links (URLs) to that information. The data submitted will be posted to the State's website as required by 42 C.F.R. § 438.10(c)(3). The data, documentation, or information submitted must be certified by either the Contractor's Chief Executive Officer, Chief Financial Officer, or an individual who reports directly to the Chief Executive Officer or Chief Financial Officer with delegated authority to sign for the Chief Executive Officer or Chief Financial Officer so that the Chief Executive Officer or Chief Financial Officer is ultimately responsible for the certification. The certification provided must attest that, based on best information, knowledge, and belief, the data, documentation, and information is accurate, complete and truthful and is submitted concurrently with the submission of the data, documentation, or information.

16.16 Auditing and Monitoring

Contractor legal affiliates and related parties, including but not limited to the Contractor parent company, and Subcontractors shall upon request provide all accounting transactions and supporting records that relate to expenses charged or billed to the Contractor and any allocations of expenses charged to the Contractor.

Upon request, the Contractor shall submit to the Division historical or current transaction codes, charts of accounts and subaccounts, charts of intercompany accounts and intersegment accounts, charts of accounts for subledgers and journals, and accounting and management system fields, codes, and code names. The Contractor's parent company and related parties shall submit similar descriptive system fields and charts of account as requested, including those that relate to financial charges and expenses that are or have been allocated to be paid by the Contractor.

All records pertaining to the Contract, including financial and accounting records, must be readily retrievable within three (3) business days for review at the request of the Division. The retrievable records shall include financial and accounting records of related parties and Subcontractors that charge amounts payable by the Contractor.

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MISSISSIPPI DIVISION OF
MEDICAID

Exhibit A: Capitation Rates

The table below are the rates for State Fiscal Year 2026 (July 1, 2025 through June 30, 2026).

(Insert CCO Name)	
MississippiCAN Capitation Rates State Fiscal Year (SFY 26)	
Capitation Rates PMPM (excluding Risk Scores)	
Effective July 1, 2025 - June 30, 2026	
Rate Cell	**SFY 2026 Statewide Capitation Rates**
Non-Newborn SSI / Disabled	$871.27
Breast and Cervical Cancer	$4,468.36
MA Adult	$375.66
Pregnant Women	$654.11
SSI / Disabled Newborn	$7,090.56
Non-SSI Newborns 0 to 2 Months	$2,382.32
Non-SSI Newborns 3 to 12 Months	$291.40
Foster Care	$724.03
MA Children	$217.63
Quasi-CHIP	$213.05

The MSCAN capitation rates in this table are per the April 7, 2025 MSCAN Actuarial Report (Report08) attached as part of Exhibit A to this Amendment. Rates are prior to application of a 2.00% quality withhold. Rates exclude state directed payments.

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, 2025 through June 30, 2026 is $237.50. See the April 7, 2025 CHIP Actuarial Report (Report09) attached as part of Exhibit A to this Amendment.

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April 7, 2025

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

Re: Report08 State Fiscal Year 2026 MississippiCAN Preliminary Rate Calculation and Certification - DRAFT

Dear Jennifer:

The Mississippi Division of Medicaid (DOM) has retained Milliman to develop actuarially sound capitation rates for state fiscal year (SFY) 2026 for Mississippi Coordinated Access Network (MississippiCAN), a coordinated care program for Medicaid beneficiaries.

The attached report documents the preliminary capitation rates for all populations enrolled in MississippiCAN. Overall, the SFY 2026 capitation rates in this report are 1.7% higher than the SFY 2025 capitation rates issued on February 6, 2025.[1] (when compositing rates using projected SFY 2026 membership). This report assumes ultimate approval of the preprints submitted to CMS for state directed payments.

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

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

This recertification will be done at one time for capitation rates for the entire SFY 2026 period. This recertification is anticipated to happen two quarters following the end of SFY 2026.

There are several considerations made in the development of SFY 2026 capitation rates to reflect impacts of COVID-19 and the unwinding of the continuous coverage requirement (CCR) in the Families First Coronavirus Act (FFCRA). Explicit adjustments for COVID-19 are made in the rate development for the following:

- **Acuity Adjustments:** MississippiCAN enrollment fluctuated significantly throughout CY 2023 due to the CCR and the resumption of eligibility redeterminations starting midyear. Under the continuous coverage requirement DOM could not disenroll members who would normally lose eligibility during the public health emergency (PHE), as declared by the Department of Health and Human Services (HHS).

  Per the Consolidated Appropriations Act, 2023 (CAA), the continuous coverage requirement, which was previously tied to the federal PHE ended on March 31, 2023. Additional guidance from the Centers for Medicare and Medicaid Services (CMS) indicated that states had 14 months after this date to complete redeterminations for affected enrollees. Within the options outlined by CMS, DOM began eligibility redeterminations starting in April 2023 and began disenrolling Mississippi Medicaid recipients who were no longer eligible in July 2023 and throughout the following year. We have been monitoring membership and population acuity changes as of a result of the end of the continuous coverage requirements and have applied an acuity adjustment in preliminary SFY 2026 capitation rates for certain populations based on the most recent data available as of January 2025.

[1] *"Report02 - SFY 2025 Preliminary MississippiCAN Rate Calculation and Certification.pdf" dated February 6, 2025.*

DRAFT

We will amend the capitation rates accordingly in a subsequent release for the following reimbursement changes, program changes, or items we need additional information regarding.

- Final estimated charge trends from CY 2023 to SFY 2026 for inpatient, outpatient, and certain physician services provided by DOM's payment methodology development vendor.
- Population adjustments related to procedural changes in presumptive eligibility or passive enrollment that may be starting in SFY 2026.
- Any required updates resulting from the CY 2025 legislative session.

❖ ❖ ❖ ❖ ❖

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

Sincerely,

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

Katarina N. Lorenz, FSA, MAAA
Consulting Actuary

JAB/KNL/mb

Attachments

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MILLIMAN REPORT

State of Mississippi Division of Medicaid

State Fiscal Year 2026 MississippiCAN Preliminary Rate Calculation and Certification - DRAFT

April 7, 2025

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

Katarina N. Lorenz, FSA, MAAA
Consulting Actuary

DRAFT

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This report assumes the reader is familiar with the State of Mississippi's MississippiCAN program, its benefits, and rate setting principles. The report was prepared solely to provide assistance to DOM to set SFY 2026 capitation rates for the MississippiCAN program. It may not be appropriate for other purposes. Milliman does not intend to benefit, and assumes no duty or liability to, other parties who receive this work. This material should only be reviewed in its entirety.

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I. SUMMARY AND DISCUSSION OF RESULTS

The Mississippi Division of Medicaid (DOM) retained Milliman to calculate, document, and certify to capitation rates for Mississippi Coordinated Access Network (MississippiCAN), a coordinated care program for targeted Medicaid beneficiaries, effective for state fiscal year (SFY) 2026. This report provides preliminary SFY 2026 capitation rates and documents their development. This report is structured as follows:

- Section I includes a high-level overview of the change in capitation rates relative to the July 1, 2024 to June 30, 2025 (SFY 2025) capitation rates.
- Section II provides a short background of the MississippiCAN program.
- Section III documents the development of the base data.
- Section IV documents the rate setting process for SFY 2026 capitation rates.
- Appendices A and B contain additional details on the SFY 2026 rate cell definitions and base period data sources and processing.
- Appendix C provides responses to the CMS managed care rate setting guide for all rate cells. ***This is intentionally left blank for the draft report.***
- Appendix D contains an Actuarial Certification for all MississippiCAN rate cells. ***This is intentionally left blank for the draft report.***
- Appendix E documents our reliance on DOM for data and other assumptions in the development of the capitation rates. ***This is intentionally left blank for the draft report.***

SFY 2026 CAPITATION RATES

Table 1 includes per member per month (PMPM) preliminary capitation rates effective for SFY 2026 that will be paid to the Coordinated Care Organizations (CCOs) on a monthly basis (excluding all directed payments and any payments earned through the value-based payment (VBP) incentive program) to provide medical and certain pharmacy services to their enrolled beneficiaries. Each CCO will be paid based on the distribution of members enrolled in each rate cell.

There are two structural changes to the capitation rate assignment from SFY 2025 to SFY 2026.

- For SFY 2026, DOM has decided to remove regional variation from the capitation rates and any regional cost differences will be included in risk adjustment going forward.
- The Mississippi Youth Around the Clock (MYPAC) members will be reassigned to a rate cell consistent with their category of eligibility (i.e., Foster Care, MA Children, etc.) rather than a separate MYPAC rate cell. The SFY 2026 risk adjustment methodology will be reevaluated for consideration of these higher-than-average cost members in each rate cell. For transparency purposes we developed separate MYPAC service cost estimates for SFY 2026 and then blended the MYPAC membership into the applicable rate cells prior to applying non-service costs. Therefore, throughout the sections of this report describing the service cost development there are still mentions of the MYPAC rate cell.

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Table 1 MississippiCAN Capitation Rates Per Member Per Month (PMPM)[1] Effective SFY 2026	
Rate Cell	**Capitation Rate**
Non-Newborn SSI / Disabled	$871.27
Breast and Cervical Cancer	$4,468.36
MA Adult	$375.66
Pregnant Women	$654.11
SSI / Disabled Newborn	$7,090.56
Non-SSI Newborns 0 to 2 Months	$2,382.32
Non-SSI Newborns 3 to 12 Months	$291.40
Foster Care	$724.03
MA Children	$217.63
Quasi-CHIP	$213.05

[1] Capitation rates in Table 1 exclude state directed payments and are prior to the application of the quality withhold or VBP.

In addition, there are multiple state directed payments that are separate payment terms outside of the monthly capitation rates and excluded from Table 1. The estimated cost for each state directed payment is included as a PMPM amount in the preliminary SFY 2026 capitation rates. These PMPM amounts will be retrospectively adjusted on a CCO-specific basis to reflect final payments made for each program.

- The Mississippi Hospital Access Program (MHAP) hospital fee schedule adjustment (FSA) payments are paid outside of the capitation rates on a monthly basis. This amount varies by rate cell on a PMPM basis based on projected utilization of inpatient and outpatient services and actual membership. The MHAP FSA payments are projected to be $694.7 million in SFY 2026. Please see Section IV of this report for additional details on the MHAP FSA.

- Payments for the MHAP quality incentive payment program (QIPP) are paid outside of the capitation rates on a quarterly basis. The MHAP QIPP payments are projected to be $815.6 million in SFY 2026. Please see Section IV of this report for additional details on the MHAP QIPP.

- The Mississippi Medicaid Access to Physician Services (MAPS) program in MississippiCAN enhances payments to physicians who are employed by a qualifying hospital or who have Mississippi Medicaid payments for a qualifying hospital. The MAPS payments are made quarterly and are estimated to be $31.0 million in SFY 2026. Please see Section IV of this report for additional details on the MAPS program.

- The payments for the Transforming Reimbursement for Emergency Ambulance Transportation (TREAT) program in MississippiCAN for SFY 2026 enhances payments to eligible emergency ambulance providers. The TREAT payments are paid on a quarterly basis and estimated to be $26.5 million in SFY 2026. Please see Section IV of this report for additional details on the TREAT program.

- Payments for the MOMS program are paid outside of the capitation rates on an annual basis. This program aims to improve maternal outcomes in Mississippi through enhanced payments to hospitals and outpatient providers. These payments are estimated to be $6.6 million in SFY 2026. Please see Section IV of this report for additional details on the MOMS program.

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

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SFY 2026 capitation rates will additionally be adjusted on a CCO-specific basis for the following rate adjustments:

- Quality Withhold: As in SFY 2025 rates, DOM will apply a quality withhold to MississippiCAN payments in SFY 2026 based on metrics reported by the CCOs. For SFY 2026, the withhold percentage will be increased from 1.0% to 2.0%. The PMPM capitation rates in Table 1 are prior to the application of this quality withhold. Please see Section IV for more information on the quality withhold for SFY 2026.

- Value-Based Payment Program (VBP): Consistent with SFY 2025, DOM will operate a VBP program where CCOs can earn up to a 0.25% incentive payment. Please see Section IV for more information on this program.

- Risk Adjustment: The capitation rates for the Non-Newborn SSI / Disabled, MA Adult, MA Children, and Quasi-CHIP rate cells will be risk adjusted for each CCO using the combined Chronic Illness and Disability Payment System and Medicaid Rx risk adjuster (CDPS + Rx). The CDPS + Rx risk adjuster will be used to adjust for the acuity differences between the enrolled populations of each CCO and will be budget-neutral to DOM. The CDPS + Rx demographic and disease category weights will be calculated using Mississippi FFS and encounter data for the populations enrolled and services provided during SFY 2026.

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

  The risk adjustment mechanisms outlined above will be reevaluated for SFY 2026 capitation rates given the consolidation of current MYPAC members into other rate cells and the removal of region-specific capitation rates. Please see Section IV for more information on the application of risk adjustment.

- High-Cost Pharmacy Risk Corridor: Similar to SFY 2025, a high-cost pharmacy risk corridor will be applied to recognize the uncertainty in determining rate setting assumptions for the impact of current and anticipated high-cost medications.

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

This report includes preliminary capitation rates for SFY 2026. These rates will be updated for the following. It is anticipated that all adjustments will be made during the rating period.

- Final charge trends for inpatient, outpatient, and certain physician services provided by DOM's vendor.

- Population adjustments related to procedural changes in presumptive eligibility or passive enrollment potentially occurring in SFY 2026.

- Any required updates resulting from the CY 2025 legislative session.

- A separate report will be issued outlining the risk adjustment methodologies for SFY 2026.

Our Actuarial Certification of the SFY 2026 MississippiCAN capitation rates will be included as Appendix D in the final capitation rate report. **Appendix D is omitted in this draft release.** It should be emphasized that capitation rates are a projection of future costs based on a set of starting data and assumptions. Actual costs will be dependent on each contracted CCO's situation, experience, and enrolled population.

SELECTION OF BASE DATA

The base data used in the development of SFY 2026 capitation rates is comprised of calendar year (CY) 2023 data for rate cells with over 100,000 member months. For smaller rate cells, data from CY 2022 is adjusted for estimated trend and program changes to put it on a CY 2023 basis. The two years of data are then blended using the historical membership in CY 2022 and CY 2023.

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In October 2022, a new MMIS vendor began processing all data for the Mississippi Medicaid and CHIP programs. In order to have consistency in the data for all months, the CY 2022 encounter data that serves as part of the basis for rate cells with less than 100,000 member months was supplied by DOM's new MMIS vendor, including restated months of data prior to October 2022. Milliman has worked closely with DOM and their MMIS vendor to refine our data process and validate the CY 2022 and CY 2023 data.

CATEGORIES OF SERVICE

Table 2 below shows the categories of service for the SFY 2026 capitation rates. Similar to SFY 2025 capitation rates, we use a more granular category of service methodology to develop the capitation rates. In this more granular methodology inpatient, outpatient, and physician services are further subset into more specific sub-categories of service.

Starting in July 2024, DOM entered into an arrangement with their Pharmacy Benefits Administrator (PBA) in which certain pharmacy claims are paid through the PBA. While these pharmacy services are not carved-out of managed care, the CCO is not at risk for these expenses. As such, we identified and removed the associated pharmacy claims from the base data for the purpose of developing SFY 2026 capitation rates. Please see Appendix B for a further description of the associated pharmacy services.

Table 2
MississippiCAN Capitation Rate Development
SFY 2026 Categories of Service

High Level Service Category	Detailed Service Category
Inpatient Hospital	Inpatient Hospital Services - Maternity / Deliveries
	Inpatient Hospital Services - Psychiatric / Substance Abuse
	Inpatient Hospital Services - All Other
Outpatient Hospital	Outpatient Hospital Services - Emergency Room
	Outpatient Hospital Services - Pharmacy
	Outpatient Hospital Services - All Other
Physician	Physician Services - Maternity / Deliveries
	Physician Services - Psychiatric / Substance Abuse
	Physician Services - All Other
Dental	Dental - All Services
Other	All Other Services

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PHE UNWIND AND COVID-19 CONSIDERATIONS IN SFY 2026 RATE DEVELOPMENT

The following adjustment(s) were made in the SFY 2026 capitation rates to reflect changes as a result of COVID-19 and the unwinding impacts of the associated CCR, including:

- Acuity adjustments: Enrollment information through December 2024 was utilized as part of a risk score analysis to estimate changes in population acuity between the base period (CY 2023) and SFY 2026 for certain populations. Please see Section IV (Step 2) for more information on this adjustment.

CAPITATION RATE CHANGE SUMMARY

Table 3 summarizes the change in capitation rates from SFY 2025 to SFY 2026. This comparison is shown excluding the impact of state directed payments, the quality withhold, and any payments earned through the VBP program, and is composited across all rate cells using projected SFY 2026 membership. Table 3 also summarizes changes excluding the impact of program changes (noted by footnote 2 in Table 3), which increase or decrease total program costs concurrently with revenue for the CCOs and excluding the impact of COVID-19 adjustments (noted by footnote 3 in Table 3).

This report assumes the reader is familiar with the State of Mississippi's MississippiCAN program, its benefits, and rate setting principles. The report was prepared solely to provide assistance to DOM to set SFY 2026 capitation rates for the MississippiCAN program. It may not be appropriate for other purposes. Milliman does not intend to benefit, and assumes no duty or liability to, other parties who receive this work. This material should only be reviewed in its entirety.

Table 3 Mississippi Division of Medicaid MississippiCAN Capitation Rates Summary of SFY 2026 Rate Change Components[1]	Aggregated with SFY 2026 Membership
SFY 2025 Capitation Rate	**$383.35**
Base Period Data Update	1.002
SFY 2026 Cell / Gene Therapy Coverage[2]	0.989
SFY 2026 Postpartum Coverage Extension[2]	1.003
Other Updated Assumptions	0.998
Restate CY 2023 to SFY 2025 Trends	0.993
SFY 2025 to SFY 2026 Utilization Trends	1.022
SFY 2025 to SFY 2026 Unit Cost Trends	1.013
SFY 2026 Population Acuity Adjustment[3]	0.994
SFY 2026 MYPAC Removal[2]	1.000
Update SFY 2026 Admin	1.005
Preliminary SFY 2026 Rate Change	**1.017**
SFY 2026 Rate Change - Excluding Program Changes[2]	**1.025**
SFY 2026 Rate Change - Excluding COVID-19 Adjustments[3]	**1.024**

[1] Rate changes exclude state directed payments, the quality withhold, and the VBP.
[2] Program change that increases or decreases total program costs outside of the control of the CCOs.
[3] COVID-19 adjustments include the population acuity adjustment.

The values quoted below are all based on the program wide impact using projected SFY 2026 membership to composite the rate cells.

The development of SFY 2026 capitation rates is a ground-up approach where the base data and each assumption is evaluated separate from the SFY 2025 capitation rates. However, for the purposes of explaining the rate change from SFY 2025 to SFY 2026, we break apart the total rate change into sub-components as shown in Table 3 above. This demonstrates the impact of incrementally updating each rate component to better assess the impact each contributes to the overall rate change. Each component is described in more detail below.

- Base Period Data Update: As stated above, SFY 2025 rates used CY 2022 data as the basis for capitation rate development. For SFY 2026, we rely on CY 2023 encounter data (supplemented by CY 2022 encounter data for rate cells with less than 100,000 member months) as the basis for rate development. This line includes the associated impact of updating the base period data along with other related assumptions, including:

  - IBNR estimates
  - TPL recoveries
  - Missing data
  - Non-covered services
  - MYPAC member identification adjustments
  - Removal of the SFY 2025 seasonal virus adjustment

  The impact of updating the base period data and the associated adjustments was an increase of 0.2% across all rate cells.

- SFY 2026 Cell / Gene Therapy Coverage: Several high-cost gene therapies are currently available or will become available during SFY 2026. Updating anticipated medical and non-PBA eligible pharmacy costs associated with these treatments, as well as the carve-in of Zolgensma from FFS, decreased rates by 1.1%. To date, the actual utilization of these high-cost gene therapies has been very low and the SFY 2026 estimates reflect a reduction in anticipated utilization for SFY 2026 compared to SFY 2025. Ultimate utilization levels are likely to be greater than or less than the estimates included in the SFY 2026 capitation rates. Therefore, a high-cost drug risk corridor has been implemented for SFY 2026 to mitigate the uncertainty in the estimation of utilization of these therapies and other high-cost pharmaceuticals.

- SFY 2026 Postpartum Coverage Extension: The postpartum coverage extension implemented as part of SB 2212 extended postpartum coverage from 60 days to 12 months for members who gave birth on or after

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April 1, 2023, such that the first enrollment month under the coverage extension was July 2023. Milliman performed an updated analysis for SFY 2026 capitation rates to estimate the impact on Pregnant Women costs, given changes to the expected distribution of members by coverage period (prenatal care, delivery month, postpartum coverage, etc.). Updating this adjustment for SFY 2026 capitation rates resulted in an increase of 0.3% on a PMPM basis across all rate cells.

- Other Updated Assumptions: Various other assumptions were updated, most notably the application of the preventative and diagnostic dental and restorative dental reimbursement increases that occurred on July 1, 2022, July 1, 2023, and July 1, 2024. Utilizing CY 2023 base period data (instead of CY 2022) means we no longer need to apply an adjustment for the July 1, 2022 change, and the July 1, 2023 adjustment is dampened to only apply to half the year. Incorporating these new adjustments reduced overall rates by approximately 0.2% across all rate cells.

- Restate CY 2023 to SFY 2025 Trends: Milliman restated CY 2023 to SFY 2025 trend assumptions. This includes reviewing annual trend assumptions based on more recent data. The same utilization trends are used for the entire projection time period, so updated utilization trends reflect the revised trend assumptions selected for CY 2023 to SFY 2026, which may differ from those selected for SFY 2025 rate setting. Additionally, fee schedule impacts are recalculated based on base data for CY 2023 (rather than CY 2022). Overall, this trend restatement resulted in a 0.7% decrease to capitation rates. See Section IV for more information related to trends.

- SFY 2025 to SFY 2026 Utilization Trends: Composite utilization trend assumptions from SFY 2025 to SFY 2026 increased projected costs 2.2%. Please see Section IV for more information on trend assumptions included in SFY 2026 capitation rates.

- SFY 2025 to SFY 2026 Unit Cost Trends: Composite unit cost trend assumptions from SFY 2025 to SFY 2026 increased projected costs 1.3%. This change includes physician administered drug (PAD) trends and any fee schedule changes modeled by DOM's payment methodology development (PMD) vendor, and fee schedule updates developed by Milliman where not modeled by the PMD team. Please see Section IV for more information on the fee schedule changes currently modeled.

- SFY 2026 Population Acuity Adjustment: As mentioned above, the continuous coverage requirement ended on March 31, 2023 and DOM started redeterminations in April 2023, with disenrollments of ineligible recipients starting in July 2023. During the redetermination period we generally saw CCO enrollment increase throughout CY 2023 and CY 2024 as some eligible individuals were moved back to managed care from FFS. Given the changes in enrollment, Milliman developed a population acuity adjustment for the impacted populations based on risk scores to estimate the relative acuity of the base period compared to the projected SFY 2026 population. A similar adjustment was also applied for SFY 2025 capitation rate setting to reflect acuity differences between the base period and the projection period. Across all rate cells, the impact of updating the population acuity adjustment from the adjustment applied in SFY 2025 to the SFY 2026 adjustment is a decrease of approximately 0.6%, however a partially offsetting impact of the acuity change is likely included in the base data update which reflects the change from CY 2022 to CY 2023. Please see Section IV for a further description of the population acuity adjustment.

- SFY 2026 MYPAC Removal: As mentioned above, starting in SFY 2026, MYPAC rate cell members will be reassigned to a rate cell consistent with their category of eligibility (i.e., Foster Care, MA Children, etc.) rather than a separate MYPAC rate cell. We transitioned these members and their associated projected SFY 2026 costs into their anticipated SFY 2026 rate cells. Across all rate cells this adjustment is net neutral as it represents a shifting of membership and costs from one rate cell to another.

- Update SFY 2026 Admin: Changes to administrative expenses on a PMPM basis result in an increase to the rate of approximately 0.5%, based upon CCO administrative expenses for CY 2023 trended to SFY 2026. A positive rate change in Table 3 indicates that the administrative costs increased as a percentage of the overall rate (i.e., administrative costs trended at a higher percentage than the overall rate). The overall PMPM for administrative expenses increased 3.9% from the SFY 2025 allowance, comprised of a fixed administrative expense increase from $9.99 PMPM in the SFY 2025 rate to $10.38 PMPM in the SFY 2026 rate, and a variable administrative expense increase from $23.31 in the SFY 2025 rate to $24.21 in the SFY 2026 rate.

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The rate change included in Table 3 does not include the impact of changes in state directed payment amounts from SFY 2025 to SFY 2026. The following changes in state directed payments, excluding the impact of premium taxes, are expected for SFY 2026:

- The total MHAP payment across all MississippiCAN members decreases from $1.540 billion in SFY 2025 to $1.510 billion in SFY 2026.
- The total MAPS payment increases from $29.5 million in SFY 2025 to $31.0 million in SFY 2026.
- The TREAT payment amount increases from $25.3 million in SFY 2025 to $26.5 million in SFY 2026.
- The MOMS payment amount remains consistent between SFY 2025 and SFY 2026 at $6.6 million.

Please see Section IV of this report for more information on changes to the state directed payments for SFY 2026.

CAPITATION RATE CHANGE BY RATE CELL

Rate changes vary by capitation rate cell as shown in Table 4, which compares SFY 2026 capitation rates to SFY 2025 capitation rates, on a similar basis as Table 3. The level of detail for the rate change included in Table 3 above is shown by rate cell in Exhibit 5.

Table 4
Mississippi Division of Medicaid
MississippiCAN Capitation Rates
Summary of Statewide SFY 2026 Rate Change[1]

Rate Cell	Overall Rate Change	Excluding Program Changes[2]	Excluding COVID-19 Adjustments[3]
Non-Newborn SSI / Disabled	0.8%	2.1%	0.8%
Breast and Cervical Cancer	40.6%	40.6%	40.6%
MA Adult	2.9%	2.9%	2.9%
Pregnant Women	4.6%	-0.5%	4.6%
SSI / Disabled Newborn	6.3%	6.3%	6.3%
Non-SSI Newborns 0 to 2 Months	2.4%	-0.6%	2.4%
Non-SSI Newborns 3 to 12 Months	-5.2%	1.5%	-5.2%
Foster Care	16.0%	5.2%	16.0%
MA Children	5.5%	4.2%	7.3%
Quasi-CHIP	5.2%	3.0%	7.5%
Total - Aggregated with CY 2023 MMs	**1.7%**	**2.5%**	**2.4%**

[1] Rate changes exclude state directed payments and are prior to the application of the quality withhold or VBP.
[2] Program change that increases or decreases total program costs outside of the control of the CCOs.
[3] COVID-19 adjustments include the acuity adjustment.

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DATA RELIANCE AND IMPORTANT CAVEATS

Milliman has developed certain models to estimate the values included in this report. The intent of the models was to estimate SFY 2026 capitation rates. We have reviewed the models, including their inputs, calculations, and outputs for consistency, reasonableness, and appropriateness to the intended purpose and in compliance with generally accepted actuarial practice and relevant actuarial standards of practice (ASOPs).

The models rely on data and information as input to the models. We used CCO encounter data and CCO financial reporting for January 2022 to December 2022 with runout through June 2023, January 2023 to December 2023 with runout through August 2024, historical and projected reimbursement information, fee schedules, and other information from DOM, MississippiCAN CCOs, Gainwell Technologies, Myers and Stauffer, and CMS to calculate the preliminary MississippiCAN capitation rates shown in this report. If the underlying data used is inadequate or incomplete, the results will be likewise inadequate or incomplete. Please see Appendix E for a full list of the data relied upon to develop the SFY 2026 base data.

This report assumes the reader is familiar with the State of Mississippi's MississippiCAN program, its benefits, and rate setting principles. The report was prepared solely to provide assistance to DOM to set SFY 2026 capitation rates for the MississippiCAN program. It may not be appropriate for other purposes. Milliman does not intend to benefit, and assumes no duty or liability to, other parties who receive this work. This material should only be reviewed in its entirety.

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

Our report is intended for the internal use of DOM to review the preliminary MississippiCAN capitation rates for SFY 2026. The report and the models used to develop the values in this report may not be appropriate for other purposes. We anticipate the report will be shared with contracted CCOs and other interested parties. Milliman does not intend to benefit, and assumes no duty or liability to, other parties who receive this work. It should only be distributed and reviewed in its entirety. These capitation rates may not be appropriate for all CCOs. Any CCO considering participating in MississippiCAN should consider their unique circumstances before deciding to contract under these rates.

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

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

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II. MISSISSIPPICAN BACKGROUND

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

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

TARGET POPULATION

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

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

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

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

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

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

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

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

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

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

Starting October 1, 2018, Severely Emotionally Disturbed (SED) Children are covered by MississippiCAN. These children are identified using distinct "lock-in" codes and other identifying criteria. To receive Mississippi Youth Program Around the Clock (MYPAC) services, a child must have an SED lock-in code.

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

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

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

Rate Cells	Rate Cell Grouping
Non-Newborn SSI / Disabled	SSI
Breast and Cervical Cancer	SSI
MA Adult	Adults
Pregnant Women	Adults
SSI / Disabled Newborn	Children
Non-SSI Newborns 0 to 2 Months	Children
Non-SSI Newborns 3 to 12 Months	Children
Foster Care	Children
MYPAC[1]	Children
MA Children	Children
Quasi-CHIP	Children

[1] *MYPAC service costs are projected separate prior to transitioning into other rate cells.*

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COVERED SERVICES

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

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

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

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

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

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

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

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

ENROLLMENT PERIOD

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

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

For SFY 2026 DOM is contracting with three CCOs, similar to prior years. However, one plan who was operating in the program prior to SFY 2026 will be exiting and another new plan will be joining. DOM is finalizing a transition plan for members impacted by this change to provide for member choice. If members do not select a CCO, they will be assigned to a CCO if a prior relationship exists or randomly assigned if no such relationship exists. It is anticipated that all CCOs will receive at least a 20% membership share.

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

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

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III. BASE DATA DEVELOPMENT

This section of the report describes the development of the base data used for the preliminary SFY 2026 MississippiCAN capitation rates.

METHODOLOGY OVERVIEW

For the SFY 2026 capitation rates, CY 2023 experience forms the primary base data. For smaller MississippiCAN populations that were not credible based on CY 2023 experience alone (using a threshold of 100,000 member months), we blend CY 2022 and CY 2023 experience to form the base data. The rate cells where two years of data was used include:

- Breast and Cervical Cancer
- Foster Care
- MYPAC
- Non-SSI Newborns 0 to 2 Months
- SSI / Disabled Newborn

The base data for the SFY 2026 capitation rates was developed using the following steps:

1. Summarize eligibility, encounter claims, and financial claim data for CY 2023 MississippiCAN enrollees.
2. Summarize eligibility, encounter claims, and financial claim data for CY 2022 MississippiCAN enrollees. This information is only used for low-credibility rate cells.
3. Blend CY 2022 and CY 2023 data (if applicable).

Each of the steps above is described in detail in the remainder of this report.

Exhibits 9A – 9C contain a detailed databook summarizing CY 2022 and CY 2023 encounter data for all MississippiCAN rate cells.

Please note, the total and PMPM costs shown in the CY 2023 databook tie to the starting totals in row (b) of Exhibit 1A with an adjustment for the missing data included in row (f) of Exhibit 1A. However, the CY 2022 databook values will not tie exactly to the starting totals on Exhibit 1B, since Exhibit 1B blends region-specific PMPM values using regional membership distributions from the CY 2023 enrollment data, whereas the CY 2022 databook uses the actual distribution by region in the CY 2022 enrollment. Additionally, no information is included in the CY 2022 or CY 2023 databooks related to utilization given issues with duplicate claims and counting units.

Step 1: Summarize CY 2023 Data

Membership

Member months by rate cell in CY 2023 were summarized from the detailed Medicaid MMIS eligibility data, excluding populations not covered by MississippiCAN and individuals that opted out of the program (where applicable). These enrollment counts were validated against enrollment information provided by the CCOs. In total, the enrollment in the eligibility files is 0.04% lower than reported by the CCOs.

Row (a) of Exhibit 1A includes the CY 2023 member months included in base data development.

Claim Data

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

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As part of rate development, Milliman requests financial reporting data from each CCO. This financial reporting data was reconciled to each CCO's 2023 audited NAIC financial statement. After several rounds of questions to clarify, adjust, and confirm understanding of the reported financial information, Milliman compared the encounter data to the financial reporting data, for paid claims and subcapitated claims. This comparison excludes any claims that were identified as missing from the processed encounter data.

Traditionally, claims runout in the encounter data is limited to align with the CCO submitted financial template data. However, when reconciling encounter data utilizing the available paid date fields, we observed material differences in the paid amounts when comparing encounter data (with runout through June 2024) to the paid data submitted by the CCOs. Therefore, we removed paid date limitations from the encounter data processing and are reconciling the encounter data with run-out through August 2024 to the paid amounts provided by the CCOs. A separate adjustment is then applied to reflect the CCO reported incurred but not reported (IBNR) values. Additional details on the calculation of the IBNR adjustment are discussed in more detail below.

DOM transitioned to a new MMIS data vendor during CY 2022. In the process of reviewing the CY 2023 data from the new data vendor, Gainwell, we noted several issues, including duplicate claims and other outstanding claims adjustments. We are still working with DOM and Gainwell to determine the timeline for resolution of these issues. Therefore, this base data report includes adjustments to calibrate encounters to CCO reported financial levels at a high-level service category level. This adjustment is discussed in more detail below.

Additionally, starting on July 1, 2024, DOM entered an arrangement with their PBA in which certain pharmacy claims are provided through the PBA. While these pharmacy services are not carved-out of managed care, the CCO is not at risk for these expenses. As such, we identified and removed the associated pharmacy claims from the base data for the purpose of developing SFY 2026 capitation rates. Please see Appendix B for a further description of the associated pharmacy services.

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

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

All experience used to develop the base period data for the SFY 2026 capitation rates excludes any member cost sharing, if applicable.

As Table 6 shows, in total adjusted encounter data was 2.14% lower than financial data for CY 2023 claims. At a category of service and rate cell level, there was a greater variance between encounter data and financial reporting. Therefore, when calculating and applying the financial to encounter data adjustments we applied separate adjustments by broad service category grouping, as shown in Table 6. We did not apply rate cell specific adjustments.

Table 6
Mississippi Division of Medicaid
SFY 2026 MississippiCAN Capitation Rate Development
Comparison of Financial and Encounter Data

Difference of Encounters and Financials (% of Encounters)	
OP / Physician / Other Services	3.38%
IP Services	0.52%
Dental Services	-3.94%
All Services	**2.14%**

Row (b) of Exhibit 1A includes the CY 2023 total service costs from the encounter data. Row (c) converts the total service costs to a PMPM basis. To reflect the differences between claims in the financial reporting and the encounter data, the financial to encounter data adjustments are applied on row (e) of Exhibit 1A. Given duplicate claims and other encounter data issues noted by Gainwell and DOM, this adjustment calibrates overall encounter claims to levels reported in the financial templates.

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Missing Data Adjustment

A separate adjustment was made to account for payments made by the CCOs that are not reflected in the detailed encounter data or cannot be reasonably applied to a specific claim (e.g., provider bonuses or settlements). These claim amounts are not included in the detailed encounter data after the processing outlined in Appendix B.

Each CCO provided separate financial reporting to support and validate the amounts reported for claims not appearing in encounters. The detailed financial reporting provided by the CCOs included splits by rate cell, which were used to allocate missing data on Exhibit 1A.

Overall, the base data is increased 0.8% on a PMPM basis for missing data.

The detailed missing data adjustments for each rate cell and service category are shown in Exhibit 1A in row (e).

IBNR Adjustment

The adjustment for IBNR claims uses the best estimate IBNR claims provided by each of the CCOs in their financial reporting. This adjustment reflects a claims runout date of June 30, 2024 as reported by the CCOs in their financial template submissions. Although the encounter data is not limited to the same runout date, we do separately reconcile the encounter claims to the paid amounts reported by the CCOs.

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

- Data, including IBNR estimates, was reported on a quarterly basis by each CCO. We reviewed the reported IBNR by quarter to determine that there was a reasonable pattern throughout the year (i.e., IBNR amounts held for Q1 2023 were significantly lower than Q4 2023).
- IBNR estimates among the CCOs were reviewed to validate that they were approximately the same as a percentage of total claims, where appropriate.
- IBNR estimates by category of service are approximately the same as a percentage of total claims as IBNR adjustments applied to the MississippiCAN data in prior years after accounting for differences in runout period between years.

Overall, the base data increased by 0.8% on a PMPM basis for IBNR claims.

This adjustment is shown in Exhibit 1A in row (f).

Non-Covered Services

Milliman is aware of a known data issue related to identifying some non-covered physician services in historical encounter data. Due to this known issue, we developed an estimate for CY 2023 non-covered physician services using information provided by the CCOs in their CY 2024 financial templates. We calculated the proportion of claims above the limit in CY 2024 and applied an adjustment for physician services in the base period.

Physician services provided for sports physicals are not covered under MississippiCAN. Using identification criteria provided by DOM, we identified and removed claims from the CY 2023 base period where the primary diagnosis code (Z02.5) indicated a sports physical.

Additionally, we summarized the costs of home health services exceeding CY 2023 service limits in the encounter data using the definitions provided by DOM, as detailed in Appendix B.

The combined amount for non-covered services and services exceeding CY 2023 service limits, which totaled approximately 0.5% of CY 2023 MississippiCAN service costs, were removed from CY 2023 base data at the rate cell level of detail. Service limits do not apply up to age 21, thus, base period costs were not adjusted for these members.

The adjustment to remove non-covered services in CY 2023 is shown in Exhibit 1A in row (g).

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Cell / Gene Therapy Claim Removal

Starting on July 1, 2023, several cell and gene therapies (CGTs) were carved into MississippiCAN. Prior to July 1, 2023, Zolgensma, a CGT used to treat Spinal Muscular Atrophy (SMA), was carved-out and reimbursed separately by DOM on a case-by-case basis. Although CGTs were covered in MississippiCAN in the second half of CY 2023, we remove CGT claims for all of CY 2023 for use in the base data so that rate cells that use two years of base data (CY 2022 and CY 2023) will be on the same basis (i.e., without any CGT costs). **Note, although we remove these costs from the CY 2023 base data, a separate adjustment is applied later in the rate setting process to account for total expected SFY 2026 CGT costs (rather than marginal changes between CY 2023 and SFY 2026).**

We removed three claims for Zolgensma totaling approximately $6.8 million and one claim for Elevydis, a gene therapy used to treat Duchenne muscular dystrophy (DMD), for $3.2 million from the base data. Across all rate cells, this reduced base data by about $10.0 million or roughly 0.5%.

The adjustment to remove CGT treatments in CY 2023 is shown in Exhibit 1A in row (h).

Third-Party Liability (TPL) Recoveries

The CCOs provided Milliman with a summary of recoveries for TPL payments related to claims incurred in CY 2023 and recovered through December 2024. Using CY 2023 data, Milliman reviewed the portion of total CY 2023 recoveries. We removed the total TPL amounts as a percentage of total paid claims across all rate cells and categories of services from the CY 2023 base data. Across all rate cells, these TPL recoveries amounted to a 0.3% reduction to CY 2023 base data. We do not have information to apply this estimate at either a rate cell or category of service level and therefore apply a uniform adjustment for the estimate of TPL recoveries.

This adjustment is shown in Exhibit 1A in row (i).

IMD (Institution for Mental Disease) Stays Beyond 15 Days

Per CMS regulations, services rendered at an IMD beyond 15 days in a given month for individuals aged 21 to 64 cannot be covered by Medicaid. CMS requires all claims (not just IMD claims) incurred by members and the enrollment records for those same months be removed from base data for the month with the IMD stay exceeding 15 days. The enrollment shown in row (a) of Exhibit 1A is after the removal of these 69 member months. An additional adjustment was made to remove all claims for these members in the impacted months, resulting in approximately a 0.04% reduction to the CY 2023 encounter data.

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

IMD Unit Cost Adjustment

Some IMD stays for 15 days or fewer for individuals aged 21 to 64 will be covered under MississippiCAN. We would normally adjust the unit cost for these claims to use DOM's fee schedule for these services, but these claims are currently not being shadow priced by DOM's MMIS vendor. Therefore, we based the CY 2023 adjustment on the CY 2022 repricing ratio used in SFY 2025 capitation rate development. These unit cost adjustments resulted in a cost increase of approximately $1,200 in total.

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

Adjusted CY 2023 PMPM Costs

Total CY 2023 base period PMPM costs by rate cell are shown in the final row of Exhibit 1A.

Step 2: Summarize CY 2022 Data (if Applicable)

For smaller MississippiCAN populations that were not credible based on CY 2023 experience alone (using a threshold of 100,000 member months), we used two years of base period data. This includes the following rate cells:

- Breast and Cervical Cancer
- Foster Care

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- MYPAC
- SSI / Disabled Newborn
- Non-SSI Newborns 0 to 2 Months

As the second year of base period data, we used CY 2022 encounter and eligibility information and applied similar adjustments from the SFY 2025 rates for program changes and trend between CY 2022 and CY 2023 to put the experience on a comparable basis to the CY 2023 base period data.

Row (a) of Exhibit 1B includes the CY 2022 member months summarized from the detailed Medicaid eligibility data reweighted by region to match the CY 2023 regional membership distribution.

Row (b) of Exhibit 1B includes the CY 2022 total service costs from the encounter data. This data has been validated using the same process described above for the CY 2023 encounter data.

Row (c) converts the total service costs to a PMPM basis.

Rows (d) through (m) of Exhibit 1B replicate the adjustments made to CY 2022 base data used for SFY 2025 capitation rates. In most cases more recent data is not available and therefore the adjustments are consistent with SFY 2025 rate setting. However, we received and reviewed more recent data on CY 2022 TPL collections and updated this assumption consistent with the most recent data provided by the CCOs. The row labeled "Subtotal: CY 2022 Adjusted Costs" in Exhibit 1B shows adjusted CY 2022 base data costs.

Factors in rows (n) through (q) of Exhibit 1B further adjust CY 2022 costs to a CY 2023 basis. All adjustments are described below.

MYPAC Member Identification Adjustment

We applied the same adjustment as developed for SFY 2025 rates to account for members who were not assigned to the MYPAC rate cell and instead were assigned to other children rate cells. We kept this identification process consistent with SFY 2025 for the CY 2022 data given the new "SEDMY" lock-in code has not been validated for periods prior to CY 2023. We queried our enrollment records and claims data to identify members who were not identified via the "SED" lock-in flag and reassigned them accordingly. We reassigned membership and corresponding claims amounts for 3,819 member months totaling approximately $9.7 million from other children rate cells to the MYPAC rate cell.

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

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

Encounter to Financial Adjustment

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

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

All experience used to develop the CY 2022 base period data excludes any member cost sharing

Overall, the paid amounts in the encounters reconcile reasonably well to the paid amounts shown in the CCO financial reporting for the MississippiCAN populations. As Table 7 shows, in total encounter data was 0.32% higher than financial data. At a category of service and rate cell level, there was a greater variance between encounter data and financial reporting, particularly for the inpatient and dental categories of service. Therefore, when calculating and applying the financial to encounter data adjustments we applied separate adjustments for inpatient and dental services. All other service categories receive the same adjustment.

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Table 7 Mississippi Division of Medicaid SFY 2026 MississippiCAN Capitation Rate Development Comparison of Financial and Encounter Data	
Difference of Encounters and Financials (% of Encounters)	
OP / Physician / Other Services	0.69%
IP Services	-2.13%
Dental Services	-2.92%
All Services	**-0.32%**

To reflect the differences between claims in the financial reporting and the encounter data, the financial to encounter data adjustments are applied on row (e) of Exhibit 1B. This adjustment calibrates overall encounter claims to levels reported in the CY 2022 financial templates.

Missing Data Adjustment

A separate adjustment was made to account for payments made by the CCOs that are not reflected in the detailed encounter data or cannot be reasonably applied to a specific claim (e.g., provider bonuses or settlements). These claim amounts are not included in the detailed encounter data after the processing outlined in Appendix B. Each CCO provided separate financial reporting to support and validate the amounts reported for claims not appearing in encounters. The detailed financial reporting provided by the CCOs included splits by rate cell, which were used to allocate missing data on Exhibit 1B.

Overall, the CY 2022 base data is increased 0.5% on a PMPM basis for missing data.

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

IBNR Adjustment

The adjustment for IBNR claims as of June 30, 2023 uses the best estimate IBNR claims provided by each of the CCOs in their financial reporting.

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

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

Overall, the CY 2022 base data increased by 0.7% on a PMPM basis for IBNR claims.

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

Non-Covered Services

Milliman is aware of a known data issue related to identifying some non-covered physician services in historical encounter data. Due to this known issue, we developed an estimate for CY 2022 non-covered physician services using information provided by the CCOs in their CY 2024 financial templates. We calculated the proportion of claims above the limit in CY 2024 and applied an adjustment for physician services in CY 2022.

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Physician services provided for sports physicals are not covered under MississippiCAN. Using identification criteria provided by DOM, we identified and removed claims from the CY 2022 base period where the primary diagnosis code (Z02.5) indicated a sports physical.

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

The combined amount for physician and home health services estimated to exceed CY 2022 service limits, which totaled approximately 0.3% of CY 2022 MississippiCAN service costs, were removed from CY 2022 base data at the rate cell level of detail. Service limits do not apply up to age 21, thus, base period costs were not adjusted for these members.

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

Zolgensma Removal

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

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

Third-Party Liability (TPL) Recoveries

The CCOs provided Milliman with a summary of recoveries for TPL payments related to claims incurred in CY 2022 and recovered through December 2024. Using this data along with CY 2023 collections to date, Milliman reviewed the portion of total CY 2022 and CY 2023 recoveries recovered after the end of each year. It is assumed that TPL recoveries are complete with two years of runout, and therefore, the most recent CY 2022 amounts were used without further adjustments.

We removed the total TPL amounts as a percentage of total paid claims across all rate cells and categories of services from the CY 2022 base data. Across all rate cells, these TPL recoveries amounted to a 0.4% reduction to CY 2022 base data. We do not have information to apply this estimate at either a rate cell or category of service level and therefore apply a uniform adjustment for the estimate of TPL recoveries.

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

IMD (Institution for Mental Disease) Stays Beyond 15 Days

Per CMS regulations, services rendered at an IMD beyond 15 days in a given month for individuals aged 21 to 64 cannot be covered by Medicaid. CMS requires all claims (not just IMD claims) incurred by members and the enrollment records for those same months be removed from base data for the month with the IMD stay exceeding 15 days. The enrollment shown in row (a) of Exhibit 1B is after the removal of these 93 member months. An additional adjustment was made to remove all claims for these members in the impacted months, resulting in approximately a 0.09% reduction to the CY 2022 encounter data.

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

IMD Unit Cost Adjustment

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

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

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SSI Children Formerly Moved to FFS Due to PRTF Stay

From October 2018 through May 2022, DOM moved certain SSI children from COE 001 to COE 005, which is not a MississippiCAN covered population, due to a psychiatric residential treatment facility (PRTF) stay. In SFY 2026, these members will remain in COE 001 during their PRTF stay, and MississippiCAN CCOs will be responsible for expenses incurred during these stays.

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

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

CY 2022 to CY 2023 Trends

Utilization and unit cost trends are applied to the CY 2022 adjusted experience data in order to put it on a CY 2023 basis. The CY 2022 experience is trended from the base period midpoint, July 1, 2022, to the midpoint of the second year of base data, July 1, 2023. These trends are consistent with trends used for SFY 2025 rate setting, with the exception of fee schedule adjustments, which have been updated to reflect distinct fee schedule changes occurring from CY 2022 to CY 2023 (rather than the average fee schedule change from CY 2022 to SFY 2025). Please see Exhibit 11B for further information on how these fee schedules were blended.

These fee schedule changes applied from CY 2022 to CY 2023 include:

- Prescribed Pediatric Extended Care (PPEC)
- Private Duty Nursing (PDN)
- Behavioral Health Services (BHS)
- Ambulatory Surgical Centers (ASC)
- Autism Spectrum Disorder (ASD)
- Home Health (HH)
- Psychiatric Residential Treatment Facility (PRTF)
- Mississippi Youth Programs Around the Clock (MYPAC)
- Orthodontia

The overall adjustments for the given months of trend are shown in Exhibit 1B in rows (n) and (o).

Preventative and Diagnostic Dental Reimbursement Change

Per SB2799 signed into law on April 19, 2021, the payment rate for preventative and diagnostic dental services was increased by 5% effective on both July 1, 2022 and July 1, 2023. We determined the proportion of CY 2022 dental claims identified as preventative or diagnostic (defined as procedure codes D0100 through D1999) applicable in each time period. We calculated the overall dental reimbursement change within each rate cell as a blend of a 5% reimbursement adjustment on preventative and diagnostic dental services with a 0% reimbursement adjustment on other dental services to put it on a CY 2023 level. Across all rate cells, this increased CY 2022 PMPM costs by 0.11%.

The preventive and diagnostic dental reimbursement change is shown in row (p) in Exhibit 1B.

Restorative Dental Reimbursement Change

Per SB2799 signed into law on April 19, 2021, the payment rate for restorative dental services was increased by 5% effective on both July 1, 2022 and July 1, 2023. We determined the proportion of CY 2022 dental claims identified as restorative (defined as procedure codes D2000 through D2999) applicable in each time period. We calculated the overall dental reimbursement change within each rate cell as a blend of a 5% reimbursement adjustment on restorative dental services with a 0% reimbursement adjustment on other dental services to put it on a CY 2023 level. Across all rate cells, this increased CY 2022 PMPM costs by 0.08%.

The restorative dental reimbursement change is shown in row (q) in Exhibit 1B.

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Adjusted CY 2022 PMPM Costs

Total CY 2022 base period PMPM costs on a CY 2023 basis by rate cell (if applicable) are shown in the final row of Exhibit 1B.

Step 3: Blend CY 2022 and CY 2023 Data (if Applicable)

For rate cells using two years of base period data, the final adjusted CY 2023 PMPM cost from Exhibit 1A is blended with the final adjusted CY 2022 PMPM cost from Exhibit 1B based on member months within each time period.

This final base period PMPM is shown in Exhibit 2A in row (a).

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IV. PROJECTED SFY 2026 CAPITATION RATES

Many adjustments must be applied to the base period data to develop SFY 2026 capitation rates. This section describes the adjustments applied to the base period data described in Section III to develop SFY 2026 capitation rates. These adjustments are applied in eight steps:

1. Trend costs from base period to SFY 2026.
2. Apply adjustments for population, program, and reimbursement methodology changes.
3. Include an allowance for CCO non-service expenses.
4. Apply quality withhold.
5. Adjust for CCO specific risk scores (if applicable).
6. Retrospectively adjust for state directed payments.
7. Calculate risk corridor settlements.
8. Other program considerations.

STEP 1: TREND COSTS FROM BASE PERIOD TO SFY 2026

Starting with the blended base data developed in Section III, we apply trend adjustments to project the base period to SFY 2026. Below, we describe each trend adjustment shown on Exhibit 2A. The adjustments for non-pharmacy and pharmacy services for which the CCOs are responsible (physician administered drugs) are developed using differing methodologies, and therefore, described separately in this section.

Non-Pharmacy Trend Overview

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

Exhibits 7A to 7E include a historical trend summary of PMPM costs from January 2021 through June 2024 for each high-level population type and in total for the MississippiCAN program. This data has been normalized for the following to put it on a consistent basis across time:

- IBNR from the financial templates was added to the encounter data to review PMPM trends on a completed basis.
- Estimates of the impact of the following material program or reimbursement changes were removed for the applicable time periods. These changes are accounted for in separate adjustments in this report, and therefore, should not be included in data analyzed for trends.
  - Removal of CGT claims
  - 5% assessment removal (CY 2021 only)
  - Dental reimbursement changes
  - Provider settlements
  - Financial to encounter adjustments
- PMPMs at a rate cell level were aggregated using June 2024 membership into higher level population groupings and MississippiCAN in total. This removes the impact of membership mix changes across rate cells over time on the aggregate PMPMs.
- No adjustments were made to account for population acuity changes over time.

Table 8 below shows the annualized utilization trends assumed in SFY 2026 capitation rates. Please see Exhibit 11A for a summary of unit cost changes for each service category and rate cell. For the MYPAC rate cell, utilization trends for physician services are dampened relative to the trends shown for other children rate cells to reflect the high proportion of physician services obtained through the MYPAC providers, for which flat utilization trends were assumed. The impact of MYPAC reimbursement changes is reflected through a separate MYPAC fee schedule adjustment, shown on Exhibit 11A.

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Table 8
Mississippi Division of Medicaid
MississippiCAN Capitation Rates
CY 2023 to SFY 2026 Utilization Trends (Annualized)

	Population				
Service Category	**SSI**	**BCCP**	**Adults**	**Children**	**Newborn**
Inpatient Hospital – Maternity / Deliveries	1.00%	0.00%	1.00%	1.00%	1.00%
Inpatient Hospital – Psychiatric / Substance Abuse	3.00%	0.00%	3.00%	3.00%	3.00%
Inpatient Hospital – Other	1.00%	1.00%	1.00%	1.00%	1.00%
Outpatient Hospital – Emergency Room	0.00%	0.00%	0.00%	0.00%	0.00%
Outpatient Hospital – Pharmacy	1.50%	13.50%	1.00%	2.50%	2.50%
Outpatient Hospital – Other	3.00%	3.00%	3.00%	3.00%	3.00%
Physician – Maternity / Deliveries	1.00%	0.00%	1.00%	1.00%	0.00%
Physician – Psychiatric / Substance Abuse	5.00%	5.00%	3.00%	3.00%	3.00%
Physician – Other	4.50%	9.50%	3.00%	2.00%	2.00%
Dental	4.00%	4.00%	4.00%	4.00%	4.00%
Other	5.00%	5.00%	3.00%	2.00%	2.00%

For the MYPAC rate cell, utilization trends for physician services are dampened relative to the trends shown for other children rate cells to reflect the high proportion of physician services obtained through the MYPAC providers, for which flat utilization trends were assumed. The impact of MYPAC reimbursement changes is reflected through a separate MYPAC fee schedule adjustment, shown on Exhibit 11A.

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

Utilization Trend for Non-Pharmacy Costs

Utilization trend reflects expected changes in:

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

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

- Historical MississippiCAN specific trends as shown in Exhibits 7A through 7E.
- Emerging Q1 through Q3 2024 experience as reported by the CCOs was additionally reviewed to analyze recent claim trend patterns by population. As part of this process, we normalized the emerging experience for reimbursement and program changes over time.
- Experience from similar programs in other states

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

Unit Charge Trends for Non-Pharmacy Costs

The hospital inpatient, hospital outpatient, physician, and dental Medicaid FFS fee schedules are updated each year consistent with the following sources. DOM does not mandate provider reimbursement levels other than to require that reimbursement be at least as great as FFS for network providers. We assume that CCO reimbursement levels will move in tandem with changes to FFS reimbursement. Pursuant to SB2799 that was passed into Mississippi law on April 19, 2021, changes in reimbursement after July 1, 2021 will require legislative notification. HB657 was subsequently signed into law on April 19, 2022, allowing for changes in reimbursement rates as long as the payment methodology remains consistent. Based on direction from DOM we are modeling fee schedule changes for each service category as noted below. The below sections discuss unit cost trends developed based on the fee schedule modeling provided by Conduent and M&S for inpatient, outpatient, and professional services. Unless otherwise noted, the fee schedule changes for prior years remained unchanged.

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- **Inpatient:** DOM reimburses hospital inpatient claims using an APR-DRG methodology based upon the Solventum (previously named 3M) grouper. Due to issues with the detailed CY 2022 inpatient data as a result of the MMIS vendor transition, the unit cost trends continue to rely on the simulations provided by Conduent for SFY 2024 capitation rates showing the estimated impact of payment rate changes effective July 1, 2023 using an underlying mix of CY 2021 claims. No changes were made to the APR-DRG payment methodology for July 1, 2024. Preliminary rates assume that any changes made on July 1, 2025 will be budget neutral. ***These assumptions will be updated in a subsequent version of capitation rates once simulations of payment updates from M&S are complete.***

  Table 9 below shows the assumed annualized inpatient charge trends from CY 2023 to SFY 2026 by rate cell grouping including a 0% change for July 1, 2024 and July 1, 2025. These trends are also shown by rate cell in the inpatient rows of the "all other" column in Exhibit 11A.

Table 9
Mississippi Division of Medicaid
Inpatient Unit Cost Trends for CY 2023 to SFY 2026

Population	Inpatient
SSI	-0.93%
Adult	0.76%
Newborn[1]	1.62%
Children[2]	-0.53%
All	**0.27%**

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

- **Outpatient:** DOM reimburses hospital outpatient claims using the Medicare APC methodology updated on July 1 of each year. We received the simulation of reimbursement changes for OPPS services from M&S for SFY 2025 capitation rates, and these continue to be used to develop our unit cost trends for preliminary SFY 2026 capitation rates. The simulations utilize a CY 2022 claims base data set, with separate projections for July 1, 2023 fee schedule changes and July 1, 2024 fee schedule updates. Updated simulations including any payment changes effective July 1, 2025 are not available at this time. An assumed increase of 2.9%, applied uniformly across all rate cells, is in included in preliminary rates to estimate the impact of July 1, 2025 OPPS fee schedule updates, consistent with our high level review of Medicare OPPS changes effect January 1, 2025. Not all services included in our outpatient service category are billed using the OPPS payment methodology, and therefore, we dampened the impact of the OPPS reimbursement changes to apply to applicable services only. ***These assumptions will be updated in a subsequent version of capitation rates once simulations of payment updates from M&S are complete.***

  Table 10 shows the assumed annualized outpatient charge trends for non-pharmacy services from CY 2023 to SFY 2026 by rate cell grouping. These trends are also shown by rate cell in the non-pharmacy outpatient rows of the "all other" column in Exhibit 11A.

Table 10
Mississippi Division of Medicaid
Outpatient Unit Cost Trends for CY 2023 to SFY 2026

Population	Outpatient
SSI	2.57%
Adult	2.81%
Newborn[1]	4.11%
Children[2]	3.62%
All	**3.09%**

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

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- **Physician:** DOM generally reimburses physician services as a percentage of Mississippi Medicare fee schedules and updates the FFS fee schedules on July 1 of each year for the Medicare fee schedule changes from January 1 of the given year. We received the simulated impact of fee schedule changes between CY 2022 and SFY 2025 from M&S for SFY 2025 capitation rate setting, and these continue to be used for preliminary SFY 2026 capitation rates.

  The simulations utilize a base data set of CY 2022 claims with separate projections for July 1, 2023 fee schedule changes and July 1, 2024 fee schedule updates. No fee schedule changes are assumed for July 1, 2025 in preliminary SFY 2026 capitation rates. The M&S simulations excluded early and periodic screening, diagnostic, and treatment (EPSDT) claims. Therefore, we applied the same increase we observed for simulated claims for similar populations, to these claims.

  The per-encounter FQHC and RHC reimbursement is included in the MississippiCAN capitation rates to provide a steadier cash flow to the RHCs and FQHCs that serve the MississippiCAN population. The CCOs are expected to reimburse FQHCs and RHCs at DOM's per encounter rates. DOM will monitor the utilization of services at FQHCs and RHCs under MississippiCAN to ensure services are not diverted from FQHCs and RHCs to other providers. Preliminary SFY 2026 rates utilize the same trend assumptions as those applied in SFY 2025 capitation rate setting. ***These will be updated with other physician trends once the simulations for SFY 2026 are completed.***

  We assumed that reimbursement for all other services remain flat from CY 2023 to SFY 2026. Additionally, we excluded PAD claims from this analysis given we develop and apply trends separately for those services.

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

Table 11
Mississippi Division of Medicaid
Physician Unit Cost Trends for CY 2023 to SFY 2026

Population	Physician
SSI	-1.05%
Adult	-0.07%
Newborn[1]	-0.71%
Children[2]	0.14%
All	**-0.24%**

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

- **Other:** The simulated impact of fee schedule changes for July 1, 2023 and July 1, 2024 for durable medical equipment (DME), medical supplies, audiology, and vision were provided by M&S along with other professional claims for SFY 2025 capitation rate setting. The additional claim level detail provided in this analysis allowed us to more precisely align the claims we bucket into the "other" service category with the correct fee schedule changes. We continue to utilize this data for preliminary SFY 2026 capitation rates. Similar to other physician services, no change is assumed for July 1, 2025 in preliminary SFY 2026 capitation rates. ***Updates will be incorporated as appropriate in subsequent updates.*** These trends are shown by rate cell in the "all other services" row and "all other" column of Exhibit 11A.

Fee schedules were also updated between CY 2023 and SFY 2026 for several additional services, which were modeled separately by Milliman. The impact of changes in reimbursement for each service are shown individually in Exhibit 11A and include the following services:

- Behavioral Health Services (BHS)
- Ambulatory Surgical Centers (ASC)
- Autism Spectrum Disorder (ASD)
- Psychiatric Residential Treatment Facility (PRTF)

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- Mississippi Youth Programs Around the Clock (MYPAC)
- Orthodontia

The unit cost trends for each of the above services were calculated by comparing the CY 2023 payment rates with those currently expected to be in place during SFY 2026, as of the time of this report, composited based on the mix of services during CY 2023. See Exhibit 11A for additional details regarding the base period costs and applied trend for each service and Exhibit 10 for documentation of the date of fee schedule changes incorporated into each type of service

Row (c) in Exhibit 2A includes the aggregate unit cost adjustment factors from CY 2023 to SFY 2026.

Physician Administered Drug Trends

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

- ***MississippiCAN-Specific Data*** – We analyzed completed January 2023 to July 2024 experience for pharmacy claims administered in a medical setting, also referred to in this report as physician administered drugs (PADs). We analyzed historical experience in CY 2023 and YTD 2024 by high level population and drug type.
- ***Industry Research*** – We reviewed recent drug trend reports from PBMs to benchmark the prospective list price and utilization trends used in our detailed modeling of MississippiCAN-specific data. Additionally, we conducted industry research to adjust trends for anticipated market events, including but not limited to, recent average sales price (ASP) price change, biosimilars, novel brand drugs, expanded treatable population for approved drugs (e.g., new indication or age expansion), and drug mix in MississippiCAN medical experience.
- ***FDA Drug Approvals*** – When developing prospective PAD trends, we consider the FDA approval of various new therapies. However, building explicit additional trend into capitation rates for these products is difficult due to a lack of information on expected pricing and uptake among the various populations. Therefore, we build in modest additional trend to reflect the expansion of new approvals for each population. We note, the historical experience reviewed in trend development also reflects the impact of FDA approvals that were new during those periods. For select high-cost pharmaceuticals we build explicit adjustments into the capitation rates, as outlined in Step 2, rather than incorporating into the PAD trend assumption.

Based on our analyses, we estimate annualized utilization and unit cost trends from CY 2023 to SFY 2026 shown in Table 12. For SFY 2026 capitation rates we calculated separate trends for the Breast and Cervical Cancer rate cell due to large observed trends between CY 2023 and emerging CY 2024 data. These higher trends are driven by increased utilization of high-cost oncology medications. Differences in aggregate trends by population in Table 12 are due to each population's historical trends and drug mix.

Table 12
Mississippi Division of Medicaid
Physician Administered Drug (PAD) Trends for CY 2023 to SFY 2026

	SSI	BCCP	Adults	Children
Annualized Unit Cost Trends	1.59%	13.75%	1.05%	2.42%
Annualized Utilization Trends	1.50%	13.50%	1.00%	2.50%

STEP 2: APPLY ADJUSTMENTS FOR POPULATION, PROGRAM, AND REIMBURSEMENT METHODOLOGY CHANGES

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

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

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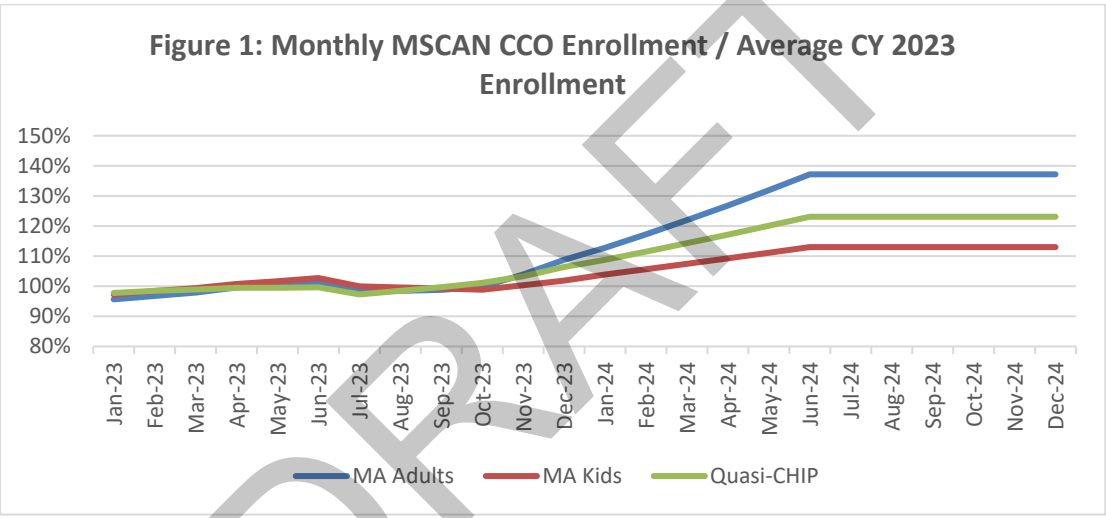
Exhibit 10 summarizes the program, population, and reimbursement changes discussed in this section, the impacted rate cells for each change, and where the change is reflected in the rate development.

Population Acuity Adjustment

Beginning in June 2021, DOM began transitioning individuals for whom Medicaid eligibility would have lapsed absent the continuous coverage requirement from the CCOs into FFS Medicaid. This transition from the CCOs into FFS Medicaid was concentrated in several populations where members commonly churn in and out of the Medicaid population or transition between rate cells due to different income eligibility at different ages, including the MA Adults and MA Children populations. These transitions continued well into CY 2023, impacting the CY 2023 membership mix included in the base data used to develop SFY 2026 capitation rates.

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



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To estimate the change in acuity due to population changes between the CY 2023 base period data and the population we expect to be enrolled during SFY 2026 (using December 2024 as a proxy), we performed a risk score-based acuity analysis. We calculated risk scores for two distinct time frames:

1. CY 2023 (April 2022 through March 2023 diagnoses and CY 2023 enrollment).

2. December 2024 (October 2023 through September 2024 diagnoses and December 2024 enrollment used as a proxy for the population enrolled during SFY 2026).

To develop the acuity adjustments for SFY 2026, we used the MississippiCAN custom risk weights for SFY 2025, as described in a previous letter.[2] As outlined there, when creating the Mississippi custom cost weights, we removed the associated pharmacy claims from the member-level cost calculations used as the basis for our regression analysis. Pharmacy claims remain in the diagnosis data for the development of risk scores for flagging conditions via relevant NDC codes; however, diagnosis periods were selected to avoid the May through September 2023 timeframe due to known pharmacy related data issues. Given the large changes in membership between CY 2023 and December 2024 we only looked at members that were able to be "scored," meaning they had at least six months of enrollment during

[2] *Wentworth13 – July 2024 MSCAN Risk Weight Development.pdf, dated October 31, 2024*

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the diagnosis period. As shown in Table 13 below, the scored percentages are not materially different between the two time periods.

To calculate the acuity adjustments, we compared the average risk scores for December 2024 enrollment compared to the average risk score in CY 2023 for each population. The final acuity adjustments applied are a downward adjustment of 1.5% for MA Adults and an upward adjustment of 0.5% for MA Children, as shown in Table 13. The acuity analysis supported no adjustment for the Quasi-CHIP population. Note, the risk scores shown in Table 13 are not directly comparable to the risk scores included in the development of the acuity adjustment applied in SFY 2025 capitation rates due to the use of different risk adjustment models.

Table 13
Mississippi Division of Medicaid
SFY 2026 MississippiCAN Capitation Rate Development
Population Acuity Adjustment

	CY 2023 - Scored Members			December 2024 - Scored Members					
Cap Cell	Average Monthly Membership	Scored %	Average Risk Score	Members	Scored %	Average Risk Score	Membership Change	Risk Score Change	Final Acuity Adjustment
	A	B	C	D	E	F	G = D / A	H = F / C	I[1]
MA Adult	39,736	95.1%	1.000	46,817	93.7%	0.983	1.178	0.983	0.985
MA Children	224,666	98.0%	0.996	239,822	96.5%	1.000	1.067	1.004	1.005
Quasi-CHIP	24,299	97.9%	1.032	28,925	97.4%	1.032	1.190	1.000	1.000

[1] *The final acuity adjustment in column I is the rounded risk score change in column H.*

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

Postpartum Coverage Extension

Per SB 2212, postpartum coverage extended from 60 days to 12 months effective July 1, 2023. Previously, at 60 days postpartum individuals in the Pregnant Women rate cell had their Medicaid eligibly redetermined and unless they had a qualifying reason to remain in Medicaid (such as meeting eligibility qualifications for the MA Adult rate cell) the member was disenrolled from MississippiCAN. After July 1, 2023, this redetermination will not occur until the end of the 12 months of postpartum coverage. While this program change has the largest impact on the Pregnant Women rate cell, other rate cells are also expected to have minor increases in enrollment due to extending the time until eligibility redetermination to 12 months postpartum (i.e., if someone would have been disenrolled during their annual redetermination they now will remain for the additional months until 12 months postpartum). We believe any impact on the MA Adult or MA Children rate cells would be captured in the acuity adjustment described above. Therefore, a separate adjustment was only applied to the Pregnant Women rate cell. The projected membership in Exhibit 3 includes the impact of extending postpartum coverage for all rate cells.

While this program change will add membership and service costs to the Pregnant Women rate cell, these additional months of coverage are expected to be lower on a PMPM basis than the costs included in the CY 2023 base data. We developed separate adjustments to apply to the maternity / delivery categories of service versus all other categories of service included in Exhibit 2A.

Due to the extension of Pregnant Women eligibility and the impact of eligibility redeterminations during CY 2023, there is a unique distribution of membership and costs during CY 2023 that differs from the expected distribution during SFY 2026. To analyze and quantify this, we split CY 2023 member months and costs into various cohorts, described below, by first identifying their delivery claim and then assigning prenatal and postpartum months in relation to this delivery. To flag deliveries, we reviewed claims data from January 2022 (i.e., January 2023 reflects month 12 postpartum) through September 2024 (i.e., December 2023 reflects nine months prenatal) to capture the full spectrum of potential CY 2023 enrollment in the Pregnant Women rate cell.

Pregnant Women Coverage Cohorts:

- No Delivery: This includes member months enrolled in the Pregnant Women rate cell that did not have an associated delivery. We are unable to assign these members into one of the following buckets.

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- Prenatal: This includes the time period from when a member was first enrolled in MississippiCAN until the month of delivery
- Delivery: Includes the month of delivery
- Postpartum Months 1-2: This covers the initial eligibility period of birth to 60 days postpartum
- Coverage Extension: This includes coverage from 60 days postpartum to 12 months postpartum
- Other: This includes experience for months when we would not expect a woman to be enrolled in the Pregnant Women rate cell (i.e., more than nine months before a delivery or 12 months after)

The proportion of membership and CY 2023 costs for each cohort is shown below in Table 14. This distribution reflects that since the postpartum extension was implemented in July 2023 there was only six months of coverage and did not reflect ultimate levels of expected enrollment while extension coverage ramped up. In other words, July 2023 would only cover one additional month, August 2023 would cover two additional months, and so forth as individuals reached their 60 days postpartum. In reviewing actual Pregnant Women enrollment from CY 2023 into CY 2024, membership does level out as of May 2024.

To develop the expected distribution for SFY 2026 we analyzed recent enrollment and claims data through June 2024 for the number of deliveries and observed enrollment patterns by month relative to a member's delivery. In addition, for the No Delivery and Other cohorts we reviewed CY 2019 data to understand the enrollment patterns without the impact of the continuous coverage requirements, which may lead to more individuals in those cohorts in CY 2023 than expected in SFY 2026 now that redeterminations are complete.

The adjustment applied to estimate SFY 2026 Pregnant Women costs was developed by remixing the CY 2023 PMPMs by cohort with the expected SFY 2026 distribution of membership. These adjustments were then further stratified by maternity / delivery services versus other services.

Table 14 below demonstrates the development of the population change factors.

Table 14
Mississippi Division of Medicaid
SFY 2026 Postpartum Coverage Extension Adjustment
Pregnant Women Rate Cell

Time Period	CY 2023 PMPM	CY 2023 Distribution	Projected SFY 2026 Distribution	Final Adjustment
No Delivery	$159.23	16.0%	5.9%	
Prenatal	$429.12	32.5%	23.3%	
Delivery Month	$5,601.27	8.9%	5.4%	
Up to 60 Days	$222.69	18.5%	10.8%	
60 Days to 12 Months	$148.60	16.8%	52.2%	
Other	$151.70	7.2%	2.4%	
	Total PMPM	$740.23	$519.71	0.702
	Maternity / Delivery Services	$463.37	$280.15	**0.605**
	Other Services	$276.86	$239.55	**0.865**

Row (e) in Exhibit 2A shows this adjustment.

Hemophilia Population Carve-In

Starting on January 1, 2024, eligible members diagnosed with Hemophilia and Von Willebrand's disease transitioned from FFS to MississippiCAN. Historically this population has been carved-out of MississippiCAN due to the relatively high-cost associated with treatment and the infrequent and non-uniform distribution across the CCOs. DOM provided a list of 167 members with hemophilia that were transitioned from FFS to MississippiCAN on January 1, 2024. We

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included an adjustment to include these members' CY 2023 FFS claims and enrollment in the appropriate MississippiCAN rate cell.

Row (f) in Exhibit 2A shows this adjustment.

Gene Therapy Coverage

There are several high-cost gene therapies currently available on the market or in the pipeline to be released in the near future. We worked closely with our clinical team and the clinical team at DOM to identify eligible members and estimate potential treatment uptake percentages and total costs for treatment for gene therapies by rate cell. Table 15 below details the assumptions and estimated SFY 2026 impact for each treatment. Additionally, please see Exhibits 13C and 13D for the full development of these amounts by rate cell.

We recognize that Table 15 is not the full spectrum of gene therapies that may be utilized by MississippiCAN members during SFY 2026 and a high-cost pharmacy risk corridor is in place to mitigate the risk of these additional costs to the CCOs, if applicable, as described later in this report.

Table 15
Mississippi Division of Medicaid
SFY 2026 Capitation Rate Development
Gene Therapy Estimates

Condition	Therapy	Number of Treatments	Therapy Cost per Treatment	Inpatient Cost per Treatment	Total Anticipated Treatment Cost
Duchene Muscular Dystrophy	Elevydis	2	$3,200,000	$0	$6,400,000
Sickle Cell Disease	Lyfgenia / Casgevy	2	$2,650,000	$200,000	$5,700,000
Spinal Muscular Atrophy	Zolgensma	3	$2,391,705	$0	$7,175,116
Total		**7**	**$2,696,445**	**$57,143**	**$19,275,116**

Row (g) in Exhibit 2A shows this adjustment.

Preventative and Diagnostic Dental Reimbursement Change

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

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

Restorative Dental Reimbursement Change

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

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

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MYPAC Rate Cell Removal and Redistribution

As noted above, starting in SFY 2026, DOM intends to discontinue the use of a separate rate cell for MYPAC members. Members currently enrolled in the MYPAC rate cell will be transitioned into other applicable MississippiCAN rate cells based upon their category of eligibility and age, as outlined in Appendix A. Exhibit 2B shows the development of the blended PMPM cost for each rate cell after the MYPAC members have been redistributed.

We examined the detailed enrollment records for MYPAC members enrolled in CY 2023 and used DOM's eligibility criteria to determine which other MississippiCAN rate cells these MYPAC members will transition to in SFY 2026. Based on this analysis, we subset the MYPAC rate cell into smaller cohorts (i.e., MYPAC members that would likely transition to MA Children) and calculated PMPM cost relativities between the cohorts and the MYPAC rate cell as a whole. The development of these population specific MYPAC costs is shown in Table 16 below. These relativities were also applied to the final projected MYPAC cost calculated on Exhibit 2A to determine the projected MYPAC costs to blend with each impacted rate cell on Exhibit 2B.

For transparency purposes we developed separate MYPAC service cost estimates for SFY 2026 and then blended the MYPAC membership into the applicable rate cells prior to applying non-service costs. While we recognize each sub cohort (i.e., MYPAC members transitioning to MA Children) of MYPAC members are not credible on their own, applying the PMPM relativities of costs for MYPAC members in this sub cohorts emulates the impact if we had moved the MYPAC members into each of their new applicable rate cells as part of the base data.

Table 16
Mississippi Division of Medicaid
SFY 2026 MYPAC Rate Cell Relativities

Rate Cell	SFY 2026 Projected PMPM Costs	SFY 2026 MYPAC PMPM Relativity
MYPAC Total	$2,986.46	N/A
MYPAC to Non-Newborn SSI / Disabled	$3,155.17	1.056
MYPAC to Foster Care	$3,029.35	1.014
MYPAC to MA Children	$2,897.59	0.970
MYPAC to Quasi-CHIP	$2,812.34	0.942

The projected SFY 2026 membership and PMPM cost from Exhibit 2A appear in rows (a) and (b) in Exhibit 2B.

The projected SFY 2026 membership and PMPM cost for members transitioning from the MYPAC rate cell appear in rows (c) and (d) in Exhibit 2B.

The blended SFY 2026 projected PMPM cost is shown in row (e) in Exhibit 2B.

Immaterial Program, Population, and Reimbursement Methodology Changes

There are several program, population, and reimbursement changes between the base period experience and SFY 2026 that we did not build an explicit adjustment into rates for, given the projected budget neutral or immaterial impact. These changes are described below.

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

- Home health fee schedule – there were minor updates made to the home health fee schedule effective October 1, 2024. We evaluated the impact of repricing CY 2023 home health claims to the updated fee schedule and found the impact to be immaterial.

- Incontinence supplies – effective January 1, 2025, the Mississippi administrative code was revised to allow DOM to provide coverage for certain medical supplies due to incontinence. We assume almost all of these costs will apply to the Medicaid FFS population not enrolled in MississippiCAN.

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- Coverage for incarcerated youth – effective January 1, 2025, CCOs are required to cover certain services, including screening, diagnostic, and targeted case management, for eligible juveniles 30 days prior to their scheduled date of release from a public institution through 30 days after release. Based on conversations with DOM, we expect the number of additional members covered under this program and the total additional cost to be immaterial.

STEP 3: NON-SERVICE EXPENSE ALLOWANCE

Administrative Expenses, Premium Tax, and Targeted Margin

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

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

Exhibit 3 shows the build-up of the non-service expenses, comprised of the following components for SFY 2026:

- $10.38 PMPM for fixed administrative costs.
- 6.21% of revenue less directed payments for variable administrative costs.
- 1.80% of revenue less directed payments for target underwriting margin and cost of capital.
- 3.00% for the Mississippi premium tax.

Table 17 displays the non-service expense allowance included in the SFY 2026 rates. All percentages of revenue are shown excluding directed payment revenue, which is ultimately not at risk to the CCOs.

Table 17
Mississippi Division of Medicaid
SFY 2026 MississippiCAN Non-Benefit Expenses

	% of Revenue	PMPM
Fixed Costs[1]	2.66%	**$10.38**
Variable Costs[2]	**6.21%**	$24.21
Premium Tax[2]	**3.00%**	$11.70
Margin[2]	**1.80%**	$7.02
Total	**13.67%**	**$53.31**

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

The administrative expense allowance for SFY 2026 was developed by trending the adjusted CY 2022 PMPM costs reported by the CCOs, excluding any PBA related costs, and supporting the SFY 2025 administrative cost assumption. We reviewed updated financial template data supplied by the CCOs for CY 2023 and were not able to collect sufficient documentation to support the large increases reported by several of the CCOs. Therefore, this data was not directly used in calculating the SFY 2026 administrative expense assumptions. We additionally reviewed publicly available data showing administrative costs for Medicaid programs nationwide to validate that the assumed administrative costs are sufficient for the MississippiCAN program.

Adjusted CY 2022 administrative expenses were trended by an annual trend of 3.9% from CY 2022 to SFY 2026. The 3.9% annual trend is a blend of actual employment cost index (ECI) data from CY 2022 through CY 2024 of 4.1% annually and an assumed 3.6% annual trend from CY 2024 to SFY 2026. The future 3.6% trend assumption is consistent with the average ECI annual change from CY 2018 through CY 2023. The ECI data reflects expected changes in wages and other services that comprise a majority of administrative costs. In addition, we reviewed the

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CMS Medicare Economic Index (MEI) that includes actual changes through June 2024 and forecasted quarterly changes afterwards. The MEI from CY 2022 through SFY 2026 has an annualized change of 3.7%, similar to our analysis with the ECI data.

The final overall projected administrative cost PMPM (for fixed and variable expenses) is $34.59 for the MississippiCAN program in SFY 2026 as shown in columns (c) and (e) of Exhibit 3.

The margin of 1.8% of revenue is applied in column (f) of Exhibit 3 and premium tax of 3.00% of revenue is applied in column (i) of Exhibit 3 for costs included in the capitation rates and Exhibit 12 for state directed payments.

STEP 4: ADJUST FOR QUALITY WITHHOLD

In SFY 2026 a 2.0% quality withhold will be placed on capitation rates for the MississippiCAN program. The terms of the withhold arrangement are outlined in the contract with the CCOs. To earn back the withhold the CCOs must achieve HEDIS scores and other metrics for the following conditions that meet the target improvement compared to the benchmarks as set by DOM, with an equal percentage of the withhold assigned to each category. The benchmarks for SFY 2026 will be set based on the average of all CCO reported scores from calendar years 2022 and 2023 (prorated based on member months). A floor will be implemented for SFY 2026 for all new measures to allow CCOs to earn back a prorated amount. This floor will be calculated at 75% of the SFY 26 increase between the baseline and target. If a CCO achieves the new measure floor rate, but does not reach the target, the amount returned will be prorated. All new measures are denoted with an asterisk below.

Each of the following measures will be used to earn back one tenth (10%) of the quality withhold, for 90.0% total across all measures:

- Developmental Screening in the First Three Years of Life (DEV-CH)*
- Immunization for Adolescents (IMA-CH)*:
  - Combination 1: Meningococcal Conjugate and Tdap
- Anti-Depressant Management - Acute (AMM-AD):
  - Effective Acute Phase Treatment
- Follow-Up After Hospitalization for Mental Illness (FUH):
  - 30 Days – Ages 6 to 17
- Timeliness of Postpartum Care (PPC)*:
  - Prenatal and Postpartum Care
- Postpartum Depression Screening and Follow-up (PDS-E)*
- Metabolic Monitoring*
  - Children and Adolescents on Antipsychotics (APM-E)
- Avoidance of Antibiotic Treatment for Acute Bronchitis / Bronchiolitis*:
  - Ages 3 Months to 17 Years (AAB-CH)
- Adults Pharmacotherapy Management of COPD Exacerbation: Systemic Corticosteroid

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DOM will be monitoring readmission rates reported as part of the QIPP in SFY 2026. For SFY 2026, this will be included as a scored metric for the quality withhold. During SFY 2026, CCOs will be required to improve their actual-to-expected (A/E) ratio compared to the baseline years by 2.0% if the baseline A/E ratio is >1.0 or not allow the A/E ratio to be >1.0 for the reporting period if the baseline A/E ratio is <1.0. During SFY 2026, CY 2022 and CY 2023 will serve as the baseline years. This PPHR measure will be used to earn back the final 10% of the quality withhold.

If a CCO does not have sufficient data to consider its scores credible, DOM will not hold the CCO liable for not meeting the measurement. In this case, the portion of the incentive withheld related to that measurement will be returned to the CCO. Other than the new measures, DOM will not prorate the results for a CCO based on the outcomes of the measures attained during SFY 2026. After discussions with DOM about the metric development and expectations, we believe that a return of 100% of the withhold is reasonably achievable by the CCOs.

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

STEP 5: ADJUST FOR CCO-SPECIFIC RISK SCORE (IF APPLICABLE)

Regional Variation in Risk Adjustment

As mentioned above, starting in SFY 2026, DOM has decided to remove regional variation from the base capitation rates and any regional cost differences will be included as part of risk adjustment going forward. We are currently working with DOM to develop risk models for all rate cells to incorporate regional variation. The below sections describe the risk adjustment process we plan to use for rate cells where risk adjustment is currently applied. This will be updated as needed to account for regional variation.

Based on a review of historical costs by region we do not observe consistent regional cost variations for the following rate cells. Therefore, we do not currently intend to implement a regional cost component for the below rate cells.

- Breast and Cervical Cancer
- Non-SSI Newborns 3 to 12 Months
- Pregnant Women

We are continuing to evaluate cost patterns in the Non-SSI Newborns 0 to 2 Months and SSI / Disabled Newborn rate cells and will provide additional details on our approach for these rate cells once available.

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

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

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

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

Risk Adjustment for the Foster Care Rate Cell

Starting in SFY 2021, the Foster Care rate cell is concurrently risk adjusted after the risk adjustment period ends. The Foster Care rate cell will be risk adjusted using a custom risk adjustment model that does not depend on the CDPS + Rx

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risk adjuster. After testing the predictive ability of several potential models, we determined the member's eligibility for either state or federal financial assistance was the most accurate indicator of the member's risk score. This status is captured by the money code field on DOM's enrollment records. Updated risk weights for each money code will be calculated using recent data and reflecting changes to the covered population in SFY 2026. These risk weights will be used for calculating foster care risk scores for SFY 2026.

Unlike the other risk-adjusted populations, risk adjustment for the Foster Care rate cell will be applied concurrently after the risk adjustment period ends. Given the small size of the Foster Care rate cell, small fluctuations in membership could have a material impact on risk adjustment if applied prospectively. Therefore, we will continue to concurrently risk adjust the Foster Care rate cell in SFY 2026.

Risk Score Timing

For the SFY 2026 rate setting period DOM plans to contract with three CCOs, similar to prior years. However, it is currently planned that one existing CCO will exit the program and a new CCO will join. Therefore, we expect that risk adjustment will be applied retroactively for SFY 2026 while enrollment stabilizes for each of the CCOs. We will monitor emerging enrollment as it becomes available and provide timing updates on this process as available.

Application of Risk Scores

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

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

The base capitation rates are found in Exhibit 4.

The CCO normalized risk factor will equal the average risk factor across all beneficiaries that a CCO enrolls divided by the average risk factor for the rate cell's population.

STEP 6: STATE DIRECTED PAYMENTS

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

MHAP Overview

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

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

Per CMS's approval on January 12, 2018, beginning in SFY 2018 MHAP began to transition to directed payments according to the specifications and requirements of 42 CFR 438.6 et seq. Table 18 displays the two components of MHAP (FSA and QIPP) and compares the total dollars in each component for SFY 2025 and SFY 2026.

Table 18
Mississippi Division of Medicaid
MississippiCAN Capitation Rates
MHAP Distribution by SFY

SFY	MHAP FSA	MHAP QIPP	Total MHAP
2025	$719,679,373	$820,744,321	$1,540,423,694
2026	$694,749,941	$815,576,017	$1,510,325,958

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MHAP FSA

For SFY 2026, a payment of $694.7 million is included as a directed FSA on inpatient and outpatient claims that will be paid monthly outside the capitation rates as a separate payment term.

The preliminary FSA amounts are shown in column (c) of Exhibit 12, consistent with the program design that 65% of the $694.7 million will be paid for inpatient hospital services, and 35% will be paid for outpatient hospital services using projected SFY 2026 membership. These calculations were performed across all MississippiCAN rate cells with each of the inpatient and outpatient FSA percentage impacts applied uniformly. This results in a larger proportion of the FSA funding included in rate cells with higher inpatient and outpatient utilization.

The estimated FSA PMPM in Exhibit 12 is based on projected SFY 2026 membership and estimated utilization across all CCOs. Due to actual versus projected CCO-specific MississippiCAN membership and claim utilization, this estimated capitation adjustment may result in an overpayment or underpayment of the FSA in SFY 2026 if no adjustments are made. The final CCO specific FSA amounts will be calculated on a PMPM basis at the end of SFY 2026, and the appropriate documentation will be provided to CMS.

The adjustments to capitation rates are consistent with the preprint submitted to CMS for SFY 2026 on March 14, 2025. The control name for this preprint is MS_Fee.VBP_IPH.OPH_Renewal_20250701-20260630.

The MHAP FSA additive adjustment is shown in column (c) in Exhibit 12. An additional allowance for premium tax on the MHAP FSA is included in column (d) in Exhibit 12.

MHAP QIPP

Beginning in SFY 2020, a quality incentive payment program (QIPP) was included as a component of MHAP. Consistent with the preprint submitted to CMS, the QIPP will be paid as a uniform payment arrangement for SFY 2026. The goal of the QIPP is to utilize state and federal investments to improve the quality of care and health status of the Mississippi Medicaid population. The introduction of QIPP was a multi-year process with an increasing percentage of the payments linked to performance improvements achieved and maintained by the hospital industry.

For SFY 2026, the QIPP will consist of approximately $815.6 million, which will be paid outside of the capitation rates on a quarterly basis as a separate payment term. DOM will determine the payments made to facilities based on agreed upon performance measures. Capitation rates will be retroactively adjusted once actual membership and utilization is known for SFY 2026 to include a QIPP PMPM for each CCO, which will include a provision for premium tax.

For SFY 2026, DOM will carve out $50.0 million from the initial QIPP payments to fund enhanced payments for hospitals that meet the actual to expected performance ratios as outlined by DOM. These payments will only be made to hospitals that meet the prescribed performance levels and each hospital will receive a pro-rata share of the total $50.0 million pool.

The adjustments to capitation rates are consistent with the preprint submitted to CMS for SFY 2026 on March 14, 2025. The control name for this preprint is MS_Fee.VBP_IPH.OPH_Renewal_20250701-20260630.

The MHAP QIPP additive adjustment is shown in column (e) in Exhibit 12. An additional allowance for premium tax on the MHAP QIPP is included in column (f) in Exhibit 12.

TREAT Program

Beginning July 1, 2022, emergency ambulance reimbursement are proposed to be increased consistent with a §438.6(c) directed payment for eligible providers. Subject to CMS approval, payments for the TREAT program are estimated to be $26.5 million for SFY 2026, to be paid outside the capitation rates as a separate payment term as part of a uniform payment increase.

Capitation rates will be retroactively adjusted once actual membership and utilization is known for SFY 2026 to include a TREAT PMPM for each CCO, which will include a provision for premium tax.

The adjustments to capitation rates are consistent with the preprint that will be submitted to CMS for SFY 2026.

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The TREAT additive adjustment is shown in column (g) in Exhibit 12. An additional allowance for premium tax on the TREAT payments is included in column (h) in Exhibit 12.

Mississippi MAPS Program

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

DOM will require that CCOs provide the same supplemental percentage increase to all qualifying providers. Payments in SFY 2026 are expected to be $31.0 million, paid outside the capitation rates as part of a separate payment term. Similar to MHAP, capitation rates will be retroactively adjusted for SFY 2026 to include a MAPS PMPM including a provision for premium tax for each CCO and rate cell based on actual membership and utilization. The appropriate documentation will be submitted to CMS at the time of this retroactive adjustment.

This program is being made under a §438.6(c) payment arrangement consistent with the preprint that will be submitted to CMS for SFY 2026.

The MAPS additive adjustment is shown in column (i) in Exhibit 12. An additional allowance for premium tax on the MAPS is included in column (j) in Exhibit 12.

MOMS Program

Beginning in SFY 2025, the Mississippi Outcomes for Maternal Safety (MOMS) program was established to address Mississippi's high rates of severe maternal morbidity (SMM). This program will support redesigned care delivery by incorporating new discharge protocols and requirements for post-discharge follow-up appointments. The MOMS initiative is based on a performance improvement model designed to incentive hospitals and outpatient providers to evaluate SMM risk and ensure timely postpartum follow-up, aiming to improve maternal health outcomes and reduce maternal morbidity. To qualify for the incentive payment, hospitals must complete a MOMS risk score assessment for each patient, assigning the appropriate risk score after delivery and at discharge. This score is crucial as it informs the timing requirement for incentive payment of ongoing post-discharge care. Hospitals will receive incentive payments for each patient where this process is successfully completed and submitted. Payments will be made outside the capitation rates as a separate payment term. We expect payments will be made annually after the close of the SFY 2026 time period. Capitation rates will be retroactively adjusted to include the final MOMS payment (including applicable premium tax) for each CCO and rate cell based on actual payments once known.

This program is being operated under a §438.6(c) payment arrangement consistent with the preprint that will be filed with CMS for SFY 2026.

The MOMS additive adjustment is shown in column (k) on Exhibit 12. The applicable premium tax amount is shown in column (l) on Exhibit 12.

Table 19 below shows a summary of the state directed payment amounts for SFY 2025 and SFY 2026.

Table 19
Mississippi Division of Medicaid
Summary of State Directed Payments by SFY

	SFY 2025	SFY 2026
Total MHAP	**$1,540,423,694**	**$1,510,325,958**
MHAP FSA	$719,679,373	$694,749,941
MHAP QIPP	$820,744,321	$815,576,017
MAPS	**$29,526,117**	**$31,002,486**
TREAT	**$25,285,224**	**$26,549,485**
MOMS	**$6,603,083**	**$6,603,083**
Total Directed Payments	**$1,601,838,118**	**$1,574,481,012**

All preprints in this table are pending CMS approval.

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STEP 7: CALCULATE RISK CORRIDOR SETTLEMENTS

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

High-Cost Pharmacy Risk Corridor

Some Medicaid members have conditions requiring very expensive drug treatments. These members are infrequent and not evenly distributed among the CCOs. To help mitigate the CCO's risk, the state is continuing the high-cost pharmacy risk corridor started in SFY 2024, subject to CMS approval. The risk corridor is applicable to total drug spend and related costs due to administration and monitoring for specified products of $250,000 or more per year at a member level. Table 20 below, as well as Exhibit 13A, include a PMPM estimate of the costs that will be covered in the high-cost pharmacy risk corridor specific to each rate cell. Please see Exhibits 13C and 13D for the detailed calculations of the high-cost pharmacy targets below. The actual costs from the CCOs will be compared to these estimated costs for the settlement calculations.

Table 20
Mississippi Division of Medicaid
SFY 2026 High-Cost Pharmacy Risk Corridor

Rate Cell	SFY 2026 High-Cost Pharmacy Target PMPM
Non-Newborn SSI / Disabled	$17.39
Breast and Cervical Cancer	$0.00
MA Adult	$0.36
Pregnant Women	$0.00
SSI / Disabled Newborn	$0.22
Non-SSI Newborns 0 to 2 Months	$87.43
Non-SSI Newborns 3 to 12 Months	$0.00
Foster Care	$4.51
MA Children	$1.89
Quasi-CHIP	$0.36
Total	**$4.74**

Table 21 summarizes the share of gains and losses relative to the estimated high-cost pharmacy costs for each party.

Table 21
Mississippi Division of Medicaid
Proposed High-Cost Pharmacy Risk Corridor Parameters

CCO Gain / Loss	CCO Share of Gain / Loss in Corridor	DOM Share of Gain / Loss in Corridor
Less than -6.0%	0%	100%
-6.0% to -3.0%	50%	50%
-3.0% to +3.0%	100%	0%
+3.0% to +6.0%	50%	50%
Greater than +6.0%	0%	100%

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

- Estimated high-cost pharmacy costs are calculated separately for each rate cell based on the expected mix of high-cost products.
- Each rate cell's actual high-cost pharmacy costs will include payments made for the following:
  - All drugs billed as medical claims with a HCPCS code that starts with the letter "J."

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  - Inpatient stays for the administration and monitoring for select gene therapies and other select products. The estimated pharmacy costs included in the high-cost risk corridor include the following; however, DOM will monitor and revise the list of approved products if additional products are covered by DOM for use during SFY 2026.

    - Lyfgenia
    - Casgevy
    - Zynteglo

- The timing of the initial and final high-cost pharmacy risk corridor settlements are outlined below.

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

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

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

STEP 8: OTHER PROGRAM CONSIDERATIONS

Minimum MLR Requirement

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

Value-Based Payment Incentive Program

Similar to SFY 2025, DOM will continue a value-based payment incentive program (VBP) as part of the MississippiCAN contract. In alignment with DOM's Comprehensive Quality Strategy the VBP will target three primary focus areas: maternal health, metabolic health, and mental health.

- Maternal Health. Mississippi has the highest maternal mortality rate in the country with 82 maternal deaths per 100,000 births. Mississippi also has the highest percentage of births by black mothers (42% of all births) in the country, which is significant given that black women have higher mortality rates than any other racial or ethnic group.

- Metabolic Health. Nationally, obesity rates have risen, and obesity is a significant contributor to a host of conditions, such as type II diabetes, hypertension, coronary artery disease, stroke, and many others. Mississippi has the sixth highest obesity rate in the country with more than 39% of its residents being obese. Additionally, the percentage of the Mississippi Medicaid population that is considered to be obese is estimated to be higher than the state average with obesity rates being higher among individuals with lower income.

- Mental Health. Mental health has an impact on physical health. For example, depression increases the risk for many conditions, such as diabetes, heart disease, and stroke. Mississippi was ranked 47th in the nation for access to mental health services. Additionally, mental health conditions have been shown to contribute to a large proportion of pregnancy-related deaths (23%).

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

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While the program starts on July 1, 2025 to align with the CCO contract start date, the performance period will be based on CY 2025 data and will be reported in July 2026. Each subsequent program year will be based on the calendar year and reported annually in July.

For SFY 2026, the following performance measures are to be assessed and incentivized:

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

Severe Maternal Morbidity (SMM) includes the unexpected outcomes of labor and delivery that result in significant short- or long-term consequences to a woman's health. To manage poor outcomes, Mississippi will use diagnostic information to develop a maternal health risk assessment to be used by hospitals at time of discharge. Based upon the Mississippi Outcomes for Maternal Safety (MOMS) score assigned to the beneficiary at the time of discharge, required interventions will be employed to ensure follow-up care within specified timeframes. Incentives will be based initially upon reporting on assessment and follow-up implementation activities (e.g., technology infrastructure), then transition to pay for reporting performance, and in future performance years, transition to pay for performance.

The new VBP program builds upon the current CCO incentive withhold program as a quality-based incentive (i.e., bonus) payment in addition to the CCO's monthly capitation rates. Under the VBP program, each CCO will be eligible to receive additional funds over and above base capitation rates. Monetary incentives will not exceed one-quarter percent (0.25%) above the capitation payment and, as such will not be in excess of 105% of the approved capitation payments in accordance with 42 C.F.R. § 438.6(b). The introduction of the VBP program does not impact how capitation rates were calculated for SFY 2026.

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

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

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

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

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EXHIBITS 1 THROUGH 14

(Provided in Excel Format Only)

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APPENDIX A

SFY 2026 Rate Cell Definitions

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APPENDIX A

SFY 2026 RATE CELL DEFINITIONS

This section of our report outlines the rate cell definitions to be used for SFY 2026 for the populations addressed in this report. These definitions are summarized in Table 1 below. Capitation rate cells for SFY 2026 were kept consistent with the SFY 2025 capitation rate cells, with the exception of the MYPAC rate cell. Effective July 1, 2025, DOM intends to discontinue the MYPAC rate cell as a distinct stand-alone rate cell. Members enrolled in the MYPAC rate cell will be transitioned to other applicable MississippiCAN rate cells. Please see Section IV for further information about this transition.

Table 1
Mississippi Division of Medicaid
Rate Cell Definitions

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

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

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

Additionally, fee-for-service (FFS) eligibility and claims data will be used to summarize experience for members with hemophilia or Von Willebrand disease in CY 2023 who will be enrolled in MississippiCAN during SFY 2026 and to review acuity differences due to enrollment shifts between FFS and MississippiCAN during the COVID-19 Public Health Emergency (PHE).

GEOGRAPHIC REGIONS

In the past, DOM used regional capitation payments to better reflect enrollment for CCOs that enroll a disproportionate number of members from higher-cost or lower-cost regions of the state. In SFY 2026, this regional distinction will not be explicitly accounted for through regional capitation rates, but will be developed and adjusted for in risk adjustment. For more information about the risk adjustment mechanism for the MississippiCAN program, please see Section IV.

If a beneficiary could not be assigned to a region, we excluded their eligibility and claim experience from the base data. Although this information is not needed to calculate regional capitation rates, we continue to exclude these members for which we cannot validate eligibility. This accounts for less than 0.19% of all current MississippiCAN eligible members in CY 2022 and CY 2023.

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APPENDIX B

Data Sources and Processing

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APPENDIX B

DATA SOURCES AND PROCESSING

A number of data sources are used to develop the base data for the SFY 2026 MississippiCAN capitation rates.

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

CY 2023 experience forms the primary base data for the SFY 2026 capitation rates. Rate cells with less than 100,000 member months in CY 2023 additionally rely on CY 2022 experience to form the base data.

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

MEDICAID ELIGIBILITY

DOM's MMIS vendor provided detailed Medicaid eligibility data for CY 2022 and CY 2023. Before analyzing claims, we pared down the eligibility data to groups that are eligible to enroll in MississippiCAN, as defined in Appendix A of our report. In order to isolate data only for this group, we applied various filters as described in the rest of this appendix.

We relied upon the 'CAN' lock-in code for each eligibility span to include individuals enrolled in MississippiCAN in the base period. This assumes that MMIS-calculated enrollment criteria in the base period is consistent with how it will be applied for SFY 2026 capitation rate payments. In addition, this removes opt-outs from voluntary populations (SSI children and Mississippi Band of Choctaw Indians) from the base data used to develop capitation rates.

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

Removal of Retroactive Eligibility Periods

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

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

- Eligibility months prior to the date that a beneficiary was added to the Medicaid enrollment file were removed. For example, if a beneficiary is active January 15, 2023, but they were added to the enrollment file February 1, 2023, we only included data on or after February 1, 2023 to exclude any retroactivity that may have occurred.

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

Geographic Area

If a beneficiary could not be assigned to a county of residence in Mississippi, we excluded them from the base data. This accounts for less than 0.19% of all current MississippiCAN eligible member months in CY 2022 and CY 2023.

FFS DATA

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

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

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APPENDIX B

DATA SOURCES AND PROCESSING

ENCOUNTER DATA

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

For all service categories we used CY 2022 encounter data with runout through June 2023 and CY 2023 encounter data with runout through August 2024.

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

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

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

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

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

Removal of Pharmacy Benefit Administered Claims

Starting in July 2024, DOM entered into an arrangement with their Pharmacy Benefits Administrator (PBA) in which certain pharmacy claims will be paid through the PBA. As such, we identified and removed the associated pharmacy claims from the CY 2022 and CY 2023 base data for the purpose of developing SFY 2026 capitation rates. These claims were identified and removed using the follow logic:

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

FINANCIAL REPORTING DATA

For base data development, each CCO submitted a financial report reconciled to their organization's audited CY 2022 and CY 2023 financial statements for Mississippi. Reports were submitted for CY 2022 and CY 2023 including earned premium, claim experience with run out through June 2023 for CY 2022 data and June 2024 for CY 2023 data, best estimate IBNR claim amounts, subcapitated arrangements, non-service expenses, and membership. The reported membership was close in total to the MMIS enrollment, so we utilized the MMIS enrollment for rate development.

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

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APPENDIX B

DATA SOURCES AND PROCESSING

CLAIMS ABOVE STATE-PLAN COVERED SERVICE LIMITS

When processing encounter data, we identify claims above Mississippi's state-plan covered service limits. These services are provided by some CCOs as an expanded benefit. However, as they are not state-plan-covered, these services are excluded from the base data when setting capitation rates. We identified two types of benefits offered by CCOs that are above state-plan covered service limits, described below. Children receiving EPSDT services, identified as individuals under the age of 21, are exempt from the service limits described below.

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

  To identify physician visits, claims are required to have a claim type of "M" (Professional). Additionally, the claim must have one of a list of specific procedure codes. Exhibits 15A and 15B show the required procedure codes for non-psychiatric and psychiatric physician visits, respectively. Due to issues identifying claims at this level of detail within the CY 2022 and CY 2023 encounter data we are estimating the value of physician visits above the limit based on percentages from CCO financial templates.

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

Additionally, physician visits that are coded with a primary diagnosis code associated with an examination for the purpose of sports are considered to be a non-covered service for the MississippiCAN program. These sports physicals are identified as claims with a primary diagnosis of Z02.5. These services are not subject to a limit and all claims with the associated primary diagnosis code are considered to be non-covered.

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APPENDIX C

CMS Managed Care Rate Setting Guide Response

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APPENDIX D

Actuarial Certification of SFY 2026 MississippiCAN Capitation Rates

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APPENDIX E

Data Reliance Letter

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Exhibit 3
Mississippi Division of Medicaid
SFY 2026 MississippiCAN Capitation Rate Development
Statewide Non-Service Expense Allocation Development

Rate Cell	*a* Projected SFY 2026 Membership	*b* SFY 2026 PMPM Cost	*c* Fixed Non-Service Expense Load	*d* Non-Service Percentage	*e = d × j* Non-Service PMPM	*f* Margin Percentage	*g = f × j* Margin PMPM	*h* Premium Tax Percentage	*i = h × j* Premium Tax PMPM	*j = (b + c) / (1 - d - f - h)* Total
Non-Newborn SSI / Disabled	740,802	$764.97	$10.38	6.21%	$54.10	1.80%	$15.68	3.00%	$26.14	$871.27
Breast and Cervical Cancer	598	$3,966.05	$10.38	6.21%	$277.45	1.80%	$80.43	3.00%	$134.05	$4,468.36
MA Adult	603,476	$323.93	$10.38	6.21%	$23.33	1.80%	$6.76	3.00%	$11.27	$375.66
Pregnant Women	221,974	$571.72	$10.38	6.21%	$40.62	1.80%	$11.77	3.00%	$19.62	$654.11
SSI / Disabled Newborn	5,867	$6,299.56	$10.38	6.21%	$440.27	1.80%	$127.63	3.00%	$212.72	$7,090.56
Non-SSI Newborns 0 to 2 Months	73,493	$2,109.67	$10.38	6.21%	$147.93	1.80%	$42.88	3.00%	$71.47	$2,382.32
Non-SSI Newborns 3 to 12 Months	232,659	$248.95	$10.38	6.21%	$18.09	1.80%	$5.25	3.00%	$8.74	$291.40
Foster Care	97,653	$633.95	$10.38	6.21%	$44.96	1.80%	$13.03	3.00%	$21.72	$724.03
MA Children	3,118,841	$183.30	$10.38	6.21%	$13.51	1.80%	$3.92	3.00%	$6.53	$217.63
Quasi-CHIP	379,285	$179.21	$10.38	6.21%	$13.23	1.80%	$3.83	3.00%	$6.39	$213.05
Total	**5,474,647**	**$336.63**	**$10.38**	**6.21%**	**$24.21**	**1.80%**	**$7.02**	**3.00%**	**$11.70**	**$389.94**

Caveats and Limitations
Mississippi Division of Medicaid

READ BEFORE PROCEEDING

Milliman has developed certain models to estimate the values included in these exhibits. The intent of the models was to estimate SFY 2026 capitation rates. We have reviewed the models, including their inputs, calculations, and outputs for consistency, reasonableness, and appropriateness to the intended purpose and in compliance with generally accepted actuarial practice and relevant actuarial standards of practice (ASOPs).

The models rely on data and information as input to the models. We used CCO encounter data and CCO financial reporting for January 2022 to December 2022 with runout through June 2023, January 2023 to December 2023 with runout through August 2024, historical and projected reimbursement information, fee schedules, and other information from DOM, MississippiCAN CCOs, Gainwell Technologies, Myers and Stauffer, and CMS to calculate the preliminary MississippiCAN capitation rates shown in these exhibits. If the underlying data used is inadequate or incomplete, the results will be likewise inadequate or incomplete. Please see Appendix E in the report for a full list of the data relied upon to develop the SFY 2026 base data.

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

Our exhibits are intended for the internal use of DOM to review the preliminary MississippiCAN capitation rates for SFY 2026. The exhibits and the models used to develop the values in the exhibits may not be appropriate for other purposes. We anticipate the exhibits will be shared with contracted CCOs and other interested parties. Milliman does not intend to benefit, and assumes no duty or liability to, other parties who receive this work. It should only be distributed and reviewed in its entirety. These capitation rates may not be appropriate for all CCOs. Any CCO considering participating in MississippiCAN should consider their unique circumstances before deciding to contract under these rates.

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

Exhibit 1
Mississippi Division of Medicaid
All Regions SFY 2026 MississippiCAN Capitation Rate Development
CY 2023 Encounter Data

Non-Newborn SSI / Disabled Rate Cell

		Category of Service											
Calculation Step	CY 2023 PMPM Cost Development	Inpatient Hospital - Maternity / Deliveries	Inpatient Hospital - Psychiatric / Substance Abuse	Inpatient Hospital - Other	Outpatient Hospital - Emergency Room	Outpatient Hospital - Pharmacy	Outpatient Hospital - Other	Physician - Maternity / Deliveries	Physician - Psychiatric / Substance Abuse	Physician - Other	Dental	Other	Total
a	CY 2023 Member Months	719,929	719,929	719,929	719,929	719,929	719,929	719,929	719,929	719,929	719,929	719,929	**719,929**
b	Total Allowed Dollars	$1,852,389	$25,053,794	$89,714,414	$22,810,057	$37,320,495	$84,432,767	$383,279	$35,223,691	$128,293,528	$7,271,074	$45,499,951	**$477,855,438**
c = b / a	CY 2023 PMPM Costs	$2.57	$34.80	$124.62	$31.68	$51.84	$117.28	$0.53	$48.93	$178.20	$10.10	$63.20	**$663.75**
d	Encounter to Financial Adjustment	1.005	1.005	1.005	1.034	1.034	1.034	1.034	1.034	1.034	0.961	1.034	**1.026**
e	Missing Data	1.001	1.000	1.001	1.001	1.002	1.001	1.001	1.000	1.004	1.000	1.023	**1.004**
f	IBNR Adjustment	1.024	1.031	1.029	1.003	1.000	1.002	1.000	1.001	1.001	1.000	1.006	**1.008**
g	Non-Covered Services	1.000	1.000	1.000	1.000	1.000	0.999	1.000	0.975	0.974	1.000	1.000	**0.991**
h	Remove Cell / Gene Therapy Claims	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	**1.000**
i	TPL Adjustment	0.997	0.997	0.997	0.997	0.997	0.997	0.997	0.997	0.997	0.997	0.997	**0.997**
j	IMD Removal	1.000	0.988	0.999	0.999	1.000	1.000	1.000	0.998	1.000	1.000	1.000	**0.999**
k	IMD Repricing	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	**1.000**
Product of c through k	**Adjusted CY 2023 PMPM Costs**	**$2.64**	**$35.52**	**$128.50**	**$32.76**	**$53.51**	**$121.17**	**$0.55**	**$49.08**	**$179.71**	**$9.67**	**$67.01**	$680.11

Breast and Cervical Cancer Rate Cell

		Category of Service											
Calculation Step	CY 2023 PMPM Cost Development	Inpatient Hospital - Maternity / Deliveries	Inpatient Hospital - Psychiatric / Substance Abuse	Inpatient Hospital - Other	Outpatient Hospital - Emergency Room	Outpatient Hospital - Pharmacy	Outpatient Hospital - Other	Physician - Maternity / Deliveries	Physician - Psychiatric / Substance Abuse	Physician - Other	Dental	Other	Total
a	CY 2023 Member Months	1,038	1,038	1,038	1,038	1,038	1,038	1,038	1,038	1,038	1,038	1,038	**1,038**
b	Total Allowed Dollars	$0	$0	$142,266	$29,724	$855,635	$643,675	$0	$8,128	$875,481	$7,963	$50,370	**$2,613,243**
c = b / a	CY 2023 PMPM Costs	$0.00	$0.00	$137.06	$28.64	$824.31	$620.11	$0.00	$7.83	$843.43	$7.67	$48.53	**$2,517.57**
d	Encounter to Financial Adjustment	1.000	1.000	1.005	1.034	1.034	1.034	1.000	1.034	1.034	0.961	1.034	**1.032**
e	Missing Data	1.000	1.000	1.002	1.002	1.003	1.001	1.000	1.000	1.002	1.000	1.022	**1.002**
f	IBNR Adjustment	1.000	1.000	1.012	1.006	1.001	1.004	1.000	1.000	1.001	1.000	1.004	**1.002**
g	Non-Covered Services	1.000	1.000	1.000	1.000	1.000	1.000	1.000	0.974	0.974	1.000	1.000	**0.991**
h	Remove Cell / Gene Therapy Claims	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	**1.000**
i	TPL Adjustment	1.000	1.000	0.997	0.997	0.997	0.997	1.000	0.997	0.997	0.997	0.997	**0.997**
j	IMD Removal	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	**1.000**
k	IMD Repricing	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	**1.000**
Product of c through k	**Adjusted CY 2023 PMPM Costs**	**$0.00**	**$0.00**	**$139.23**	**$29.74**	**$852.62**	**$642.23**	**$0.00**	**$7.86**	**$848.33**	**$7.35**	**$51.30**	$2,578.66

Exhibit 1
Mississippi Division of Medicaid
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CY 2023 Encounter Data

MA Adult Rate Cell

		Category of Service											
Calculation Step	**CY 2023 PMPM Cost Development**	**Inpatient Hospital - Maternity / Deliveries**	**Inpatient Hospital - Psychiatric / Substance Abuse**	**Inpatient Hospital - Other**	**Outpatient Hospital - Emergency Room**	**Outpatient Hospital - Pharmacy**	**Outpatient Hospital - Other**	**Physician - Maternity / Deliveries**	**Physician - Psychiatric / Substance Abuse**	**Physician - Other**	**Dental**	**Other**	**Total**
a	CY 2023 Member Months	501,768	501,768	501,768	501,768	501,768	501,768	501,768	501,768	501,768	501,768	501,768	**501,768**
b	Total Allowed Dollars	$13,785,202	$2,385,223	$13,790,356	$12,607,670	$6,815,641	$28,967,449	$3,352,709	$4,953,048	$52,674,909	$2,492,736	$5,714,860	**$147,539,802**
c = b / a	CY 2023 PMPM Costs	$27.47	$4.75	$27.48	$25.13	$13.58	$57.73	$6.68	$9.87	$104.98	$4.97	$11.39	**$294.04**
d	Encounter to Financial Adjustment	1.005	1.005	1.005	1.034	1.034	1.034	1.034	1.034	1.034	0.961	1.034	**1.027**
e	Missing Data	1.001	1.000	1.001	1.001	1.001	1.001	1.001	1.000	1.005	1.000	1.145	**1.008**
f	IBNR Adjustment	1.026	1.023	1.029	1.002	1.001	1.002	1.001	1.001	1.001	1.000	1.007	**1.007**
g	Non-Covered Services	1.000	1.000	1.000	1.000	1.000	1.000	1.000	0.974	0.974	1.000	1.000	**0.990**
h	Remove Cell / Gene Therapy Claims	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	**1.000**
i	TPL Adjustment	0.997	0.997	0.997	0.997	0.997	0.997	0.997	0.997	0.997	0.997	0.997	**0.997**
j	IMD Removal	1.000	0.982	1.000	1.000	1.000	1.000	1.000	0.999	1.000	1.000	0.999	**1.000**
k	IMD Repricing	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	**1.000**
Product of c through k	**Adjusted CY 2023 PMPM Costs**	**$28.25**	**$4.78**	**$28.38**	**$25.97**	**$14.02**	**$59.71**	**$6.89**	**$9.90**	**$105.96**	**$4.76**	**$13.53**	**$302.16**

Pregnant Women Rate Cell

		Category of Service											
Calculation Step	**CY 2023 PMPM Cost Development**	**Inpatient Hospital - Maternity / Deliveries**	**Inpatient Hospital - Psychiatric / Substance Abuse**	**Inpatient Hospital - Other**	**Outpatient Hospital - Emergency Room**	**Outpatient Hospital - Pharmacy**	**Outpatient Hospital - Other**	**Physician - Maternity / Deliveries**	**Physician - Psychiatric / Substance Abuse**	**Physician - Other**	**Dental**	**Other**	**Total**
a	CY 2023 Member Months	108,557	108,557	108,557	108,557	108,557	108,557	108,557	108,557	108,557	108,557	108,557	**108,557**
b	Total Allowed Dollars	$40,226,066	$169,548	$529,136	$3,169,749	$1,010,672	$5,803,905	$10,075,622	$328,909	$17,583,259	$425,332	$1,034,819	**$80,357,017**
c = b / a	CY 2023 PMPM Costs	$370.55	$1.56	$4.87	$29.20	$9.31	$53.46	$92.81	$3.03	$161.97	$3.92	$9.53	**$740.23**
d	Encounter to Financial Adjustment	1.005	1.005	1.005	1.034	1.034	1.034	1.034	1.034	1.034	0.961	1.034	**1.019**
e	Missing Data	1.001	1.000	1.005	1.001	1.001	1.001	1.001	1.000	1.004	1.000	1.161	**1.004**
f	IBNR Adjustment	1.025	1.022	1.058	1.002	1.001	1.003	1.001	1.001	1.001	1.000	1.009	**1.014**
g	Non-Covered Services	1.000	1.000	1.000	1.000	1.000	1.000	1.000	0.998	0.998	1.000	1.000	**1.000**
h	Remove Cell / Gene Therapy Claims	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	**1.000**
i	TPL Adjustment	0.997	0.997	0.997	0.997	0.997	0.997	0.997	0.997	0.997	0.997	0.997	**0.997**
j	IMD Removal	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	**1.000**
k	IMD Repricing	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	**1.000**
Product of c through k	**Adjusted CY 2023 PMPM Costs**	**$380.96**	**$1.60**	**$5.19**	**$30.18**	**$9.61**	**$55.32**	**$95.79**	**$3.12**	**$167.44**	**$3.75**	**$11.51**	**$764.46**

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SSI / Disabled Newborn Rate Cell

		Category of Service											
Calculation Step	CY 2023 PMPM Cost Development	Inpatient Hospital - Maternity / Deliveries	Inpatient Hospital - Psychiatric / Substance Abuse	Inpatient Hospital - Other	Outpatient Hospital - Emergency Room	Outpatient Hospital - Pharmacy	Outpatient Hospital - Other	Physician - Maternity / Deliveries	Physician - Psychiatric / Substance Abuse	Physician - Other	Dental	Other	Total
a	CY 2023 Member Months	5,313	5,313	5,313	5,313	5,313	5,313	5,313	5,313	5,313	5,313	5,313	**5,313**
b	Total Allowed Dollars	$15,952,712	$0	$4,405,952	$333,740	$188,844	$950,575	$0	$4,589	$8,371,116	$4,240	$1,672,669	**$31,884,438**
c = b / a	CY 2023 PMPM Costs	$3,002.58	$0.00	$829.28	$62.82	$35.54	$178.91	$0.00	$0.86	$1,575.59	$0.80	$314.83	**$6,001.21**
d	Encounter to Financial Adjustment	1.005	1.000	1.005	1.034	1.034	1.034	1.000	1.034	1.034	0.961	1.034	**1.016**
e	Missing Data	1.000	1.000	1.001	1.000	1.000	1.001	1.000	1.000	1.002	1.000	1.004	**1.001**
f	IBNR Adjustment	1.027	1.000	1.030	1.001	1.000	1.002	1.000	1.000	1.000	1.001	1.001	**1.018**
g	Non-Covered Services	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	**1.000**
h	Remove Cell / Gene Therapy Claims	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	**1.000**
i	TPL Adjustment	0.997	1.000	0.997	0.997	0.997	0.997	1.000	0.997	0.997	0.997	0.997	**0.997**
j	IMD Removal	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	**1.000**
k	IMD Repricing	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	**1.000**
Product of c through k	**Adjusted CY 2023 PMPM Costs**	**$3,088.61**	**$0.00**	**$857.40**	**$64.83**	**$36.63**	**$184.79**	**$0.00**	**$0.89**	**$1,627.22**	**$0.76**	**$325.92**	**$6,187.07**

Non-SSI Newborns 0 to 2 Months Rate Cell

		Category of Service											
Calculation Step	CY 2023 PMPM Cost Development	Inpatient Hospital - Maternity / Deliveries	Inpatient Hospital - Psychiatric / Substance Abuse	Inpatient Hospital - Other	Outpatient Hospital - Emergency Room	Outpatient Hospital - Pharmacy	Outpatient Hospital - Other	Physician - Maternity / Deliveries	Physician - Psychiatric / Substance Abuse	Physician - Other	Dental	Other	Total
a	CY 2023 Member Months	67,416	67,416	67,416	67,416	67,416	67,416	67,416	67,416	67,416	67,416	67,416	**67,416**
b	Total Allowed Dollars	$83,409,924	$0	$6,312,020	$1,680,223	$160,894	$2,047,216	$0	$6,071	$30,763,439	$66,642	$1,122,870	**$125,569,300**
c = b / a	CY 2023 PMPM Costs	$1,237.24	$0.00	$93.63	$24.92	$2.39	$30.37	$0.00	$0.09	$456.32	$0.99	$16.66	**$1,862.60**
d	Encounter to Financial Adjustment	1.005	1.000	1.005	1.034	1.034	1.034	1.000	1.034	1.034	0.961	1.034	**1.013**
e	Missing Data	1.000	1.000	1.018	1.001	1.086	1.002	1.000	1.000	1.003	1.000	1.096	**1.003**
f	IBNR Adjustment	1.023	1.000	1.108	1.002	1.001	1.021	1.000	1.001	1.001	1.000	1.006	**1.022**
g	Non-Covered Services	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	**1.000**
h	Remove Cell / Gene Therapy Claims	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	0.838	1.000	1.000	**0.960**
i	TPL Adjustment	0.997	1.000	0.997	0.997	0.997	0.997	1.000	0.997	0.997	0.997	0.997	**0.997**
j	IMD Removal	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	**1.000**
k	IMD Repricing	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	**1.000**
Product of c through k	**Adjusted CY 2023 PMPM Costs**	**$1,268.58**	**$0.00**	**$105.71**	**$25.76**	**$2.67**	**$32.01**	**$0.00**	**$0.09**	**$395.60**	**$0.95**	**$18.93**	**$1,850.30**

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Non-SSI Newborns 3 to 12 Months Rate Cell

		Category of Service											
Calculation Step	**CY 2023 PMPM Cost Development**	**Inpatient Hospital - Maternity / Deliveries**	**Inpatient Hospital - Psychiatric / Substance Abuse**	**Inpatient Hospital - Other**	**Outpatient Hospital - Emergency Room**	**Outpatient Hospital - Pharmacy**	**Outpatient Hospital - Other**	**Physician - Maternity / Deliveries**	**Physician - Psychiatric / Substance Abuse**	**Physician - Other**	**Dental**	**Other**	**Total**
a	CY 2023 Member Months	232,841	232,841	232,841	232,841	232,841	232,841	232,841	232,841	232,841	232,841	232,841	**232,841**
b	Total Allowed Dollars	$615,039	$11,369	$6,697,007	$5,973,777	$569,299	$7,617,298	$0	$6,386	$28,351,033	$290,159	$1,656,337	**$51,787,702**
c = b / a	CY 2023 PMPM Costs	$2.64	$0.05	$28.76	$25.66	$2.45	$32.71	$0.00	$0.03	$121.76	$1.25	$7.11	**$222.42**
d	Encounter to Financial Adjustment	1.005	1.005	1.005	1.034	1.034	1.034	1.000	1.034	1.034	0.961	1.034	**1.029**
e	Missing Data	1.000	1.000	1.002	1.001	1.001	1.001	1.000	1.000	1.005	1.000	1.222	**1.010**
f	IBNR Adjustment	1.018	1.035	1.025	1.002	1.001	1.002	1.000	1.002	1.001	1.000	1.009	**1.005**
g	Non-Covered Services	1.000	1.000	1.000	1.000	1.000	1.000	1.000	0.999	0.999	1.000	1.000	**0.999**
h	Remove Cell / Gene Therapy Claims	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	**1.000**
i	TPL Adjustment	0.997	0.997	0.997	0.997	0.997	0.997	1.000	0.997	0.997	0.997	0.997	**0.997**
j	IMD Removal	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	**1.000**
k	IMD Repricing	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	**1.000**
Product of c through k	**Adjusted CY 2023 PMPM Costs**	**$2.69**	**$0.05**	**$29.60**	**$26.51**	**$2.52**	**$33.83**	**$0.00**	**$0.03**	**$126.00**	**$1.19**	**$9.04**	$231.48

Foster Care Rate Cell

		Category of Service											
Calculation Step	**CY 2023 PMPM Cost Development**	**Inpatient Hospital - Maternity / Deliveries**	**Inpatient Hospital - Psychiatric / Substance Abuse**	**Inpatient Hospital - Other**	**Outpatient Hospital - Emergency Room**	**Outpatient Hospital - Pharmacy**	**Outpatient Hospital - Other**	**Physician - Maternity / Deliveries**	**Physician - Psychiatric / Substance Abuse**	**Physician - Other**	**Dental**	**Other**	**Total**
a	CY 2023 Member Months	88,226	88,226	88,226	88,226	88,226	88,226	88,226	88,226	88,226	88,226	88,226	**88,226**
b	Total Allowed Dollars	$87,687	$22,102,736	$735,780	$737,774	$272,536	$3,471,732	$30,108	$5,318,576	$7,980,316	$2,806,554	$1,235,700	**$44,779,499**
c = b / a	CY 2023 PMPM Costs	$0.99	$250.52	$8.34	$8.36	$3.09	$39.35	$0.34	$60.28	$90.45	$31.81	$14.01	**$507.55**
d	Encounter to Financial Adjustment	1.005	1.005	1.005	1.034	1.034	1.034	1.034	1.034	1.034	0.961	1.034	**1.015**
e	Missing Data	1.001	1.000	1.001	1.001	1.000	1.001	1.001	1.000	1.012	1.000	1.009	**1.002**
f	IBNR Adjustment	1.046	1.033	1.035	1.004	1.002	1.003	1.002	1.001	1.001	1.000	1.001	**1.017**
g	Non-Covered Services	1.000	1.000	1.000	1.000	1.000	1.000	1.000	0.997	0.995	1.000	1.000	**0.999**
h	Remove Cell / Gene Therapy Claims	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	**1.000**
i	TPL Adjustment	0.997	0.997	0.997	0.997	0.997	0.997	0.997	0.997	0.997	0.997	0.997	**0.997**
j	IMD Removal	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	**1.000**
k	IMD Repricing	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	**1.000**
Product of c through k	**Adjusted CY 2023 PMPM Costs**	**$1.04**	**$259.16**	**$8.65**	**$8.66**	**$3.19**	**$40.68**	**$0.35**	**$61.99**	**$93.95**	**$30.46**	**$14.58**	$522.72

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MYPAC Rate Cell

		Category of Service											
Calculation Step	**CY 2023 PMPM Cost Development**	**Inpatient Hospital - Maternity / Deliveries**	**Inpatient Hospital - Psychiatric / Substance Abuse**	**Inpatient Hospital - Other**	**Outpatient Hospital - Emergency Room**	**Outpatient Hospital - Pharmacy**	**Outpatient Hospital - Other**	**Physician - Maternity / Deliveries**	**Physician - Psychiatric / Substance Abuse**	**Physician - Other**	**Dental**	**Other**	**Total**
a	CY 2023 Member Months	11,130	11,130	11,130	11,130	11,130	11,130	11,130	11,130	11,130	11,130	11,130	**11,130**
b	Total Allowed Dollars	$21,910	$5,049,637	$278,492	$258,808	$69,801	$442,814	$4,979	$16,106,481	$8,037,368	$428,181	$347,419	**$31,045,890**
c = b / a	CY 2023 PMPM Costs	$1.97	$453.70	$25.02	$23.25	$6.27	$39.79	$0.45	$1,447.12	$722.14	$38.47	$31.21	**$2,789.39**
d	Encounter to Financial Adjustment	1.005	1.005	1.005	1.034	1.034	1.034	1.034	1.034	1.034	0.961	1.034	**1.028**
e	Missing Data	1.004	1.000	1.003	1.002	1.001	1.003	1.003	1.000	1.001	1.000	1.055	**1.001**
f	IBNR Adjustment	1.026	1.033	1.046	1.004	1.000	1.010	1.001	1.000	1.000	1.000	1.007	**1.006**
g	Non-Covered Services	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	**1.000**
h	Remove Cell / Gene Therapy Claims	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	**1.000**
i	TPL Adjustment	0.997	0.997	0.997	0.997	0.997	0.997	0.997	0.997	0.997	0.997	0.997	**0.997**
j	IMD Removal	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	**1.000**
k	IMD Repricing	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	**1.000**
Product of c through k	**Adjusted CY 2023 PMPM Costs**	**$2.03**	**$469.42**	**$26.31**	**$24.11**	**$6.47**	**$41.55**	**$0.46**	**$1,491.69**	**$745.11**	**$36.83**	**$34.19**	$2,878.18

MA Children Rate Cell

		Category of Service											
Calculation Step	**CY 2023 PMPM Cost Development**	**Inpatient Hospital - Maternity / Deliveries**	**Inpatient Hospital - Psychiatric / Substance Abuse**	**Inpatient Hospital - Other**	**Outpatient Hospital - Emergency Room**	**Outpatient Hospital - Pharmacy**	**Outpatient Hospital - Other**	**Physician - Maternity / Deliveries**	**Physician - Psychiatric / Substance Abuse**	**Physician - Other**	**Dental**	**Other**	**Total**
a	CY 2023 Member Months	2,754,615	2,754,615	2,754,615	2,754,615	2,754,615	2,754,615	2,754,615	2,754,615	2,754,615	2,754,615	2,754,615	**2,754,615**
b	Total Allowed Dollars	$2,926,502	$29,756,359	$16,984,225	$27,249,964	$5,414,975	$65,396,248	$796,718	$33,803,552	$160,255,263	$71,640,420	$13,512,585	**$427,736,811**
c = b / a	CY 2023 PMPM Costs	$1.06	$10.80	$6.17	$9.89	$1.97	$23.74	$0.29	$12.27	$58.18	$26.01	$4.91	**$155.28**
d	Encounter to Financial Adjustment	1.005	1.005	1.005	1.034	1.034	1.034	1.034	1.034	1.034	0.961	1.034	**1.018**
e	Missing Data	1.001	1.000	1.001	1.001	1.001	1.001	1.001	1.000	1.006	1.000	1.365	**1.015**
f	IBNR Adjustment	1.024	1.022	1.026	1.002	1.000	1.002	1.001	1.001	1.001	1.000	1.006	**1.004**
g	Non-Covered Services	1.000	1.000	1.000	1.000	1.000	1.000	1.000	0.998	0.996	1.000	1.000	**0.998**
h	Remove Cell / Gene Therapy Claims	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	0.982	1.000	1.000	**0.993**
i	TPL Adjustment	0.997	0.997	0.997	0.997	0.997	0.997	0.997	0.997	0.997	0.997	0.997	**0.997**
j	IMD Removal	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	**1.000**
k	IMD Repricing	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	**1.000**
Product of c through k	**Adjusted CY 2023 PMPM Costs**	**$1.09**	**$11.06**	**$6.35**	**$10.23**	**$2.03**	**$24.55**	**$0.30**	**$12.63**	**$59.05**	**$24.90**	**$6.94**	$159.14

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Quasi-CHIP Rate Cell

		Category of Service											
Calculation Step	**CY 2023 PMPM Cost Development**	**Inpatient Hospital - Maternity / Deliveries**	**Inpatient Hospital - Psychiatric / Substance Abuse**	**Inpatient Hospital - Other**	**Outpatient Hospital - Emergency Room**	**Outpatient Hospital - Pharmacy**	**Outpatient Hospital - Other**	**Physician - Maternity / Deliveries**	**Physician - Psychiatric / Substance Abuse**	**Physician - Other**	**Dental**	**Other**	**Total**
a	CY 2023 Member Months	298,064	298,064	298,064	298,064	298,064	298,064	298,064	298,064	298,064	298,064	298,064	**298,064**
b	Total Allowed Dollars	$281,161	$3,524,145	$1,678,546	$2,169,899	$912,645	$5,776,450	$73,735	$4,106,216	$15,715,887	$10,163,725	$1,614,875	**$46,017,283**
c = b / a	CY 2023 PMPM Costs	$0.94	$11.82	$5.63	$7.28	$3.06	$19.38	$0.25	$13.78	$52.73	$34.10	$5.42	**$154.39**
d	Encounter to Financial Adjustment	1.005	1.005	1.005	1.034	1.034	1.034	1.034	1.034	1.034	0.961	1.034	**1.014**
e	Missing Data	1.001	1.000	1.002	1.001	1.001	1.001	1.001	1.000	1.006	1.000	1.330	**1.014**
f	IBNR Adjustment	1.031	1.021	1.030	1.002	1.000	1.003	1.000	1.001	1.001	1.000	1.006	**1.004**
g	Non-Covered Services	1.000	1.000	1.000	1.000	1.000	1.000	1.000	0.998	0.994	1.000	1.000	**0.998**
h	Remove Cell / Gene Therapy Claims	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	**1.000**
i	TPL Adjustment	0.997	0.997	0.997	0.997	0.997	0.997	0.997	0.997	0.997	0.997	0.997	**0.997**
j	IMD Removal	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	**1.000**
k	IMD Repricing	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	**1.000**
Product of c through k	**Adjusted CY 2023 PMPM Costs**	**$0.98**	**$12.10**	**$5.82**	**$7.53**	**$3.16**	**$20.05**	**$0.26**	**$14.18**	**$54.41**	**$32.65**	**$7.47**	**$158.60**

All Rate Cells

		Category of Service											
Calculation Step	**CY 2023 PMPM Cost Development**	**Inpatient Hospital - Maternity / Deliveries**	**Inpatient Hospital - Psychiatric / Substance Abuse**	**Inpatient Hospital - Other**	**Outpatient Hospital - Emergency Room**	**Outpatient Hospital - Pharmacy**	**Outpatient Hospital - Other**	**Physician - Maternity / Deliveries**	**Physician - Psychiatric / Substance Abuse**	**Physician - Other**	**Dental**	**Other**	**Total**
a	CY 2023 Member Months	4,788,897	4,788,897	4,788,897	4,788,897	4,788,897	4,788,897	4,788,897	4,788,897	4,788,897	4,788,897	4,788,897	**4,788,897**
b	Total Allowed Dollars	$159,158,593	$88,052,809	$141,268,193	$77,021,386	$53,591,435	$205,550,129	$14,717,151	$99,865,647	$458,901,600	$95,597,025	$73,462,457	**$1,467,186,423**
c = b / a	CY 2023 PMPM Costs	$33.23	$18.39	$29.50	$16.08	$11.19	$42.92	$3.07	$20.85	$95.83	$19.96	$15.34	**$306.37**
d	Encounter to Financial Adjustment	1.005	1.005	1.005	1.034	1.034	1.034	1.034	1.034	1.034	0.961	1.034	**1.021**
e	Missing Data	1.000	1.000	1.002	1.001	1.002	1.001	1.001	1.000	1.005	1.000	1.109	**1.008**
f	IBNR Adjustment	1.024	1.028	1.032	1.002	1.000	1.003	1.001	1.001	1.001	1.000	1.006	**1.008**
g	Non-Covered Services	1.000	1.000	1.000	1.000	1.000	1.000	1.000	0.989	0.988	1.000	1.000	**0.995**
h	Remove Cell / Gene Therapy Claims	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	0.983	1.000	1.000	**0.995**
i	TPL Adjustment	0.997	0.997	0.997	0.997	0.997	0.997	0.997	0.997	0.997	0.997	0.997	**0.997**
j	IMD Removal	1.000	0.996	0.999	1.000	1.000	1.000	1.000	0.999	1.000	1.000	1.000	**1.000**
k	IMD Repricing	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	**1.000**
Product of c through k	**Adjusted CY 2023 PMPM Costs**	**$34.12**	**$18.86**	**$30.55**	**$16.63**	**$11.55**	**$44.38**	**$3.17**	**$21.25**	**$96.41**	**$19.11**	**$17.64**	**$313.68**

Exhibit 1B
Mississippi Division of Medicaid
All Regions SFY 2026 MississippiCAN Capitation Rate Development
CY 2022 Encounter Data

Breast and Cervical Cancer Rate Cell

		Category of Service											
Calculation Step	CY 2022 PMPM Cost Development	Inpatient Hospital - Maternity / Deliveries	Inpatient Hospital - Psychiatric / Substance Abuse	Inpatient Hospital - Other	Outpatient Hospital - Emergency Room	Outpatient Hospital - Pharmacy	Outpatient Hospital - Other	Physician - Maternity / Deliveries	Physician - Psychiatric / Substance Abuse	Physician - Other	Dental	Other	Total
a	CY 2022 Member Months	961	961	961	961	961	961	961	961	961	961	961	**961**
b	Total Allowed Dollars	$0	$0	$157,940	$20,994	$827,754	$564,167	$0	$6,154	$839,806	$8,239	$38,735	**$2,463,790**
c	CY 2022 PMPM Costs	$0.00	$0.00	$164.35	$21.85	$861.35	$587.06	$0.00	$6.40	$873.89	$8.57	$40.31	**$2,563.78**
d	MYPAC Member Identification Change	N/A	N/A	1.000	1.000	1.000	1.000	N/A	1.000	1.000	1.000	1.000	**1.000**
e	Encounter to Financial Adjustment	N/A	N/A	0.979	1.007	1.007	1.007	N/A	1.007	1.007	0.971	1.007	**1.005**
f	Missing Data	N/A	N/A	1.002	1.003	1.002	1.002	N/A	1.003	1.002	0.990	0.996	**1.002**
g	IBNR Adjustment	N/A	N/A	1.008	1.003	1.002	1.003	N/A	1.002	1.002	1.000	1.003	**1.003**
h	Non-Covered Services	N/A	N/A	1.000	1.000	1.000	1.000	N/A	1.000	0.993	1.000	1.000	**0.998**
i	Remove Zolgensma Claims	N/A	N/A	1.000	1.000	1.000	1.000	N/A	1.000	1.000	1.000	1.000	**1.000**
j	TPL Adjustment	N/A	N/A	0.996	0.996	0.996	0.996	N/A	0.996	0.996	0.996	0.996	**0.996**
k	IMD Removal	N/A	N/A	1.000	1.000	1.000	1.000	N/A	1.000	1.000	1.000	1.000	**1.000**
l	IMD Repricing	N/A	N/A	1.000	1.000	1.000	1.000	N/A	1.000	1.000	1.000	1.000	**1.000**
m	SSI Children - COE Change	N/A	N/A	1.000	1.000	1.000	1.000	N/A	1.000	1.000	1.000	1.000	**1.000**
Product of c through m	**Subtotal: CY 2022 Adjusted Costs**	**$0.00**	**$0.00**	**$161.93**	**$22.06**	**$868.22**	**$592.08**	**$0.00**	**$6.46**	**$874.69**	**$8.22**	**$40.37**	$2,574.03
	CY 2022 to CY 2023 Trends												
n	Utilization Trend 2022 to 2023	N/A	N/A	1.030	1.000	1.020	1.030	N/A	1.030	1.060	1.040	1.030	**1.037**
o	Charge Trend 2022 to 2023	N/A	N/A	0.982	1.023	1.020	1.053	N/A	1.061	1.009	1.000	1.015	**1.021**
	CY 2022 to CY 2023 Reimbursement Methodology Changes												
p	Preventative and Diagnostic Dental Adjustment	N/A	N/A	1.000	1.000	1.000	1.000	N/A	1.000	1.000	1.015	1.000	**1.000**
q	Restorative Dental Adjustment	N/A	N/A	1.000	1.000	1.000	1.000	N/A	1.000	1.000	1.000	1.000	**1.000**
Product of c through q	**CY 2022 PMPM Costs - Adjusted to CY 2023**	**$0.00**	**$0.00**	**$163.74**	**$22.57**	**$903.31**	**$642.03**	**$0.00**	**$7.05**	**$935.90**	**$8.68**	**$42.22**	$2,725.51

SSI / Disabled Newborn Rate Cell

		Category of Service											
Calculation Step	CY 2022 PMPM Cost Development	Inpatient Hospital - Maternity / Deliveries	Inpatient Hospital - Psychiatric / Substance Abuse	Inpatient Hospital - Other	Outpatient Hospital - Emergency Room	Outpatient Hospital - Pharmacy	Outpatient Hospital - Other	Physician - Maternity / Deliveries	Physician - Psychiatric / Substance Abuse	Physician - Other	Dental	Other	Total
a	CY 2022 Member Months	5,039	5,039	5,039	5,039	5,039	5,039	5,039	5,039	5,039	5,039	5,039	**5,039**
b	Total Allowed Dollars	$14,120,751	$71,801	$3,876,792	$290,711	$255,175	$917,712	$0	$3,901	$7,040,173	$4,630	$1,025,860	**$27,607,506**
c	CY 2022 PMPM Costs	$2,802.29	$14.25	$769.36	$57.69	$50.64	$182.12	$0.00	$0.77	$1,397.14	$0.92	$203.58	**$5,478.77**
d	MYPAC Member Identification Change	1.000	1.000	1.000	1.000	1.000	1.000	N/A	1.000	1.000	1.000	1.000	**1.000**
e	Encounter to Financial Adjustment	0.979	0.979	0.979	1.007	1.007	1.007	N/A	1.007	1.007	0.971	1.007	**0.988**
f	Missing Data	1.003	1.000	1.002	1.002	1.000	1.002	N/A	1.001	1.002	1.003	1.000	**1.002**
g	IBNR Adjustment	1.019	1.017	1.017	1.003	1.003	1.003	N/A	1.002	1.001	1.001	1.004	**1.013**
h	Non-Covered Services	1.000	1.000	1.000	1.000	1.000	1.000	N/A	1.000	1.000	1.000	1.000	**1.000**
i	Remove Zolgensma Claims	1.000	1.000	1.000	1.000	1.000	1.000	N/A	1.000	1.000	1.000	1.000	**1.000**
j	TPL Adjustment	0.996	0.996	0.996	0.996	0.996	0.996	N/A	0.996	0.996	0.996	0.996	**0.996**
k	IMD Removal	1.000	1.000	1.000	1.000	1.000	1.000	N/A	1.000	1.000	1.000	1.000	**1.000**
l	IMD Repricing	1.000	1.000	1.000	1.000	1.000	1.000	N/A	1.000	1.000	1.000	1.000	**1.000**
m	SSI Children - COE Change	1.000	1.000	1.000	1.000	1.000	1.000	N/A	1.000	1.000	1.000	1.000	**1.000**
Product of c through m	**Subtotal: CY 2022 Adjusted Costs**	**$2,792.51**	**$14.14**	**$764.74**	**$58.17**	**$50.96**	**$183.64**	**$0.00**	**$0.78**	**$1,406.02**	**$0.89**	**$205.05**	$5,476.92
	CY 2022 to CY 2023 Trends												
n	Utilization Trend 2022 to 2023	1.010	1.000	1.000	1.000	1.025	1.030	N/A	1.030	1.000	1.040	1.030	**1.007**
o	Charge Trend 2022 to 2023	1.033	1.033	1.033	1.048	1.025	1.050	N/A	1.021	0.997	1.000	1.024	**1.024**
	CY 2022 to CY 2023 Reimbursement Methodology Changes												
p	Preventative and Diagnostic Dental Adjustment	1.000	1.000	1.000	1.000	1.000	1.000	N/A	1.000	1.000	1.044	1.000	**1.000**
q	Restorative Dental Adjustment	1.000	1.000	1.000	1.000	1.000	1.000	N/A	1.000	1.000	1.000	1.000	**1.000**
Product of c through q	**CY 2022 PMPM Costs - Adjusted to CY 2023**	**$2,914.70**	**$14.61**	**$790.30**	**$60.98**	**$53.55**	**$198.67**	**$0.00**	**$0.82**	**$1,401.73**	**$0.97**	**$216.17**	$5,652.50

Exhibit 1B
Mississippi Division of Medicaid
All Regions SFY 2026 MississippiCAN Capitation Rate Development
CY 2022 Encounter Data

Non-SSI Newborns 0 to 2 Months Rate Cell

		Category of Service											
Calculation Step	**CY 2022 PMPM Cost Development**	**Inpatient Hospital - Maternity / Deliveries**	**Inpatient Hospital - Psychiatric / Substance Abuse**	**Inpatient Hospital - Other**	**Outpatient Hospital - Emergency Room**	**Outpatient Hospital - Pharmacy**	**Outpatient Hospital - Other**	**Physician - Maternity / Deliveries**	**Physician - Psychiatric / Substance Abuse**	**Physician - Other**	**Dental**	**Other**	**Total**
a	CY 2022 Member Months	67,578	67,578	67,578	67,578	67,578	67,578	67,578	67,578	67,578	67,578	67,578	**67,578**
b	Total Allowed Dollars	$87,541,195	$0	$7,539,469	$1,538,823	$151,032	$1,947,182	$0	$9,662	$29,524,969	$55,650	$960,073	**$129,268,054**
c	CY 2022 PMPM Costs[1]	$1,295.41	$0.00	$111.57	$22.77	$2.23	$28.81	$0.00	$0.14	$436.90	$0.82	$14.21	**$1,912.87**
d	MYPAC Member Identification Change	1.000	N/A	1.000	1.000	1.000	1.000	N/A	1.000	1.000	1.000	1.000	**1.000**
e	Encounter to Financial Adjustment	0.979	N/A	0.979	1.007	1.007	1.007	N/A	1.007	1.007	0.971	1.007	**0.986**
f	Missing Data	1.002	N/A	1.003	1.003	1.003	1.003	N/A	1.004	1.002	1.001	1.104	**1.003**
g	IBNR Adjustment	1.019	N/A	1.019	1.002	1.002	1.002	N/A	1.002	1.001	1.001	1.006	**1.014**
h	Non-Covered Services	1.000	N/A	1.000	1.000	1.000	1.000	N/A	1.000	1.000	1.000	1.000	**1.000**
i	Remove Zolgensma Claims	1.000	N/A	1.000	1.000	1.000	1.000	N/A	1.000	0.880	1.000	1.000	**0.972**
j	TPL Adjustment	0.996	N/A	0.996	0.996	0.996	0.996	N/A	0.996	0.996	0.996	0.996	**0.996**
k	IMD Removal	1.000	N/A	1.000	1.000	1.000	1.000	N/A	1.000	1.000	1.000	1.000	**1.000**
l	IMD Repricing	1.000	N/A	1.000	1.000	1.000	1.000	N/A	1.000	1.000	1.000	1.000	**1.000**
m	SSI Children - COE Change	1.000	N/A	1.000	1.000	1.000	1.000	N/A	1.000	1.000	1.000	1.000	**1.000**
Product of c through m	**Subtotal: CY 2022 Adjusted Costs**	**$1,290.57**	**$0.00**	**$111.09**	**$22.96**	**$2.25**	**$29.05**	**$0.00**	**$0.14**	**$387.37**	**$0.80**	**$15.82**	$1,860.06
	CY 2022 to CY 2023 Trends												
n	Utilization Trend 2022 to 2023	1.010	N/A	1.000	1.000	1.025	1.030	N/A	1.030	1.000	1.040	1.030	**1.008**
o	Charge Trend 2022 to 2023	1.033	N/A	1.033	1.048	1.025	1.049	N/A	1.035	0.996	1.000	1.006	**1.026**
	CY 2022 to CY 2023 Reimbursement Methodology Changes												
p	Preventative and Diagnostic Dental Adjustment	1.000	N/A	1.000	1.000	1.000	1.000	N/A	1.000	1.000	1.028	1.000	**1.000**
q	Restorative Dental Adjustment	1.000	N/A	1.000	1.000	1.000	1.000	N/A	1.000	1.000	1.000	1.000	**1.000**
Product of c through q	**CY 2022 PMPM Costs - Adjusted to CY 2023**	**$1,347.04**	**$0.00**	**$114.81**	**$24.07**	**$2.37**	**$31.39**	**$0.00**	**$0.15**	**$385.87**	**$0.85**	**$16.40**	$1,922.95

Foster Care Rate Cell

		Category of Service											
Calculation Step	**CY 2022 PMPM Cost Development**	**Inpatient Hospital - Maternity / Deliveries**	**Inpatient Hospital - Psychiatric / Substance Abuse**	**Inpatient Hospital - Other**	**Outpatient Hospital - Emergency Room**	**Outpatient Hospital - Pharmacy**	**Outpatient Hospital - Other**	**Physician - Maternity / Deliveries**	**Physician - Psychiatric / Substance Abuse**	**Physician - Other**	**Dental**	**Other**	**Total**
a	CY 2022 Member Months	82,463	82,463	82,463	82,463	82,463	82,463	82,463	82,463	82,463	82,463	82,463	**82,463**
b	Total Allowed Dollars	$108,997	$20,767,846	$649,443	$662,925	$191,780	$3,001,096	$11,031	$5,730,614	$7,666,114	$2,305,821	$1,250,100	**$42,345,766**
c	CY 2022 PMPM Costs	$1.32	$251.84	$7.88	$8.04	$2.33	$36.39	$0.13	$69.49	$92.96	$27.96	$15.16	**$513.51**
d	MYPAC Member Identification Change	1.000	0.980	1.000	0.974	0.998	0.987	1.000	0.676	0.947	0.975	0.990	**0.934**
e	Encounter to Financial Adjustment	0.979	0.979	0.979	1.007	1.007	1.007	1.007	1.007	1.007	0.971	1.007	**0.990**
f	Missing Data	1.000	1.000	1.000	1.001	1.001	1.001	1.001	1.001	1.000	1.001	0.981	**1.000**
g	IBNR Adjustment	1.014	1.027	1.028	1.004	1.003	1.004	1.001	1.001	1.001	1.000	1.010	**1.015**
h	Non-Covered Services	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	0.999	1.000	1.000	**1.000**
i	Remove Zolgensma Claims	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	**1.000**
j	TPL Adjustment	0.996	0.996	0.996	0.996	0.996	0.996	0.996	0.996	0.996	0.996	0.996	**0.996**
k	IMD Removal	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	**1.000**
l	IMD Repricing	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	**1.000**
m	SSI Children - COE Change	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	**1.000**
Product of c through m	**Subtotal: CY 2022 Adjusted Costs**	**$1.31**	**$247.18**	**$7.89**	**$7.90**	**$2.34**	**$36.22**	**$0.13**	**$47.19**	**$88.34**	**$26.43**	**$14.91**	$479.82
	CY 2022 to CY 2023 Trends												
n	Utilization Trend 2022 to 2023	1.010	1.030	1.030	1.000	1.025	1.030	1.010	1.030	1.030	1.040	1.030	**1.030**
o	Charge Trend 2022 to 2023	0.990	1.029	0.990	1.032	1.025	1.033	1.005	1.029	1.012	1.005	1.045	**1.025**
	CY 2022 to CY 2023 Reimbursement Methodology Changes												
p	Preventative and Diagnostic Dental Adjustment	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.022	1.000	**1.001**
q	Restorative Dental Adjustment	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.013	1.000	**1.001**
Product of c through q	**CY 2022 PMPM Costs - Adjusted to CY 2023**	**$1.31**	**$262.05**	**$8.05**	**$8.15**	**$2.46**	**$38.55**	**$0.14**	**$50.03**	**$92.08**	**$28.57**	**$16.04**	$507.41

Exhibit 1B
Mississippi Division of Medicaid
All Regions SFY 2026 MississippiCAN Capitation Rate Development
CY 2022 Encounter Data

MYPAC Rate Cell

		Category of Service											
Calculation Step	**CY 2022 PMPM Cost Development**	**Inpatient Hospital - Maternity / Deliveries**	**Inpatient Hospital - Psychiatric / Substance Abuse**	**Inpatient Hospital - Other**	**Outpatient Hospital - Emergency Room**	**Outpatient Hospital - Pharmacy**	**Outpatient Hospital - Other**	**Physician - Maternity / Deliveries**	**Physician - Psychiatric / Substance Abuse**	**Physician - Other**	**Dental**	**Other**	**Total**
a	CY 2022 Member Months	10,612	10,612	10,612	10,612	10,612	10,612	10,612	10,612	10,612	10,612	10,612	**10,612**
b	Total Allowed Dollars	$10,388	$3,295,959	$22,699	$144,476	$21,931	$299,094	$3,948	$7,517,646	$7,167,730	$247,830	$148,719	**$18,880,420**
c	CY 2022 PMPM Costs	$0.98	$310.59	$2.14	$13.61	$2.07	$28.18	$0.37	$708.41	$675.44	$23.35	$14.01	**$1,779.16**
d	MYPAC Member Identification Change	2.789	1.390	3.550	1.596	1.347	1.568	2.077	1.864	1.179	1.603	1.726	**1.512**
e	Encounter to Financial Adjustment	0.979	0.979	0.979	1.007	1.007	1.007	1.007	1.007	1.007	0.971	1.007	**1.002**
f	Missing Data	1.000	1.000	1.000	1.004	1.009	1.004	1.000	1.000	1.000	1.003	1.044	**1.001**
g	IBNR Adjustment	1.011	1.064	1.051	1.015	1.015	1.014	1.001	1.000	1.000	1.001	1.093	**1.012**
h	Non-Covered Services	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	**1.000**
i	Remove Zolgensma Claims	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	**1.000**
j	TPL Adjustment	0.996	0.996	0.996	0.996	0.996	0.996	0.996	0.996	0.996	0.996	0.996	**0.996**
k	IMD Removal	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	**1.000**
l	IMD Repricing	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	**1.000**
m	SSI Children - COE Change	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	**1.000**
Product of c through m	**Subtotal: CY 2022 Adjusted Costs**	**$2.69**	**$447.99**	**$7.78**	**$22.24**	**$2.86**	**$45.16**	**$0.78**	**$1,325.46**	**$799.27**	**$36.34**	**$27.71**	$2,718.29
	CY 2022 to CY 2023 Trends												
n	Utilization Trend 2022 to 2023	1.010	1.030	1.030	1.000	1.025	1.030	1.010	1.002	1.003	1.040	1.030	**1.008**
o	Charge Trend 2022 to 2023	0.990	1.009	0.990	1.032	1.025	1.031	1.005	1.016	1.014	1.004	1.021	**1.014**
	CY 2022 to CY 2023 Reimbursement Methodology Changes												
p	Preventative and Diagnostic Dental Adjustment	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.017	1.000	**1.000**
q	Restorative Dental Adjustment	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.013	1.000	**1.000**
Product of c through q	**CY 2022 PMPM Costs - Adjusted to CY 2023**	**$2.69**	**$465.70**	**$7.93**	**$22.94**	**$3.01**	**$47.95**	**$0.79**	**$1,348.92**	**$812.64**	**$39.11**	**$29.13**	$2,780.81

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Non-Newborn SSI / Disabled Rate Cell

		Category of Service											
Calculation Step	SFY 2026 PMPM Cost Development	Inpatient Hospital - Maternity / Deliveries	Inpatient Hospital - Psychiatric / Substance Abuse	Inpatient Hospital - Other	Outpatient Hospital - Emergency Room	Outpatient Hospital - Pharmacy	Outpatient Hospital - Other	Physician - Maternity / Deliveries	Physician - Psychiatric / Substance Abuse	Physician - Other	Dental	Other	Total
	Base Period Summaries												
a	CY 2023 PMPM Costs	$2.64	$35.52	$128.50	$32.76	$53.51	$121.17	$0.55	$49.08	$179.71	$9.67	$67.01	**$680.11**
	Trends												
b	Utilization Trend Factors CY 2023 to SFY 2026	1.025	1.077	1.025	1.000	1.038	1.077	1.025	1.130	1.116	1.103	1.130	**1.080**
c	Charge Trend Factors CY 2023 to SFY 2026	0.977	0.993	0.977	1.066	1.040	1.068	0.974	1.068	0.986	1.008	1.019	**1.017**
	Population Changes												
d	SFY 2026 Population Acuity Adjustment	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	**1.000**
e	Postpartum Coverage Extension	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	**1.000**
f	Hemophilia Population Carve-In	1.001	0.999	1.002	1.000	1.000	1.001	1.003	0.999	1.000	1.000	1.002	**1.001**
	Program Changes												
g	Gene Therapy Drug Coverage	1.000	1.000	1.004	1.000	1.000	1.000	1.000	1.000	1.036	1.000	1.000	**1.010**
	Reimbursement Changes												
h	Preventative and Diagnostic Dental Reimbursement Change	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.009	1.000	**1.000**
i	Restorative Dental Reimbursement Change	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.014	1.000	**1.000**
Product of a through i	**Projected SFY 2026 PMPM Costs**	**$2.65**	**$37.95**	**$129.50**	**$34.90**	**$57.78**	**$139.49**	**$0.55**	**$59.18**	**$205.00**	**$11.01**	**$77.34**	**$755.34**

Breast and Cervical Cancer Rate Cell

		Category of Service											
Calculation Step	SFY 2026 PMPM Cost Development	Inpatient Hospital - Maternity / Deliveries	Inpatient Hospital - Psychiatric / Substance Abuse	Inpatient Hospital - Other	Outpatient Hospital - Emergency Room	Outpatient Hospital - Pharmacy	Outpatient Hospital - Other	Physician - Maternity / Deliveries	Physician - Psychiatric / Substance Abuse	Physician - Other	Dental	Other	Total
	Base Period Summaries												
	CY 2022 MMs	961	961	961	961	961	961	961	961	961	961	961	**961**
	CY 2022 PMPM Costs - Trended to CY 2023	$0.00	$0.00	$163.74	$22.57	$903.31	$642.03	$0.00	$7.05	$935.90	$8.68	$42.22	**$2,725.51**
	CY 2023 MMs	1,038	1,038	1,038	1,038	1,038	1,038	1,038	1,038	1,038	1,038	1,038	**1,038**
	CY 2023 PMPM Costs	$0.00	$0.00	$139.23	$29.74	$852.62	$642.23	$0.00	$7.86	$848.33	$7.35	$51.30	**$2,578.66**
a	Blended CY 2022 & CY 2023 PMPM Costs	$0.00	$0.00	$151.01	$26.30	$876.99	$642.13	$0.00	$7.47	$890.43	$7.99	$46.94	**$2,649.25**
	Trends												
b	Utilization Trend Factors CY 2023 to SFY 2026	1.000	1.000	1.025	1.000	1.372	1.077	1.000	1.130	1.255	1.103	1.130	**1.232**
c	Charge Trend Factors CY 2023 to SFY 2026	1.000	1.000	0.977	1.066	1.380	1.066	1.000	1.055	1.179	1.000	1.019	**1.215**
	Population Changes												
d	SFY 2026 Population Acuity Adjustment	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	**1.000**
e	Postpartum Coverage Extension	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	**1.000**
f	Hemophilia Population Carve-In	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	**1.000**
	Program Changes												
g	Gene Therapy Drug Coverage	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	**1.000**
	Reimbursement Changes												
h	Preventative and Diagnostic Dental Reimbursement Change	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.007	1.000	**1.000**
i	Restorative Dental Reimbursement Change	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	**1.000**
Product of a through i	**Projected SFY 2026 PMPM Costs**	**$0.00**	**$0.00**	**$151.24**	**$28.02**	**$1,661.09**	**$737.25**	**$0.00**	**$8.90**	**$1,316.64**	**$8.87**	**$54.04**	**$3,966.05**

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MA Adult Rate Cell

		Category of Service											
Calculation Step	SFY 2026 PMPM Cost Development	Inpatient Hospital - Maternity / Deliveries	Inpatient Hospital - Psychiatric / Substance Abuse	Inpatient Hospital - Other	Outpatient Hospital - Emergency Room	Outpatient Hospital - Pharmacy	Outpatient Hospital - Other	Physician - Maternity / Deliveries	Physician - Psychiatric / Substance Abuse	Physician - Other	Dental	Other	Total
	Base Period Summaries												
a	CY 2023 PMPM Costs	$28.25	$4.78	$28.38	$25.97	$14.02	$59.71	$6.89	$9.90	$105.96	$4.76	$13.53	**$302.16**
	Trends												
b	Utilization Trend Factors CY 2023 to SFY 2026	1.025	1.077	1.025	1.000	1.025	1.077	1.025	1.077	1.077	1.103	1.077	**1.057**
c	Charge Trend Factors CY 2023 to SFY 2026	1.019	1.019	1.019	1.072	1.027	1.073	0.998	1.033	1.003	1.000	1.028	**1.029**
	Population Changes												
d	SFY 2026 Population Acuity Adjustment	0.985	0.985	0.985	0.985	0.985	0.985	0.985	0.985	0.985	0.985	0.985	**0.985**
e	Postpartum Coverage Extension	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	**1.000**
f	Hemophilia Population Carve-In	1.000	0.999	1.001	1.001	1.000	1.001	1.000	1.000	1.000	1.001	1.000	**1.000**
	Program Changes												
g	Gene Therapy Drug Coverage	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	**1.000**
	Reimbursement Changes												
h	Preventative and Diagnostic Dental Reimbursement Change	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.009	1.000	**1.000**
i	Restorative Dental Reimbursement Change	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.001	1.000	**1.000**
Product of a through i	**Projected SFY 2026 PMPM Costs**	**$29.08**	**$5.17**	**$29.24**	**$27.43**	**$14.54**	**$67.98**	**$6.95**	**$10.85**	**$112.72**	**$5.22**	**$14.75**	**$323.93**

Pregnant Women Rate Cell

		Category of Service											
Calculation Step	SFY 2026 PMPM Cost Development	Inpatient Hospital - Maternity / Deliveries	Inpatient Hospital - Psychiatric / Substance Abuse	Inpatient Hospital - Other	Outpatient Hospital - Emergency Room	Outpatient Hospital - Pharmacy	Outpatient Hospital - Other	Physician - Maternity / Deliveries	Physician - Psychiatric / Substance Abuse	Physician - Other	Dental	Other	Total
	Base Period Summaries												
a	CY 2023 PMPM Costs	$380.96	$1.60	$5.19	$30.18	$9.61	$55.32	$95.79	$3.12	$167.44	$3.75	$11.51	**$764.46**
	Trends												
b	Utilization Trend Factors CY 2023 to SFY 2026	1.025	1.077	1.025	1.000	1.025	1.077	1.025	1.077	1.077	1.103	1.077	**1.041**
c	Charge Trend Factors CY 2023 to SFY 2026	1.019	1.019	1.019	1.072	1.027	1.072	0.998	1.018	1.001	1.001	1.027	**1.018**
	Population Changes												
d	SFY 2026 Population Acuity Adjustment	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	**1.000**
e	Postpartum Coverage Extension	0.605	0.865	0.865	0.865	0.865	0.865	0.605	0.865	0.865	0.865	0.865	**0.706**
f	Hemophilia Population Carve-In	1.000	0.999	1.008	1.000	1.002	1.000	1.000	0.999	1.000	1.001	0.999	**1.000**
	Program Changes												
g	Gene Therapy Drug Coverage	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	**1.000**
	Reimbursement Changes												
h	Preventative and Diagnostic Dental Reimbursement Change	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.008	1.000	**1.000**
i	Restorative Dental Reimbursement Change	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.006	1.000	**1.000**
Product of a through i	**Projected SFY 2026 PMPM Costs**	**$240.57**	**$1.52**	**$4.73**	**$27.99**	**$8.77**	**$55.24**	**$59.26**	**$2.96**	**$156.05**	**$3.64**	**$11.01**	**$571.72**

Exhibit 2A
Mississippi Division of Medicaid
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Final Base Data and Projection Assumptions

SSI / Disabled Newborn Rate Cell

		Category of Service											
Calculation Step	SFY 2026 PMPM Cost Development	Inpatient Hospital - Maternity / Deliveries	Inpatient Hospital - Psychiatric / Substance Abuse	Inpatient Hospital - Other	Outpatient Hospital - Emergency Room	Outpatient Hospital - Pharmacy	Outpatient Hospital - Other	Physician - Maternity / Deliveries	Physician - Psychiatric / Substance Abuse	Physician - Other	Dental	Other	Total
	Base Period Summaries												
	CY 2022 MMs	5,039	5,039	5,039	5,039	5,039	5,039	5,039	5,039	5,039	5,039	5,039	**5,039**
	CY 2022 PMPM Costs - Trended to CY 2023	$2,914.70	$14.61	$790.30	$60.98	$53.55	$198.67	$0.00	$0.82	$1,401.73	$0.97	$216.17	**$5,652.50**
	CY 2023 MMs	5,313	5,313	5,313	5,313	5,313	5,313	5,313	5,313	5,313	5,313	5,313	**5,313**
	CY 2023 PMPM Costs	$3,088.61	$0.00	$857.40	$64.83	$36.63	$184.79	$0.00	$0.89	$1,627.22	$0.76	$325.92	**$6,187.07**
a	Blended CY 2022 & CY 2023 PMPM Costs	$3,003.96	$7.11	$824.74	$62.96	$44.87	$191.55	$0.00	$0.86	$1,517.46	$0.86	$272.50	**$5,926.86**
	Trends												
b	Utilization Trend Factors CY 2023 to SFY 2026	1.025	1.077	1.025	1.000	1.064	1.077	1.000	1.077	1.051	1.103	1.051	**1.035**
c	Charge Trend Factors CY 2023 to SFY 2026	1.041	1.000	1.041	1.106	1.062	1.106	1.000	0.984	0.983	1.000	1.008	**1.027**
	Population Changes												
d	SFY 2026 Population Acuity Adjustment	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	**1.000**
e	Postpartum Coverage Extension	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	**1.000**
f	Hemophilia Population Carve-In	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	**1.000**
	Program Changes												
g	Gene Therapy Drug Coverage	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	**1.000**
	Reimbursement Changes												
h	Preventative and Diagnostic Dental Reimbursement Change	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.021	1.000	**1.000**
i	Restorative Dental Reimbursement Change	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	**1.000**
Product of a through i	**Projected SFY 2026 PMPM Costs**	**$3,206.10**	**$7.66**	**$880.24**	**$69.63**	**$50.66**	**$228.08**	**$0.00**	**$0.91**	**$1,566.65**	**$0.97**	**$288.67**	**$6,299.56**

Non-SSI Newborns 0 to 2 Months Rate Cell

		Category of Service											
Calculation Step	SFY 2026 PMPM Cost Development	Inpatient Hospital - Maternity / Deliveries	Inpatient Hospital - Psychiatric / Substance Abuse	Inpatient Hospital - Other	Outpatient Hospital - Emergency Room	Outpatient Hospital - Pharmacy	Outpatient Hospital - Other	Physician - Maternity / Deliveries	Physician - Psychiatric / Substance Abuse	Physician - Other	Dental	Other	Total
	Base Period Summaries												
	CY 2022 MMs	67,578	67,578	67,578	67,578	67,578	67,578	67,578	67,578	67,578	67,578	67,578	**67,578**
	CY 2022 PMPM Costs - Trended to CY 2023	$1,347.04	$0.00	$114.81	$24.07	$2.37	$31.39	$0.00	$0.15	$385.87	$0.85	$16.40	**$1,922.95**
	CY 2023 MMs	67,416	67,416	67,416	67,416	67,416	67,416	67,416	67,416	67,416	67,416	67,416	**67,416**
	CY 2023 PMPM Costs	$1,268.58	$0.00	$105.71	$25.76	$2.67	$32.01	$0.00	$0.09	$395.60	$0.95	$18.93	**$1,850.30**
a	Blended CY 2022 & CY 2023 PMPM Costs	$1,307.86	$0.00	$110.27	$24.91	$2.52	$31.70	$0.00	$0.12	$390.73	$0.90	$17.66	**$1,886.67**
	Trends												
b	Utilization Trend Factors CY 2023 to SFY 2026	1.025	1.000	1.025	1.000	1.064	1.077	1.000	1.077	1.051	1.103	1.051	**1.031**
c	Charge Trend Factors CY 2023 to SFY 2026	1.041	1.000	1.041	1.106	1.062	1.106	1.000	0.980	1.000	1.000	1.008	**1.034**
	Population Changes												
d	SFY 2026 Population Acuity Adjustment	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	**1.000**
e	Postpartum Coverage Extension	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	**1.000**
f	Hemophilia Population Carve-In	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	**1.000**
	Program Changes												
g	Gene Therapy Drug Coverage	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.238	1.000	1.000	**1.049**
	Reimbursement Changes												
h	Preventative and Diagnostic Dental Reimbursement Change	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.013	1.000	**1.000**
i	Restorative Dental Reimbursement Change	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	**1.000**
Product of a through i	**Projected SFY 2026 PMPM Costs**	**$1,395.87**	**$0.00**	**$117.69**	**$27.55**	**$2.85**	**$37.75**	**$0.00**	**$0.13**	**$508.13**	**$1.00**	**$18.71**	**$2,109.67**

Exhibit 2A
Mississippi Division of Medicaid
All Regions SFY 2026 MississippiCAN Capitation Rate Development
Final Base Data and Projection Assumptions

Non-SSI Newborns 3 to 12 Months Rate Cell

		Category of Service											
Calculation Step	SFY 2026 PMPM Cost Development	Inpatient Hospital - Maternity / Deliveries	Inpatient Hospital - Psychiatric / Substance Abuse	Inpatient Hospital - Other	Outpatient Hospital - Emergency Room	Outpatient Hospital - Pharmacy	Outpatient Hospital - Other	Physician - Maternity / Deliveries	Physician - Psychiatric / Substance Abuse	Physician - Other	Dental	Other	Total
	Base Period Summaries												
a	CY 2023 PMPM Costs	$2.69	$0.05	$29.60	$26.51	$2.52	$33.83	$0.00	$0.03	$126.00	$1.19	$9.04	**$231.48**
	Trends												
b	Utilization Trend Factors CY 2023 to SFY 2026	1.025	1.077	1.025	1.000	1.064	1.077	1.000	1.077	1.051	1.103	1.051	**1.046**
c	Charge Trend Factors CY 2023 to SFY 2026	0.987	0.987	0.987	1.093	1.062	1.094	1.000	1.009	1.007	1.000	1.026	**1.028**
	Population Changes												
d	SFY 2026 Population Acuity Adjustment	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	**1.000**
e	Postpartum Coverage Extension	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	**1.000**
f	Hemophilia Population Carve-In	1.011	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	**1.000**
	Program Changes												
g	Gene Therapy Drug Coverage	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	**1.000**
	Reimbursement Changes												
h	Preventative and Diagnostic Dental Reimbursement Change	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.023	1.000	**1.000**
i	Restorative Dental Reimbursement Change	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	**1.000**
Product of a through i	**Projected SFY 2026 PMPM Costs**	**$2.75**	**$0.05**	**$29.94**	**$28.97**	**$2.85**	**$39.86**	**$0.00**	**$0.03**	**$133.39**	**$1.35**	**$9.74**	**$248.95**

Foster Care Rate Cell

		Category of Service											
Calculation Step	SFY 2026 PMPM Cost Development	Inpatient Hospital - Maternity / Deliveries	Inpatient Hospital - Psychiatric / Substance Abuse	Inpatient Hospital - Other	Outpatient Hospital - Emergency Room	Outpatient Hospital - Pharmacy	Outpatient Hospital - Other	Physician - Maternity / Deliveries	Physician - Psychiatric / Substance Abuse	Physician - Other	Dental	Other	Total
	Base Period Summaries												
	CY 2022 MMs	82,463	82,463	82,463	82,463	82,463	82,463	82,463	82,463	82,463	82,463	82,463	**82,463**
	CY 2022 PMPM Costs - Trended to CY 2023	$1.31	$262.05	$8.05	$8.15	$2.46	$38.55	$0.14	$50.03	$92.08	$28.57	$16.04	**$507.41**
	CY 2023 MMs	88,226	88,226	88,226	88,226	88,226	88,226	88,226	88,226	88,226	88,226	88,226	**88,226**
	CY 2023 PMPM Costs	$1.04	$259.16	$8.65	$8.66	$3.19	$40.68	$0.35	$61.99	$93.95	$30.46	$14.58	**$522.72**
a	Blended CY 2022 & CY 2023 PMPM Costs	$1.17	$260.56	$8.36	$8.41	$2.83	$39.65	$0.25	$56.21	$93.05	$29.54	$15.29	**$515.32**
	Trends												
b	Utilization Trend Factors CY 2023 to SFY 2026	1.025	1.077	1.025	1.000	1.064	1.077	1.025	1.077	1.051	1.103	1.051	**1.070**
c	Charge Trend Factors CY 2023 to SFY 2026	0.987	1.032	0.996	1.093	1.062	1.100	1.005	1.028	1.014	1.013	1.029	**1.033**
	Population Changes												
d	SFY 2026 Population Acuity Adjustment	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	**1.000**
e	Postpartum Coverage Extension	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	**1.000**
f	Hemophilia Population Carve-In	0.999	0.999	0.999	0.999	0.999	0.999	0.999	0.999	1.000	1.000	0.999	**0.999**
	Program Changes												
g	Gene Therapy Drug Coverage	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	**1.000**
	Reimbursement Changes												
h	Preventative and Diagnostic Dental Reimbursement Change	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.011	1.000	**1.001**
i	Restorative Dental Reimbursement Change	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.019	1.000	**1.001**
Product of a through i	**Projected SFY 2026 PMPM Costs**	**$1.18**	**$289.29**	**$8.53**	**$9.19**	**$3.20**	**$46.90**	**$0.26**	**$62.16**	**$99.14**	**$34.01**	**$16.53**	**$570.38**

Exhibit 2A
Mississippi Division of Medicaid
All Regions SFY 2026 MississippiCAN Capitation Rate Development
Final Base Data and Projection Assumptions

MYPAC Rate Cell

		Category of Service											
Calculation Step	SFY 2026 PMPM Cost Development	Inpatient Hospital - Maternity / Deliveries	Inpatient Hospital - Psychiatric / Substance Abuse	Inpatient Hospital - Other	Outpatient Hospital - Emergency Room	Outpatient Hospital - Pharmacy	Outpatient Hospital - Other	Physician - Maternity / Deliveries	Physician - Psychiatric / Substance Abuse	Physician - Other	Dental	Other	Total
	Base Period Summaries												
	CY 2022 MMs	10,612	10,612	10,612	10,612	10,612	10,612	10,612	10,612	10,612	10,612	10,612	**10,612**
	CY 2022 PMPM Costs - Trended to CY 2023	$2.69	$465.70	$7.93	$22.94	$3.01	$47.95	$0.79	$1,348.92	$812.64	$39.11	$29.13	**$2,780.81**
	CY 2023 MMs	11,130	11,130	11,130	11,130	11,130	11,130	11,130	11,130	11,130	11,130	11,130	**11,130**
	CY 2023 PMPM Costs	$2.03	$469.42	$26.31	$24.11	$6.47	$41.55	$0.46	$1,491.69	$745.11	$36.83	$34.19	**$2,878.18**
a	Blended CY 2022 & CY 2023 PMPM Costs	$2.35	$467.60	$17.34	$23.54	$4.78	$44.67	$0.62	$1,422.00	$778.07	$37.94	$31.72	**$2,830.65**
	Trends												
b	Utilization Trend Factors CY 2023 to SFY 2026	1.025	1.077	1.025	1.000	1.064	1.077	1.025	1.003	1.007	1.103	1.051	**1.020**
c	Charge Trend Factors CY 2023 to SFY 2026	0.987	1.005	0.990	1.093	1.062	1.096	1.005	1.045	1.031	1.017	1.029	**1.034**
	Population Changes												
d	SFY 2026 Population Acuity Adjustment	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	**1.000**
e	Postpartum Coverage Extension	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	**1.000**
f	Hemophilia Population Carve-In	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	**1.000**
	Program Changes												
g	Gene Therapy Drug Coverage	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	**1.000**
	Reimbursement Changes												
h	Preventative and Diagnostic Dental Reimbursement Change	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.010	1.000	**1.000**
i	Restorative Dental Reimbursement Change	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.018	1.000	**1.000**
Product of a through i	**Projected SFY 2026 PMPM Costs**	**$2.38**	**$505.89**	**$17.60**	**$25.73**	**$5.40**	**$52.73**	**$0.64**	**$1,490.53**	**$807.51**	**$43.75**	**$34.31**	**$2,986.46**

MA Children Rate Cell

		Category of Service											
Calculation Step	SFY 2026 PMPM Cost Development	Inpatient Hospital - Maternity / Deliveries	Inpatient Hospital - Psychiatric / Substance Abuse	Inpatient Hospital - Other	Outpatient Hospital - Emergency Room	Outpatient Hospital - Pharmacy	Outpatient Hospital - Other	Physician - Maternity / Deliveries	Physician - Psychiatric / Substance Abuse	Physician - Other	Dental	Other	Total
	Base Period Summaries												
a	CY 2023 PMPM Costs	$1.09	$11.06	$6.35	$10.23	$2.03	$24.55	$0.30	$12.63	$59.05	$24.90	$6.94	**$159.14**
	Trends												
b	Utilization Trend Factors CY 2023 to SFY 2026	1.025	1.077	1.025	1.000	1.064	1.077	1.025	1.077	1.051	1.103	1.051	**1.062**
c	Charge Trend Factors CY 2023 to SFY 2026	0.987	1.019	0.987	1.093	1.062	1.097	1.005	1.029	1.010	1.014	1.029	**1.032**
	Population Changes												
d	SFY 2026 Population Acuity Adjustment	1.005	1.005	1.005	1.005	1.005	1.005	1.005	1.005	1.005	1.005	1.005	**1.005**
e	Postpartum Coverage Extension	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	**1.000**
f	Hemophilia Population Carve-In	1.000	1.000	1.002	1.000	1.001	1.000	1.000	1.001	1.000	1.000	1.000	**1.000**
	Program Changes												
g	Gene Therapy Drug Coverage	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.033	1.000	1.000	**1.012**
	Reimbursement Changes												
h	Preventative and Diagnostic Dental Reimbursement Change	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.010	1.000	**1.002**
i	Restorative Dental Reimbursement Change	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.020	1.000	**1.003**
Product of a through i	**Projected SFY 2026 PMPM Costs**	**$1.11**	**$12.19**	**$6.47**	**$11.24**	**$2.31**	**$29.15**	**$0.31**	**$14.08**	**$65.08**	**$28.84**	**$7.55**	**$178.32**

Exhibit 2A
Mississippi Division of Medicaid
All Regions SFY 2026 MississippiCAN Capitation Rate Development
Final Base Data and Projection Assumptions

Quasi-CHIP Rate Cell

		Category of Service											
Calculation Step	SFY 2026 PMPM Cost Development	Inpatient Hospital - Maternity / Deliveries	Inpatient Hospital - Psychiatric / Substance Abuse	Inpatient Hospital - Other	Outpatient Hospital - Emergency Room	Outpatient Hospital - Pharmacy	Outpatient Hospital - Other	Physician - Maternity / Deliveries	Physician - Psychiatric / Substance Abuse	Physician - Other	Dental	Other	Total
	Base Period Summaries												
a	CY 2023 PMPM Costs	$0.98	$12.10	$5.82	$7.53	$3.16	$20.05	$0.26	$14.18	$54.41	$32.65	$7.47	**$158.60**
	Trends												
b	Utilization Trend Factors CY 2023 to SFY 2026	1.025	1.077	1.025	1.000	1.064	1.077	1.025	1.077	1.051	1.103	1.051	**1.066**
c	Charge Trend Factors CY 2023 to SFY 2026	0.987	1.019	0.987	1.093	1.062	1.095	1.005	1.024	1.011	1.019	1.029	**1.030**
	Population Changes												
d	SFY 2026 Population Acuity Adjustment	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	**1.000**
e	Postpartum Coverage Extension	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	**1.000**
f	Hemophilia Population Carve-In	1.000	1.000	1.005	1.004	1.001	1.001	1.000	1.000	1.001	1.000	1.000	**1.001**
	Program Changes												
g	Gene Therapy Drug Coverage	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	**1.000**
	Reimbursement Changes												
h	Preventative and Diagnostic Dental Reimbursement Change	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.010	1.000	**1.002**
i	Restorative Dental Reimbursement Change	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.015	1.000	**1.003**
Product of a through i	**Projected SFY 2026 PMPM Costs**	**$0.99**	**$13.28**	**$5.92**	**$8.26**	**$3.57**	**$23.68**	**$0.26**	**$15.62**	**$57.86**	**$37.62**	**$8.07**	**$175.14**

All Rate Cells

		Category of Service											
Calculation Step	SFY 2026 PMPM Cost Development	Inpatient Hospital - Maternity / Deliveries	Inpatient Hospital - Psychiatric / Substance Abuse	Inpatient Hospital - Other	Outpatient Hospital - Emergency Room	Outpatient Hospital - Pharmacy	Outpatient Hospital - Other	Physician - Maternity / Deliveries	Physician - Psychiatric / Substance Abuse	Physician - Other	Dental	Other	Total
	Base Period Summaries												
a	Blended CY 2022 & CY 2023 PMPM Costs	$40.52	$18.05	$28.49	$16.57	$10.86	$43.43	$4.91	$20.04	$95.65	$19.06	$16.71	**$314.29**
	Trends												
b	Utilization Trend Factors CY 2023 to SFY 2026	1.025	1.077	1.025	1.000	1.042	1.077	1.025	1.083	1.072	1.103	1.097	**1.061**
c	Charge Trend Factors CY 2023 to SFY 2026	1.029	1.015	0.989	1.081	1.045	1.081	0.998	1.044	1.002	1.014	1.023	**1.026**
	Population Changes												
d	SFY 2026 Population Acuity Adjustment	0.999	1.001	0.999	0.999	0.998	0.999	0.998	1.001	1.000	1.003	1.000	**1.000**
e	Postpartum Coverage Extension	0.851	1.000	0.999	0.990	0.995	0.993	0.687	0.999	0.990	0.999	0.996	**0.972**
f	Hemophilia Population Carve-In	1.000	1.000	1.002	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.001	**1.000**
	Program Changes												
g	Gene Therapy Drug Coverage	1.000	1.000	1.003	1.000	1.000	1.000	1.000	1.000	1.034	1.000	1.000	**1.011**
	Reimbursement Changes												
h	Preventative and Diagnostic Dental Reimbursement Change	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.010	1.000	**1.001**
i	Restorative Dental Reimbursement Change	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.019	1.000	**1.001**
Product of a through i	**Projected SFY 2026 PMPM Costs**	**$36.33**	**$19.73**	**$28.95**	**$17.72**	**$11.77**	**$50.20**	**$3.44**	**$22.67**	**$105.17**	**$21.97**	**$18.69**	**$336.63**

Exhibit 2B
Mississippi Division of Medicaid
All Regions SFY 2026 MississippiCAN Capitation Rate Development
SFY 2026 PMPM Costs After the Removal of the MYPAC Rate Cell

Non-Newborn SSI / Disabled Rate Cell

		Category of Service											
Calculation Step	**SFY 2026 PMPM Cost Development - MYPAC Rate Cell Removal**	**Inpatient Hospital - Maternity / Deliveries**	**Inpatient Hospital - Psychiatric / Substance Abuse**	**Inpatient Hospital - Other**	**Outpatient Hospital - Emergency Room**	**Outpatient Hospital - Pharmacy**	**Outpatient Hospital - Other**	**Physician - Maternity / Deliveries**	**Physician - Psychiatric / Substance Abuse**	**Physician - Other**	**Dental**	**Other**	**Total - Medical PMPM**
	Projected SFY 2026 Summaries												
a	SFY 2026 Projected Member Months	737,828	737,828	737,828	737,828	737,828	737,828	737,828	737,828	737,828	737,828	737,828	**737,828**
b	SFY 2026 PMPM Costs	$2.65	$37.95	$129.50	$34.90	$57.78	$139.49	$0.55	$59.18	$205.00	$11.01	$77.34	**$755.34**
c	SFY 2026 Projected MYPAC Member Months	2,974	2,974	2,974	2,974	2,974	2,974	2,974	2,974	2,974	2,974	2,974	**2,974**
d	SFY 2026 MYPAC PMPM Costs	$4.58	$530.00	$21.34	$34.40	$14.71	$78.62	$0.58	$1,530.89	$853.69	$36.84	$49.52	**$3,155.17**
e = a + c	**Final SFY 2026 Projected MMs**	740,802	740,802	740,802	740,802	740,802	740,802	740,802	740,802	740,802	740,802	740,802	**740,802**
f = (a × b + c × d) / (a + c)	**Final SFY 2026 Projected PMPM Costs**	$2.66	$39.93	$129.06	$34.90	$57.61	$139.24	$0.55	$65.09	$207.60	$11.11	$77.23	**$764.97**

Foster Care Rate Cell

		Category of Service											
Calculation Step	**SFY 2026 PMPM Cost Development - MYPAC Rate Cell Removal**	**Inpatient Hospital - Maternity / Deliveries**	**Inpatient Hospital - Psychiatric / Substance Abuse**	**Inpatient Hospital - Other**	**Outpatient Hospital - Emergency Room**	**Outpatient Hospital - Pharmacy**	**Outpatient Hospital - Other**	**Physician - Maternity / Deliveries**	**Physician - Psychiatric / Substance Abuse**	**Physician - Other**	**Dental**	**Other**	**Total - Medical PMPM**
	Projected SFY 2026 Summaries												
a	SFY 2026 Projected Member Months	95,128	95,128	95,128	95,128	95,128	95,128	95,128	95,128	95,128	95,128	95,128	**95,128**
b	SFY 2026 PMPM Costs	$1.18	$289.29	$8.53	$9.19	$3.20	$46.90	$0.26	$62.16	$99.14	$34.01	$16.53	**$570.38**
c	SFY 2026 Projected MYPAC Member Months	2,524	2,524	2,524	2,524	2,524	2,524	2,524	2,524	2,524	2,524	2,524	**2,524**
d	SFY 2026 MYPAC PMPM Costs	$3.76	$625.82	$7.87	$20.28	$1.67	$45.20	$0.96	$1,418.46	$826.52	$58.51	$20.31	**$3,029.35**
e = a + c	**Final SFY 2026 Projected MMs**	97,653	97,653	97,653	97,653	97,653	97,653	97,653	97,653	97,653	97,653	97,653	**97,653**
f = (a × b + c × d) / (a + c)	**Final SFY 2026 Projected PMPM Costs**	$1.25	$297.99	$8.51	$9.48	$3.16	$46.86	$0.27	$97.22	$117.94	$34.64	$16.63	**$633.95**

Exhibit 2B
Mississippi Division of Medicaid
All Regions SFY 2026 MississippiCAN Capitation Rate Development
SFY 2026 PMPMs After the Removal of the MYPAC Rate Cell

MA Children Rate Cell

		Category of Service											
Calculation Step	**SFY 2026 PMPM Cost Development - MYPAC Rate Cell Removal**	**Inpatient Hospital - Maternity / Deliveries**	**Inpatient Hospital - Psychiatric / Substance Abuse**	**Inpatient Hospital - Other**	**Outpatient Hospital - Emergency Room**	**Outpatient Hospital - Pharmacy**	**Outpatient Hospital - Other**	**Physician - Maternity / Deliveries**	**Physician - Psychiatric / Substance Abuse**	**Physician - Other**	**Dental**	**Other**	**Total - Medical PMPM**
	Projected SFY 2026 Summaries												
a	SFY 2026 Projected Member Months	3,113,127	3,113,127	3,113,127	3,113,127	3,113,127	3,113,127	3,113,127	3,113,127	3,113,127	3,113,127	3,113,127	**3,113,127**
b	SFY 2026 PMPM Costs	$1.11	$12.19	$6.47	$11.24	$2.31	$29.15	$0.31	$14.08	$65.08	$28.84	$7.55	**$178.32**
c	SFY 2026 Projected MYPAC Member Months	5,714	5,714	5,714	5,714	5,714	5,714	5,714	5,714	5,714	5,714	5,714	**5,714**
d	SFY 2026 MYPAC PMPM Costs	$0.87	$467.27	$21.34	$23.92	$2.59	$41.68	$0.59	$1,490.61	$773.77	$40.93	$34.02	**$2,897.59**
e = a + c	**Final SFY 2026 Projected MMs**	3,118,841	3,118,841	3,118,841	3,118,841	3,118,841	3,118,841	3,118,841	3,118,841	3,118,841	3,118,841	3,118,841	**3,118,841**
f = (a × b + c × d) / (a + c)	**Final SFY 2026 Projected PMPM Costs**	$1.11	$13.03	$6.50	$11.26	$2.31	$29.17	$0.31	$16.78	$66.38	$28.86	$7.60	**$183.30**

Quasi-CHIP Rate Cell

		Category of Service											
Calculation Step	**SFY 2026 PMPM Cost Development - MYPAC Rate Cell Removal**	**Inpatient Hospital - Maternity / Deliveries**	**Inpatient Hospital - Psychiatric / Substance Abuse**	**Inpatient Hospital - Other**	**Outpatient Hospital - Emergency Room**	**Outpatient Hospital - Pharmacy**	**Outpatient Hospital - Other**	**Physician - Maternity / Deliveries**	**Physician - Psychiatric / Substance Abuse**	**Physician - Other**	**Dental**	**Other**	**Total - Medical PMPM**
	Projected SFY 2026 Summaries												
a	SFY 2026 Projected Member Months	378,699	378,699	378,699	378,699	378,699	378,699	378,699	378,699	378,699	378,699	378,699	**378,699**
b	SFY 2026 PMPM Costs	$0.99	$13.28	$5.92	$8.26	$3.57	$23.68	$0.26	$15.62	$57.86	$37.62	$8.07	**$175.14**
c	SFY 2026 Projected MYPAC Member Months	586	586	586	586	586	586	586	586	586	586	586	**586**
d	SFY 2026 MYPAC PMPM Costs	$0.00	$243.73	$4.07	$22.84	$1.55	$61.49	$0.00	$1,595.27	$820.27	$42.76	$20.35	**$2,812.34**
e = a + c	**Final SFY 2026 Projected MMs**	379,285	379,285	379,285	379,285	379,285	379,285	379,285	379,285	379,285	379,285	379,285	**379,285**
f = (a × b + c × d) / (a + c)	**Final SFY 2026 Projected PMPM Costs**	$0.98	$13.63	$5.92	$8.28	$3.57	$23.74	$0.26	$18.07	$59.04	$37.63	$8.09	**$179.21**

Exhibit 3
Mississippi Division of Medicaid
SFY 2026 MississippiCAN Capitation Rate Development
Statewide Non-Service Expense Allocation Development

Rate Cell	*a* Projected SFY 2026 Membership	*b* SFY 2026 PMPM Cost	*c* Fixed Non-Service Expense Load	*d* Non-Service Percentage	*e = d × j* Non-Service PMPM	*f* Margin Percentage	*g = f × j* Margin PMPM	*h* Premium Tax Percentage	*i = h × j* Premium Tax PMPM	*j = (b + c) / (1 - d - f - h)* Total
Non-Newborn SSI / Disabled	740,802	$764.97	$10.38	6.21%	$54.10	1.80%	$15.68	3.00%	$26.14	$871.27
Breast and Cervical Cancer	598	$3,966.05	$10.38	6.21%	$277.45	1.80%	$80.43	3.00%	$134.05	$4,468.36
MA Adult	603,476	$323.93	$10.38	6.21%	$23.33	1.80%	$6.76	3.00%	$11.27	$375.66
Pregnant Women	221,974	$571.72	$10.38	6.21%	$40.62	1.80%	$11.77	3.00%	$19.62	$654.11
SSI / Disabled Newborn	5,867	$6,299.56	$10.38	6.21%	$440.27	1.80%	$127.63	3.00%	$212.72	$7,090.56
Non-SSI Newborns 0 to 2 Months	73,493	$2,109.67	$10.38	6.21%	$147.93	1.80%	$42.88	3.00%	$71.47	$2,382.32
Non-SSI Newborns 3 to 12 Months	232,659	$248.95	$10.38	6.21%	$18.09	1.80%	$5.25	3.00%	$8.74	$291.40
Foster Care	97,653	$633.95	$10.38	6.21%	$44.96	1.80%	$13.03	3.00%	$21.72	$724.03
MA Children	3,118,841	$183.30	$10.38	6.21%	$13.51	1.80%	$3.92	3.00%	$6.53	$217.63
Quasi-CHIP	379,285	$179.21	$10.38	6.21%	$13.23	1.80%	$3.83	3.00%	$6.39	$213.05
Total	**5,474,647**	**$336.63**	**$10.38**	**6.21%**	**$24.21**	**1.80%**	**$7.02**	**3.00%**	**$11.70**	**$389.94**

Exhibit 4
Mississippi Division of Medicaid
SFY 2026 MississippiCAN Capitation Rate Development
Final SFY 2026 Capitation Rates

Rate Cell	*a* SFY 2026 Statewide Capitation Rates	*b = a × -2.00%* Quality Withhold	*c = a + b* Total Rate at 1.0 Risk Score after Withhold	*d* Projected SFY 2026 Member Months
Non-Newborn SSI / Disabled	$871.27	($17.43)	$853.85	740,802
Breast and Cervical Cancer	$4,468.36	($89.37)	$4,379.00	598
MA Adult	$375.66	($7.51)	$368.15	603,476
Pregnant Women	$654.11	($13.08)	$641.02	221,974
SSI / Disabled Newborn	$7,090.56	($141.81)	$6,948.75	5,867
Non-SSI Newborns 0 to 2 Months	$2,382.32	($47.65)	$2,334.68	73,493
Non-SSI Newborns 3 to 12 Months	$291.40	($5.83)	$285.58	232,659
Foster Care	$724.03	($14.48)	$709.55	97,653
MA Children	$217.63	($4.35)	$213.28	3,118,841
Quasi-CHIP	$213.05	($4.26)	$208.78	379,285

Exhibit 5
Mississippi Division of Medicaid
SFY 2025 to SFY 2026 Rate Change[1]

	Non-Newborn SSI / Disabled	Breast and Cervical Cancer	MA Adult	Pregnant Women	SSI / Disabled Newborn	Non-SSI Newborns 0 to 2 Months	Non-SSI Newborns 3 to 12 Months	Foster Care	MYPAC	MA Children	Quasi-CHIP	Total - Aggregated with Projected SFY 2026 MMs
Membership												
Actual CY 2023 MMs - Prior to MYPAC Removal	719,929	1,038	501,768	108,557	5,313	67,416	232,841	88,226	11,130	2,754,615	298,064	N/A
Actual CY 2023 MMs - After MYPAC Removal	722,734	1,038	501,769	108,557	5,313	67,416	232,841	90,607	0	2,760,005	298,617	N/A
Projected SFY 2026 MMs - Prior to MYPAC Removal	737,828	598	603,476	221,974	5,867	73,493	232,659	95,128	11,798	3,113,127	378,699	5,474,647
Projected SFY 2026 MMs - After MYPAC Removal	740,802	598	603,476	221,974	5,867	73,493	232,659	97,653	0	3,118,841	379,285	5,474,647
SFY 2025 Capitation Rate	**$864.45**	**$3,178.14**	**$365.03**	**$625.28**	**$6,667.81**	**$2,326.74**	**$307.41**	**$623.97**	**$3,375.85**	**$206.34**	**$202.58**	**$383.35**
Base Period Data Update	0.997	0.996	0.991	0.964	1.044	0.979	0.998	0.990	0.958	1.024	1.016	1.002
SFY 2026 Cell / Gene Therapy Coverage[2]	0.975	1.000	1.000	1.000	1.000	1.030	0.933	1.000	1.000	0.987	1.000	0.989
SFY 2026 Postpartum Coverage Extension[2]	1.000	1.000	1.000	1.051	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.003
Other Assumptions	0.995	0.997	0.995	1.000	1.000	1.000	0.999	0.999	1.000	0.998	0.998	0.998
Restate CY 2023 to SFY 2025 Trends	0.981	1.182	1.006	1.005	0.998	0.999	0.993	0.997	0.999	0.994	0.994	0.993
SFY 2025 to SFY 2026 Utilization Trends	1.028	1.089	1.020	1.015	1.012	1.010	1.017	1.025	1.007	1.023	1.024	1.022
SFY 2025 to SFY 2026 Unit Cost Trends	1.017	1.077	1.011	1.006	1.002	1.003	1.008	1.029	1.032	1.013	1.013	1.013
SFY 2026 Population Acuity Adjustment[3]	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	0.983	0.978	0.994
SFY 2026 MYPAC Removal[2]	1.012	1.000	1.000	1.000	1.000	1.000	1.000	1.103	0.000	1.025	1.021	1.000
Update SFY 2026 Admin	1.003	1.021	1.005	1.006	1.006	1.004	1.000	1.012	0.000	1.008	1.008	1.005
Preliminary SFY 2026 Rate Change	**1.008**	**1.406**	**1.029**	**1.046**	**1.063**	**1.024**	**0.948**	**1.160**	**0.000**	**1.055**	**1.052**	**1.017**
SFY 2026 Rate Change - Excluding Program Changes[2]	**1.021**	**1.406**	**1.029**	**0.995**	**1.063**	**0.994**	**1.015**	**1.052**	**0.000**	**1.042**	**1.030**	**1.025**
SFY 2026 Rate Change - Excluding COVID-19 Adjustments[3]	**1.008**	**1.406**	**1.029**	**1.046**	**1.063**	**1.024**	**0.948**	**1.160**	**0.000**	**1.073**	**1.075**	**1.024**

[1] Rate changes exclude directed payments, the quality withhold, and the VBP.
[2] Program change that increases or decreases total program costs outside of the control of the CCOs.
[3] COVID-19 adjustments include the population acuity adjustment.

Exhibit 6
Mississippi Division of Medicaid
SFY 2026 MississippiCAN Capitation Rate Development
Service Category to Milliman *HCGs* Grouper Category Mapping

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

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

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

PMPM Costs by Month[1]

Month	Member Months	Inpatient Hospital Services	Outpatient Hospital Services	Physician Services	Dental Services	Other Services	Non-Pharmacy Total
January 2021	478,618	$75.97	$57.00	$94.14	$15.63	$14.80	$257.55
February 2021	481,326	$70.04	$50.42	$83.65	$13.55	$12.70	$230.36
March 2021	483,763	$80.52	$65.34	$103.54	$18.51	$15.67	$283.58
April 2021	483,831	$74.29	$65.84	$103.29	$16.66	$15.00	$275.07
May 2021	486,505	$81.67	$66.28	$97.40	$14.24	$14.93	$274.52
June 2021	488,764	$81.86	$71.49	$101.02	$16.04	$15.69	$286.11
July 2021	473,300	$84.61	$69.67	$101.34	$16.39	$15.66	$287.68
August 2021	452,472	$87.74	$66.97	$119.23	$16.06	$15.88	$305.89
September 2021	439,660	$78.62	$65.95	$111.23	$17.31	$15.20	$288.32
October 2021	428,718	$74.68	$66.57	$105.86	$16.84	$15.70	$279.66
November 2021	419,121	$72.18	$64.22	$105.30	$17.47	$14.39	$273.55
December 2021	412,166	$70.48	$65.24	$100.44	$15.27	$14.15	$265.58
CY 2021[4]	**460,687**	**$77.72**	**$64.58**	**$102.20**	**$16.16**	**$14.98**	**$275.66**
January 2022	403,956	$78.31	$64.69	$114.23	$15.64	$13.61	$286.48
February 2022	396,167	$69.71	$59.83	$100.40	$16.22	$13.22	$259.38
March 2022	388,946	$74.01	$68.87	$108.72	$18.26	$14.94	$284.79
April 2022	376,626	$74.04	$65.22	$102.92	$16.72	$14.18	$273.10
May 2022	371,248	$80.84	$68.16	$108.47	$16.10	$14.81	$288.38
June 2022	365,996	$80.68	$70.76	$102.22	$17.80	$14.86	$286.32
July 2022	365,944	$77.68	$82.81	$99.74	$17.85	$14.27	$292.35
August 2022	361,677	$77.35	$77.46	$127.84	$20.07	$15.85	$318.57
September 2022	362,934	$72.81	$69.24	$115.11	$19.04	$14.84	$291.03
October 2022	366,518	$73.36	$71.03	$117.48	$19.27	$14.57	$295.70
November 2022	369,617	$72.27	$71.43	$119.54	$17.69	$14.04	$294.97
December 2022	384,909	$70.26	$63.16	$97.71	$15.43	$13.60	$260.16
CY 2022	**376,212**	**$75.11**	**$69.39**	**$109.53**	**$17.51**	**$14.40**	**$285.94**
January 2023	388,151	$73.91	$66.22	$115.90	$20.08	$14.63	$290.73
February 2023	391,727	$67.78	$63.52	$107.28	$18.08	$13.13	$269.79
March 2023	394,289	$72.44	$71.24	$116.90	$20.38	$14.81	$295.76
April 2023	398,292	$72.51	$66.64	$108.04	$17.55	$14.06	$278.80
May 2023	400,882	$81.27	$69.79	$114.97	$18.63	$15.03	$299.69
June 2023	403,521	$74.39	$70.62	$102.20	$19.00	$15.30	$281.50
July 2023	395,045	$73.90	$68.17	$99.35	$19.24	$15.31	$275.96
August 2023	395,115	$76.08	$77.54	$128.52	$22.87	$17.19	$322.20
September 2023	396,006	$71.85	$68.14	$112.24	$19.62	$15.57	$287.42
October 2023	397,178	$78.18	$72.66	$119.36	$22.26	$16.15	$308.61
November 2023	404,776	$71.59	$75.32	$133.44	$21.36	$14.89	$316.61
December 2023	412,854	$73.45	$71.06	$117.59	$16.67	$14.33	$293.09
CY 2023[3]	**398,153**	**$73.94**	**$70.08**	**$114.65**	**$19.64**	**$15.03**	**$293.35**
January 2024	420,621	$80.40	$69.62	$110.46	$20.58	$14.16	$295.22
February 2024	429,879	$71.38	$72.06	$120.26	$22.34	$13.59	$299.64
March 2024	429,905	$83.40	$70.53	$116.02	$20.07	$14.06	$304.08
April 2024	428,664	$74.64	$73.36	$122.02	$22.11	$15.43	$307.56
May 2024	431,075	$84.33	$77.06	$120.35	$20.01	$15.54	$317.28
June 2024	434,900	$77.55	$70.34	$99.86	$19.49	$14.47	$281.73
Q1-Q2 2024[3]	**429,174**	**$78.62**	**$72.16**	**$114.83**	**$20.77**	**$14.54**	**$300.92**

Annual PMPM Trends

CY 2021 to CY 2022	-3.4%	7.4%	7.2%	8.3%	-3.9%	3.7%
CY 2022 to CY 2023	-1.6%	1.0%	4.7%	12.2%	4.4%	2.6%
CY 2023 to YTD 2024	6.3%	3.0%	0.2%	5.7%	-3.3%	2.6%
CY 2021 to YTD 2024 (Annualized)	0.4%	4.1%	4.3%	9.5%	-1.1%	3.2%

[1] MississippiCAN PMPM figures have been adjusted for: the carveout of Zolgensma claims, adjustments related to the 5% assessment application and removal, financial to encounter adjustments, dental reimbursement, and IBNR, and blend MississippiCAN rate cells using consistent enrollment from June 2024 to be directly comparable by month.

[2] CY 2022 is assumed to be fully complete with no explicit IBNR adjustment.

[3] CY 2021, CY 2023, and YTD 2024 IBNR as reported by CCOs in financial templates.

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

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

PMPM Costs by Month[1]

Month	Member Months	Inpatient Hospital Services	Outpatient Hospital Services	Physician Services	Dental Services	Other Services	Non-Pharmacy Total
January 2021	63,329	$163.91	$174.85	$192.55	$7.92	$67.66	$606.90
February 2021	63,319	$164.62	$159.65	$172.16	$6.84	$57.24	$560.50
March 2021	62,918	$191.48	$201.02	$223.62	$9.05	$69.64	$694.82
April 2021	62,480	$167.43	$200.18	$210.59	$8.53	$67.09	$653.82
May 2021	62,352	$190.47	$202.28	$202.87	$8.56	$66.38	$670.56
June 2021	62,201	$176.05	$219.00	$213.78	$8.70	$69.36	$686.89
July 2021	62,317	$211.11	$208.22	$202.92	$7.73	$68.84	$698.82
August 2021	62,105	$200.87	$188.56	$211.39	$8.57	$70.07	$679.45
September 2021	61,811	$185.05	$195.53	$212.47	$9.22	$67.46	$669.72
October 2021	61,544	$163.29	$196.18	$209.64	$8.68	$69.10	$646.88
November 2021	61,417	$164.13	$191.96	$199.82	$8.73	$63.20	$627.84
December 2021	61,244	$156.74	$185.47	$187.52	$7.33	$61.66	$598.72
CY 2021[4]	**62,253**	**$177.93**	**$193.57**	**$203.28**	**$8.32**	**$66.47**	**$649.58**
January 2022	61,147	$178.98	$189.40	$213.14	$7.45	$58.39	$647.35
February 2022	60,968	$163.81	$183.81	$201.24	$8.37	$56.05	$613.27
March 2022	60,669	$163.77	$215.03	$224.08	$9.04	$62.58	$674.50
April 2022	60,165	$155.28	$198.13	$207.90	$8.03	$59.57	$628.92
May 2022	60,131	$171.12	$204.61	$217.74	$8.45	$61.89	$663.82
June 2022	60,026	$158.02	$214.22	$215.91	$8.77	$62.84	$659.76
July 2022	60,241	$166.24	$250.52	$202.94	$8.14	$59.78	$687.62
August 2022	60,080	$162.49	$228.94	$246.10	$9.96	$66.73	$714.22
September 2022	60,129	$158.25	$194.98	$222.58	$9.86	$62.77	$648.45
October 2022	60,249	$168.92	$200.73	$227.83	$10.86	$61.33	$669.66
November 2022	60,145	$163.59	$200.15	$221.15	$9.20	$61.48	$655.58
December 2022	60,807	$148.74	$181.68	$191.23	$7.60	$61.08	$590.33
CY 2022	**60,396**	**$163.27**	**$205.18**	**$215.99**	**$8.81**	**$61.21**	**$654.46**
January 2023	60,231	$170.47	$191.04	$234.09	$9.88	$63.06	$668.55
February 2023	60,804	$155.46	$187.56	$214.20	$8.68	$58.80	$624.69
March 2023	60,487	$157.04	$206.23	$240.32	$11.02	$63.60	$678.22
April 2023	60,463	$171.21	$195.31	$219.16	$8.83	$61.86	$656.37
May 2023	60,376	$170.66	$207.60	$246.77	$9.85	$65.47	$700.34
June 2023	60,245	$179.39	$212.18	$224.17	$9.44	$67.87	$693.05
July 2023	60,014	$167.80	$210.00	$217.94	$9.41	$65.73	$670.89
August 2023	59,970	$160.91	$229.02	$251.44	$12.71	$75.36	$729.44
September 2023	59,828	$139.15	$190.19	$222.26	$10.57	$66.12	$628.29
October 2023	59,600	$166.14	$208.83	$240.62	$12.05	$68.86	$696.51
November 2023	59,560	$155.43	$210.44	$232.16	$11.34	$64.73	$674.10
December 2023	59,449	$159.65	$189.35	$210.47	$8.64	$62.44	$630.54
CY 2023[3]	**60,086**	**$162.78**	**$203.15**	**$229.47**	**$10.20**	**$65.32**	**$670.92**
January 2024	59,577	$186.06	$205.69	$232.19	$9.61	$64.64	$698.19
February 2024	59,533	$168.23	$219.18	$245.88	$12.03	$59.37	$704.70
March 2024	59,305	$181.96	$205.43	$236.10	$10.13	$61.80	$695.43
April 2024	59,318	$164.70	$217.33	$251.50	$11.13	$68.15	$712.81
May 2024	59,242	$178.82	$210.54	$246.15	$10.54	$71.07	$717.13
June 2024	59,137	$166.55	$207.04	$223.70	$10.03	$66.19	$673.51
Q1-Q2 2024[3]	**59,352**	**$174.39**	**$210.87**	**$239.26**	**$10.58**	**$65.20**	**$700.30**

Annual PMPM Trends

CY 2021 to CY 2022	-8.2%	6.0%	6.3%	5.9%	-7.9%	0.8%
CY 2022 to CY 2023	-0.3%	-1.0%	6.2%	15.8%	6.7%	2.5%
CY 2023 to YTD 2024	7.1%	3.8%	4.3%	3.7%	-0.2%	4.4%
CY 2021 to YTD 2024 (Annualized)	-0.7%	3.2%	6.1%	9.1%	-0.7%	2.8%

[1] MississippiCAN PMPM figures have been adjusted for: the carveout of Zolgensma claims, adjustments related to the 5% assessment application and removal, financial to encounter adjustments, dental reimbursement, and IBNR, and blend MississippiCAN rate cells using consistent enrollment from June 2024 to be directly comparable by month.
[2] CY 2022 is assumed to be fully complete with no explicit IBNR adjustment.
[3] CY 2021, CY 2023, and YTD 2024 IBNR as reported by CCOs in financial templates.
[4] CY 2021 data is consistent with the data that supported trends in SFY 2024 rates. We rely on this data due to known issues with the data vendor transition.

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

PMPM Costs by Month[1]

Month	Member Months	Inpatient Hospital Services	Outpatient Hospital Services	Physician Services	Dental Services	Other Services	Non-Pharmacy Total
January 2021	59,089	$38.49	$92.60	$128.99	$5.12	$11.62	$276.82
February 2021	59,414	$26.76	$80.50	$111.54	$4.46	$9.42	$232.69
March 2021	59,864	$33.44	$101.41	$138.94	$5.41	$11.35	$290.55
April 2021	60,010	$31.28	$100.63	$135.64	$6.03	$10.44	$284.01
May 2021	60,641	$36.56	$97.84	$127.26	$4.59	$10.64	$276.90
June 2021	61,139	$40.55	$102.50	$138.94	$5.01	$11.18	$298.18
July 2021	59,248	$46.73	$97.87	$133.00	$3.99	$11.03	$292.61
August 2021	56,422	$64.35	$98.33	$147.00	$4.37	$12.19	$326.23
September 2021	55,101	$46.57	$99.03	$142.33	$4.63	$11.48	$304.05
October 2021	53,607	$37.90	$98.75	$130.47	$4.23	$11.41	$282.75
November 2021	52,343	$42.23	$90.23	$131.19	$4.25	$10.98	$278.88
December 2021	51,472	$40.02	$98.53	$131.05	$3.93	$11.49	$285.02
CY 2021[4]	**57,363**	**$40.41**	**$96.52**	**$133.03**	**$4.67**	**$11.10**	**$285.72**
January 2022	50,074	$40.98	$96.49	$141.09	$4.22	$11.56	$294.35
February 2022	48,791	$32.12	$82.48	$122.98	$4.52	$10.41	$252.52
March 2022	47,904	$35.14	$98.13	$138.59	$4.58	$11.96	$288.41
April 2022	45,719	$32.03	$96.14	$129.66	$4.59	$11.41	$273.82
May 2022	45,110	$37.69	$102.55	$133.07	$4.62	$11.84	$289.76
June 2022	44,288	$35.11	$100.52	$140.57	$4.38	$12.77	$293.36
July 2022	44,587	$29.46	$119.48	$132.75	$3.76	$10.55	$296.00
August 2022	43,943	$35.18	$113.96	$154.66	$4.63	$12.06	$320.49
September 2022	44,153	$32.80	$98.63	$134.93	$4.89	$11.33	$282.59
October 2022	44,600	$30.77	$92.31	$130.20	$4.49	$11.14	$268.91
November 2022	43,762	$32.28	$96.27	$134.44	$4.57	$11.75	$279.31
December 2022	47,246	$32.61	$86.58	$119.82	$3.36	$10.01	$252.38
CY 2022	**45,848**	**$33.85**	**$98.63**	**$134.40**	**$4.38**	**$11.40**	**$282.66**
January 2023	47,601	$39.93	$94.98	$140.41	$5.29	$10.92	$291.53
February 2023	47,826	$26.91	$89.67	$125.30	$4.45	$8.73	$255.06
March 2023	48,183	$28.29	$101.61	$139.70	$5.51	$10.47	$285.58
April 2023	49,234	$31.84	$90.53	$129.63	$4.26	$10.07	$266.32
May 2023	49,610	$39.61	$98.45	$140.13	$4.50	$11.20	$293.89
June 2023	49,900	$32.38	$95.76	$133.92	$4.38	$11.71	$278.15
July 2023	48,666	$29.27	$93.84	$126.53	$4.05	$11.18	$264.86
August 2023	49,224	$29.26	$106.88	$146.29	$5.81	$12.21	$300.46
September 2023	50,810	$33.69	$93.75	$122.79	$4.85	$11.31	$266.38
October 2023	52,816	$34.27	$94.71	$127.59	$5.03	$12.34	$273.93
November 2023	56,306	$24.27	$94.32	$121.43	$5.08	$9.70	$254.80
December 2023	60,158	$27.47	$93.86	$110.21	$4.09	$9.74	$245.37
CY 2023[3]	**50,861**	**$31.43**	**$95.70**	**$130.33**	**$4.78**	**$10.80**	**$273.03**
January 2024	63,204	$35.53	$95.02	$118.29	$4.85	$9.93	$263.62
February 2024	66,551	$29.46	$91.43	$116.05	$5.15	$9.43	$251.52
March 2024	68,185	$27.98	$93.97	$113.38	$4.63	$9.66	$249.62
April 2024	69,329	$32.16	$96.43	$120.73	$5.95	$11.32	$266.60
May 2024	71,033	$31.91	$94.13	$118.80	$5.18	$10.37	$260.40
June 2024	72,812	$33.86	$92.64	$109.15	$4.60	$10.42	$250.68
Q1-Q2 2024[3]	**68,519**	**$31.82**	**$93.94**	**$116.07**	**$5.06**	**$10.19**	**$257.07**

Annual PMPM Trends

CY 2021 to CY 2022	-16.2%	2.2%	1.0%	-6.1%	2.7%	-1.1%
CY 2022 to CY 2023	-7.1%	-3.0%	-3.0%	8.9%	-5.3%	-3.4%
CY 2023 to YTD 2024	1.2%	-1.8%	-10.9%	6.0%	-5.6%	-5.8%
CY 2021 to YTD 2024 (Annualized)	-8.3%	-1.0%	-4.8%	3.0%	-3.1%	-3.8%

[1] MississippiCAN PMPM figures have been adjusted for: the carveout of Zolgensma claims, adjustments related to the 5% assessment application and removal, financial to encounter adjustments, dental reimbursement, and IBNR, and blend MississippiCAN rate cells using consistent enrollment from June 2024 to be directly comparable by month.

[2] CY 2022 is assumed to be fully complete with no explicit IBNR adjustment.

[3] CY 2021, CY 2023, and YTD 2024 IBNR as reported by CCOs in financial templates.

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

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

PMPM Costs by Month[1]

Month	Member Months	Inpatient Hospital Services	Outpatient Hospital Services	Physician Services	Dental Services	Other Services	Non-Pharmacy Total
January 2021	356,200	$52.60	$25.40	$62.47	$19.66	$5.18	$165.31
February 2021	358,593	$46.53	$21.84	$55.73	$17.05	$4.74	$145.88
March 2021	360,981	$55.14	$30.15	$67.70	$23.50	$6.11	$182.60
April 2021	361,341	$50.94	$31.21	$70.52	$20.80	$5.87	$179.34
May 2021	363,512	$56.26	$32.11	$65.72	$17.66	$5.86	$177.60
June 2021	365,424	$58.16	$35.20	$65.95	$20.13	$6.22	$185.65
July 2021	351,735	$53.33	$35.81	$69.93	$21.07	$6.35	$186.49
August 2021	333,945	$54.99	$35.65	$90.61	$20.33	$6.12	$207.71
September 2021	322,748	$49.75	$32.68	$79.91	$21.94	$5.85	$190.13
October 2021	313,567	$50.74	$33.52	$75.78	$21.47	$6.27	$187.77
November 2021	305,361	$46.01	$32.99	$76.69	$22.35	$5.62	$183.67
December 2021	299,450	$45.51	$33.73	$72.19	$19.54	$5.46	$176.44
CY 2021[4]	**341,071**	**$51.66**	**$31.69**	**$71.10**	**$20.46**	**$5.80**	**$180.72**
January 2022	292,735	$52.70	$32.67	$84.62	$19.99	$5.31	$195.29
February 2022	286,408	$45.43	$30.16	$71.42	$20.56	$5.47	$173.04
March 2022	280,373	$51.27	$33.28	$75.09	$23.34	$6.30	$189.27
April 2022	270,742	$53.88	$31.81	$72.04	$21.34	$5.93	$185.00
May 2022	266,007	$58.93	$33.20	$77.38	$20.36	$6.28	$196.16
June 2022	261,682	$61.57	$35.58	$66.85	$22.79	$5.94	$192.73
July 2022	261,116	$56.84	$41.21	$67.70	$23.13	$6.22	$195.10
August 2022	257,654	$56.03	$39.10	$94.31	$25.75	$6.77	$221.95
September 2022	258,652	$51.40	$37.61	$85.46	$24.23	$6.27	$204.97
October 2022	261,669	$50.85	$40.56	$89.19	$24.46	$6.19	$211.26
November 2022	265,710	$49.78	$40.30	$92.39	$22.50	$5.27	$210.24
December 2022	276,856	$49.72	$34.36	$70.37	$19.86	$5.13	$179.45
CY 2022	**269,967**	**$53.20**	**$35.82**	**$78.90**	**$22.36**	**$5.92**	**$196.20**
January 2023	280,319	$48.98	$34.91	$83.13	$25.62	$5.99	$198.62
February 2023	283,097	$46.26	$33.00	$78.13	$23.19	$5.23	$185.81
March 2023	285,619	$52.26	$37.55	$83.36	$25.78	$6.29	$205.24
April 2023	288,595	$48.86	$35.76	$77.17	$22.44	$5.62	$189.85
May 2023	290,896	$59.70	$35.97	$79.29	$23.74	$6.07	$204.77
June 2023	293,376	$49.62	$36.90	$66.82	$24.38	$5.84	$183.57
July 2023	286,365	$51.04	$34.27	$65.82	$24.80	$6.38	$182.31
August 2023	285,921	$55.46	$40.89	$96.16	$28.95	$6.96	$228.41
September 2023	285,368	$52.59	$38.08	$84.23	$24.94	$6.66	$206.50
October 2023	284,762	$56.34	$40.75	$89.87	$28.39	$6.73	$222.09
November 2023	288,910	$50.74	$44.32	$112.78	$27.23	$6.33	$241.39
December 2023	293,247	$52.82	$42.45	$97.03	$21.26	$5.95	$219.49
CY 2023[3]	**287,206**	**$52.06**	**$37.90**	**$84.48**	**$25.06**	**$6.17**	**$205.67**
January 2024	297,840	$55.94	$36.90	$80.90	$26.50	$5.23	$205.48
February 2024	303,795	$48.06	$38.65	$92.82	$28.48	$5.58	$213.60
March 2024	302,415	$61.81	$38.51	$89.11	$25.72	$5.71	$220.85
April 2024	300,017	$51.19	$39.64	$93.07	$28.14	$6.08	$218.12
May 2024	300,800	$61.84	$46.85	$92.06	$25.42	$5.87	$232.04
June 2024	302,951	$55.01	$38.27	$69.50	$24.92	$5.28	$192.98
Q1-Q2 2024[3]	**301,303**	**$55.64**	**$39.80**	**$86.24**	**$26.53**	**$5.63**	**$213.85**

Annual PMPM Trends

CY 2021 to CY 2022	3.0%	13.0%	11.0%	9.3%	2.1%	8.6%
CY 2022 to CY 2023	-2.2%	5.8%	7.1%	12.1%	4.2%	4.8%
CY 2023 to YTD 2024	6.9%	5.0%	2.1%	5.9%	-8.8%	4.0%
CY 2021 to YTD 2024 (Annualized)	2.7%	8.6%	7.3%	9.9%	-1.1%	6.3%

[1] MississippiCAN PMPM figures have been adjusted for: the carveout of Zolgensma claims, adjustments related to the 5% assessment application and removal, financial to encounter adjustments, dental reimbursement, and IBNR, and blend MississippiCAN rate cells using consistent enrollment from June 2024 to be directly comparable by month.
[2] CY 2022 is assumed to be fully complete with no explicit IBNR adjustment.
[3] CY 2021, CY 2023, and YTD 2024 IBNR as reported by CCOs in financial templates.
[4] CY 2021 data is consistent with the data that supported trends in SFY 2024 rates. We rely on this data due to known issues with the data vendor transition.

Exhibit 7E
Mississippi Division of Medicaid
MississippiCAN Historical Completed Non-Pharmacy PMPM Costs and Trends
Deliveries

Per-Delivery Costs by Month[1]

Month	Deliveries	Inpatient Hospital Services	Outpatient Hospital Services	Physician Services	Dental Services	Other Services	Non-Pharmacy Total
January 2021	1,407	$4,269.88	$12.37	$1,149.08	$0.00	$17.68	$5,449.00
February 2021	1,314	$4,338.51	$7.37	$1,105.84	$0.04	$15.96	$5,467.73
March 2021	1,459	$4,219.80	$9.95	$1,093.70	$0.00	$19.23	$5,342.69
April 2021	1,218	$4,353.13	$10.97	$1,139.38	$0.00	$15.08	$5,518.56
May 2021	1,331	$4,216.00	$10.05	$1,101.03	$0.00	$19.13	$5,346.21
June 2021	1,424	$4,281.00	$12.71	$1,107.79	$0.00	$23.12	$5,424.63
July 2021	1,356	$4,403.17	$9.99	$1,115.62	$0.00	$13.70	$5,542.48
August 2021	1,480	$4,574.54	$11.38	$1,112.47	$0.00	$20.46	$5,718.86
September 2021	1,398	$4,436.80	$7.97	$1,147.27	$0.00	$13.67	$5,605.71
October 2021	1,354	$4,347.47	$6.05	$1,100.21	$0.08	$11.60	$5,465.42
November 2021	1,193	$4,330.23	$11.26	$1,102.57	$0.04	$17.15	$5,461.26
December 2021	1,258	$4,335.88	$11.09	$1,093.18	$0.00	$17.63	$5,457.78
CY 2021[3,4]	**1,349**	**$4,342.20**	**$10.10**	**$1,114.01**	**$0.01**	**$17.04**	**$5,483.36**
January 2022	1,226	$4,191.65	$10.14	$1,079.96	$0.00	$14.27	$5,296.02
February 2022	1,079	$4,199.42	$8.48	$1,086.80	$0.00	$16.55	$5,311.25
March 2022	1,168	$4,090.38	$5.02	$1,105.44	$0.00	$14.74	$5,215.58
April 2022	991	$4,044.87	$10.32	$1,112.78	$0.07	$17.01	$5,185.05
May 2022	1,041	$4,113.16	$15.70	$1,080.26	$0.00	$13.87	$5,222.99
June 2022	1,106	$4,199.50	$8.67	$1,108.56	$0.00	$16.04	$5,332.78
July 2022	1,162	$4,250.68	$14.58	$1,111.91	$0.00	$18.23	$5,395.40
August 2022	1,325	$4,166.66	$6.62	$1,122.99	$0.00	$16.40	$5,312.68
September 2022	1,137	$4,026.81	$4.37	$1,097.41	$0.00	$14.43	$5,143.03
October 2022	1,026	$3,958.36	$8.88	$1,034.56	$0.00	$21.83	$5,023.62
November 2022	1,074	$4,009.03	$9.41	$1,049.14	$0.00	$15.88	$5,083.45
December 2022	1,147	$4,007.44	$9.26	$1,056.54	$0.00	$18.33	$5,091.56
CY 2022[3]	**1,124**	**$4,104.83**	**$9.29**	**$1,087.19**	**$0.01**	**$16.47**	**$5,217.78**
January 2023	1,193	$3,999.19	$8.30	$1,070.95	$0.00	$21.23	$5,099.66
February 2023	946	$3,992.21	$5.96	$1,109.58	$0.00	$13.76	$5,121.52
March 2023	1,013	$4,007.80	$9.21	$1,113.51	$0.00	$11.86	$5,142.38
April 2023	876	$3,976.59	$7.85	$1,119.07	$0.00	$19.67	$5,123.19
May 2023	973	$3,966.63	$7.38	$1,098.23	$0.09	$11.53	$5,083.85
June 2023	1,007	$4,032.66	$11.61	$1,109.09	$0.00	$14.64	$5,168.00
July 2023	1,037	$4,282.81	$11.71	$1,081.36	$0.00	$21.85	$5,397.74
August 2023	1,127	$4,300.38	$9.46	$1,149.13	$0.00	$20.83	$5,479.81
September 2023	1,051	$4,296.16	$21.49	$1,122.02	$0.00	$17.37	$5,457.03
October 2023	1,050	$4,271.89	$7.16	$1,079.86	$0.00	$15.54	$5,374.44
November 2023	1,082	$4,454.11	$17.32	$1,201.89	$0.00	$22.54	$5,695.86
December 2023	1,051	$4,171.04	$11.29	$1,181.70	$0.00	$25.58	$5,389.62
CY 2023[3]	**1,034**	**$4,145.96**	**$10.73**	**$1,119.70**	**$0.01**	**$18.03**	**$5,294.42**
January 2024	1,147	$4,105.05	$14.85	$1,099.46	$0.00	$24.19	$5,243.55
February 2024	1,088	$4,069.19	$11.55	$1,102.03	$0.00	$21.26	$5,204.03
March 2024	1,013	$4,399.73	$16.26	$1,154.21	$0.00	$25.15	$5,595.35
April 2024	981	$4,517.09	$20.86	$1,118.11	$0.00	$10.47	$5,666.53
May 2024	977	$4,670.59	$15.10	$1,151.89	$0.00	$20.25	$5,857.84
June 2024	1,079	$4,400.61	$8.02	$1,110.24	$0.00	$19.53	$5,538.41
Q1-Q2 2024[3]	**1,048**	**$4,360.38**	**$14.44**	**$1,122.66**	**$0.00**	**$20.14**	**$5,517.62**

Annual PMPM Trends

CY 2021 to CY 2022	-5.5%	-8.0%	-2.4%	-55.9%	-3.3%	-4.8%
CY 2022 to CY 2023	1.0%	15.5%	3.0%	17.1%	9.5%	1.5%
CY 2023 to YTD 2024	5.2%	34.6%	0.3%	-100.0%	11.7%	4.2%
CY 2021 to YTD 2024 (Annualized)	0.2%	13.9%	0.3%	-100.0%	6.3%	0.2%

[1] MississippiCAN PMPM figures have been adjusted for: the carveout of Zolgensma claims, adjustments related to the 5% assessment application and removal, financial to encounter adjustments, dental reimbursement, and IBNR, and blend MississippiCAN rate cells using consistent enrollment from June 2024 to be directly comparable by month.
[2] CY 2022 is assumed to be fully complete with no explicit IBNR adjustment.
[3] CY 2021, CY 2023, and YTD 2024 IBNR as reported by CCOs in financial templates.
[4] CY 2021 data is consistent with the data that supported trends in SFY 2024 rates. We rely on this data due to known issues with the data vendor transition.

INTENTIONALLY BLANK FOR DRAFT RATES

Exhibit 9A
Mississippi Division of Medicaid
Summary of CY 2023 MississippiCAN Encounter Claims
Summary of Total Costs by Rate Cell

Member Months	719,929	1,038	501,768	108,557	5,313	67,416	232,841	88,226	11,130	2,754,615	298,064	4,788,897
							Total Allowed Cost					
Service Category	**Non-Newborn SSI / Disabled**	**Breast and Cervical Cancer**	**MA Adult**	**Pregnant Women**	**SSI / Disabled Newborn**	**Non-SSI Newborns 0 to 2 Months**	**Non-SSI Newborns 3 to 12 Months**	**Foster Care**	**MYPAC**	**MA Children**	**Quasi-CHIP**	**All MSCAN Rate Cells**
Inpatient Facility Services												
Medical	$36,506,078	$33,633	$4,416,983	$182,917	$1,221,391	$1,681,781	$2,834,409	$466,877	$129,363	$5,920,078	$689,252	$54,082,761
Surgical	$53,208,336	$108,633	$9,373,373	$346,219	$3,184,561	$4,630,240	$3,862,598	$268,903	$149,129	$11,064,147	$989,294	$87,185,432
Maternity / Deliveries	$1,852,389	$0	$13,785,202	$40,226,066	$15,952,712	$83,409,924	$615,039	$87,687	$21,910	$2,926,502	$281,161	$159,158,593
Psychiatric / Substance Abuse	$25,053,794	$0	$2,385,223	$169,548	$0	$0	$11,369	$22,102,736	$5,049,637	$29,756,359	$3,524,145	$88,052,809
Skilled Nursing Facility	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Missing Data	$115,682	$222	$32,253	$46,072	$6,340	$111,047	$11,929	$624	$990	$26,920	$2,975	$355,054
Inpatient Facility Total	**$116,736,279**	**$142,488**	**$29,993,034**	**$40,970,821**	**$20,365,004**	**$89,832,992**	**$7,335,344**	**$22,926,827**	**$5,351,029**	**$49,694,005**	**$5,486,827**	**$388,834,649**
Outpatient Facility Services												
Emergency Room	$22,810,057	$29,724	$12,607,670	$3,169,749	$333,740	$1,680,223	$5,973,777	$737,774	$258,808	$27,249,964	$2,169,899	$77,021,386
Urgent Care	$181	$0	$181	$0	$0	$147	$1,206	$0	$0	$2,657	$446	$4,818
Radiology / Pathology	$22,578,612	$354,313	$10,298,304	$2,574,492	$211,249	$818,981	$3,275,581	$673,083	$178,071	$17,737,672	$1,728,722	$60,429,082
Psychiatric / Alcohol & Drug Abuse	$4,101,433	$0	$312,219	$11,166	$0	$0	$0	$1,090,673	$60,427	$8,724,954	$543,249	$14,844,121
Pharmacy	$37,320,495	$855,635	$6,815,641	$1,010,672	$188,844	$160,894	$569,299	$272,536	$69,801	$5,414,975	$912,645	$53,591,435
Other	$57,752,540	$289,362	$18,356,745	$3,218,246	$739,327	$1,228,088	$4,340,511	$1,707,976	$204,315	$38,930,964	$3,504,033	$130,272,107
Missing Data	$205,561	$3,488	$66,590	$13,242	$1,038	$19,441	$16,574	$2,425	$2,018	$130,488	$13,072	$473,938
Outpatient Facility Total	**$144,768,880**	**$1,532,522**	**$48,457,349**	**$9,997,568**	**$1,474,198**	**$3,907,775**	**$14,176,948**	**$4,484,468**	**$773,440**	**$98,191,675**	**$8,872,065**	**$336,636,888**
Physician Services												
IP Visits	$10,684,550	$18,049	$1,697,515	$546,640	$6,188,311	$11,470,628	$2,254,683	$154,912	$33,207	$2,026,066	$164,933	$35,239,494
IP Surgery	$3,640,343	$11,275	$929,494	$113,699	$356,742	$352,475	$325,285	$40,601	$15,199	$1,080,366	$124,115	$6,989,594
Office / Home Visits	$35,548,339	$97,658	$17,967,812	$1,476,342	$414,446	$3,054,257	$10,200,677	$2,885,129	$493,558	$69,584,175	$7,277,520	$148,999,913
Preventive Exams & Immunizations	$5,100,694	$18,376	$7,365,386	$9,125,449	$171,203	$7,381,620	$8,830,525	$767,060	$124,985	$20,153,618	$1,500,902	$60,539,819
Urgent Care Visits	$498,558	$526	$717,345	$90,182	$2,193	$2,050	$191,767	$122,192	$20,631	$3,600,356	$388,351	$5,634,151
ER Visits and Observation Care	$6,795,330	$8,271	$3,802,361	$917,362	$90,510	$477,325	$1,799,740	$237,199	$89,528	$9,029,668	$703,373	$23,950,667
OP Surgery	$10,240,271	$71,327	$5,156,798	$297,236	$82,330	$187,290	$918,386	$449,655	$48,800	$10,877,049	$1,120,917	$29,450,060
Physical Therapy	$9,746,177	$12,050	$1,184,312	$46,101	$195,516	$9,609	$484,522	$952,286	$56,331	$11,022,416	$904,036	$24,613,355
Psychiatric / Substance Abuse	$35,223,691	$8,128	$4,953,048	$328,909	$4,589	$6,071	$6,386	$5,318,576	$16,106,481	$33,803,552	$4,106,216	$99,865,647
Radiology / Pathology	$11,859,820	$136,189	$8,759,199	$4,542,914	$182,468	$596,593	$2,684,696	$623,721	$120,529	$17,765,447	$1,856,314	$49,127,891
Vision, Hearing, and Speech Exams	$1,475,386	$3,197	$910,349	$161,980	$17,273	$5,680	$46,557	$166,342	$26,312	$4,527,288	$600,399	$7,940,763
Maternity - Anesthesia	$108,131	$0	$897,611	$3,045,288	$0	$0	$0	$13,617	$1,027	$241,745	$23,954	$4,331,373
Maternity - Non-Anesthesia - Non-Deliveries	$4,663	$0	$61,853	$13,417	$0	$0	$0	$255	$0	$10,809	$1,253	$92,250
Maternity - Non-Anesthesia - Ancillary	$13,315	$0	$99,564	$287,804	$0	$0	$0	$626	$332	$15,920	$2,381	$419,942
Maternity - Non-Anesthesia - Cesarean Deliver	$125,557	$0	$1,056,020	$2,874,702	$0	$0	$0	$2,756	$1,846	$149,523	$14,093	$4,224,497
Maternity - Non-Anesthesia - Normal Deliveries	$131,612	$0	$1,237,662	$3,854,411	$0	$0	$0	$12,854	$1,774	$378,722	$32,053	$5,649,089
Other	$32,704,060	$498,563	$4,184,337	$265,355	$670,124	$7,225,913	$614,193	$1,581,220	$7,008,289	$10,588,814	$1,075,026	$66,415,893
Missing Data	$534,594	$1,469	$248,140	$85,196	$18,084	$95,346	$134,792	$97,566	$10,180	$1,056,605	$104,984	$2,386,959
Physician Total	**$164,435,091**	**$885,078**	**$61,228,806**	**$28,072,987**	**$8,393,789**	**$30,864,857**	**$28,492,211**	**$13,426,565**	**$24,159,009**	**$195,912,140**	**$20,000,823**	**$575,871,356**
Dental Services												
Dental	$7,271,074	$7,963	$2,492,736	$425,332	$4,240	$66,642	$290,159	$2,806,554	$428,181	$71,640,420	$10,163,725	$95,597,025
Missing Data	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Dental Total	**$7,271,074**	**$7,963**	**$2,492,736**	**$425,332**	**$4,240**	**$66,642**	**$290,159**	**$2,806,554**	**$428,181**	**$71,640,420**	**$10,163,725**	**$95,597,025**
Other Services												
Ambulance	$9,761,285	$5,724	$2,227,111	$530,519	$206,468	$956,421	$727,309	$198,624	$151,105	$3,990,172	$319,362	$19,074,102
Non-Emergency Transportation	$5,266,794	$23,863	$687,704	$130,838	$105,142	$31,139	$101,651	$36,104	$14,208	$726,213	$41,802	$7,165,459
DME	$22,011,948	$13,635	$2,263,330	$281,833	$727,530	$125,523	$698,777	$517,011	$146,042	$5,693,512	$803,487	$33,282,628
Glasses / Contacts	$461,083	$1,095	$398,534	$85,272	$89	$115	$1,467	$58,020	$15,507	$2,119,562	$358,725	$3,499,468
Other	$7,998,841	$6,052	$138,183	$6,357	$633,440	$9,672	$127,133	$425,941	$20,556	$983,126	$91,499	$10,440,800
Missing Data	$1,097,016	$1,121	$859,573	$172,145	$6,214	$112,009	$380,604	$11,756	$19,901	$5,101,731	$550,253	$8,312,321
Other Total	**$46,596,968**	**$51,491**	**$6,574,433**	**$1,206,964**	**$1,678,883**	**$1,234,879**	**$2,036,941**	**$1,247,456**	**$367,320**	**$18,614,316**	**$2,165,127**	**$81,774,778**
Grand Total w/o PBA pharmacy services	**$479,808,292**	**$2,619,542**	**$148,746,359**	**$80,673,672**	**$31,916,114**	**$125,907,144**	**$52,331,602**	**$44,891,869**	**$31,078,979**	**$434,052,555**	**$46,688,567**	**$1,478,714,695**

**Pharmacy services are not included in the display due to the pharmacy carve out for SFY 2026 capitation rates and known Gainwell data issues.*

Exhibit 9B
Mississippi Division of Medicaid
Summary of CY 2023 MississippiCAN Encounter Claims
Summary of Allowed PMPM by Rate Cell

Member Months	719,929	1,038	501,768	108,557	5,313	67,416	232,841	88,226	11,130	2,754,615	298,064	4,788,897
						PMPM Allowed Cost						
Service Category	**Non-Newborn SSI / Disabled**	**Breast and Cervical Cancer**	**MA Adult**	**Pregnant Women**	**SSI / Disabled Newborn**	**Non-SSI Newborns 0 to 2 Months**	**Non-SSI Newborns 3 to 12 Months**	**Foster Care**	**MYPAC**	**MA Children**	**Quasi-CHIP**	**All MSCAN Rate Cells**
Inpatient Facility Services												
Medical	$50.71	$32.40	$8.80	$1.68	$229.89	$24.95	$12.17	$5.29	$11.62	$2.15	$2.31	$11.29
Surgical	$73.91	$104.66	$18.68	$3.19	$599.39	$68.68	$16.59	$3.05	$13.40	$4.02	$3.32	$18.21
Maternity / Deliveries	$2.57	$0.00	$27.47	$370.55	$3,002.58	$1,237.24	$2.64	$0.99	$1.97	$1.06	$0.94	$33.23
Psychiatric / Substance Abuse	$34.80	$0.00	$4.75	$1.56	$0.00	$0.00	$0.05	$250.52	$453.70	$10.80	$11.82	$18.39
Skilled Nursing Facility	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Missing Data	$0.16	$0.21	$0.06	$0.42	$1.19	$1.65	$0.05	$0.01	$0.09	$0.01	$0.01	$0.07
Inpatient Facility Total	**$162.15**	**$137.27**	**$59.77**	**$377.41**	**$3,833.05**	**$1,332.52**	**$31.50**	**$259.86**	**$480.78**	**$18.04**	**$18.41**	**$81.20**
Outpatient Facility Services												
Emergency Room	$31.68	$28.64	$25.13	$29.20	$62.82	$24.92	$25.66	$8.36	$23.25	$9.89	$7.28	$16.08
Urgent Care	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.01	$0.00	$0.00	$0.00	$0.00	$0.00
Radiology / Pathology	$31.36	$341.34	$20.52	$23.72	$39.76	$12.15	$14.07	$7.63	$16.00	$6.44	$5.80	$12.62
Psychiatric / Alcohol & Drug Abuse	$5.70	$0.00	$0.62	$0.10	$0.00	$0.00	$0.00	$12.36	$5.43	$3.17	$1.82	$3.10
Pharmacy	$51.84	$824.31	$13.58	$9.31	$35.54	$2.39	$2.45	$3.09	$6.27	$1.97	$3.06	$11.19
Other	$80.22	$278.77	$36.58	$29.65	$139.15	$18.22	$18.64	$19.36	$18.36	$14.13	$11.76	$27.20
Missing Data	$0.29	$3.36	$0.13	$0.12	$0.20	$0.29	$0.07	$0.03	$0.18	$0.05	$0.04	$0.10
Outpatient Facility Total	**$201.09**	**$1,476.42**	**$96.57**	**$92.10**	**$277.47**	**$57.97**	**$60.89**	**$50.83**	**$69.49**	**$35.65**	**$29.77**	**$70.30**
Physician Services												
IP Visits	$14.84	$17.39	$3.38	$5.04	$1,164.75	$170.15	$9.68	$1.76	$2.98	$0.74	$0.55	$7.36
IP Surgery	$5.06	$10.86	$1.85	$1.05	$67.15	$5.23	$1.40	$0.46	$1.37	$0.39	$0.42	$1.46
Office / Home Visits	$49.38	$94.08	$35.81	$13.60	$78.01	$45.30	$43.81	$32.70	$44.34	$25.26	$24.42	$31.11
Preventive Exams & Immunizations	$7.08	$17.70	$14.68	$84.06	$32.22	$109.49	$37.93	$8.69	$11.23	$7.32	$5.04	$12.64
Urgent Care Visits	$0.69	$0.51	$1.43	$0.83	$0.41	$0.03	$0.82	$1.38	$1.85	$1.31	$1.30	$1.18
ER Visits and Observation Care	$9.44	$7.97	$7.58	$8.45	$17.04	$7.08	$7.73	$2.69	$8.04	$3.28	$2.36	$5.00
OP Surgery	$14.22	$68.72	$10.28	$2.74	$15.50	$2.78	$3.94	$5.10	$4.38	$3.95	$3.76	$6.15
Physical Therapy	$13.54	$11.61	$2.36	$0.42	$36.80	$0.14	$2.08	$10.79	$5.06	$4.00	$3.03	$5.14
Psychiatric / Substance Abuse	$48.93	$7.83	$9.87	$3.03	$0.86	$0.09	$0.03	$60.28	$1,447.12	$12.27	$13.78	$20.85
Radiology / Pathology	$16.47	$131.20	$17.46	$41.85	$34.34	$8.85	$11.53	$7.07	$10.83	$6.45	$6.23	$10.26
Vision, Hearing, and Speech Exams	$2.05	$3.08	$1.81	$1.49	$3.25	$0.08	$0.20	$1.89	$2.36	$1.64	$2.01	$1.66
Maternity - Anesthesia	$0.15	$0.00	$1.79	$28.05	$0.00	$0.00	$0.00	$0.15	$0.09	$0.09	$0.08	$0.90
Maternity - Non-Anesthesia - Non-Deliveries	$0.01	$0.00	$0.12	$0.12	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.02
Maternity - Non-Anesthesia - Ancillary	$0.02	$0.00	$0.20	$2.65	$0.00	$0.00	$0.00	$0.01	$0.03	$0.01	$0.01	$0.09
Maternity - Non-Anesthesia - Cesarean Delive	$0.17	$0.00	$2.10	$26.48	$0.00	$0.00	$0.00	$0.03	$0.17	$0.05	$0.05	$0.88
Maternity - Non-Anesthesia - Normal Deliverie	$0.18	$0.00	$2.47	$35.51	$0.00	$0.00	$0.00	$0.15	$0.16	$0.14	$0.11	$1.18
Other	$45.43	$480.31	$8.34	$2.44	$126.13	$107.18	$2.64	$17.92	$629.68	$3.84	$3.61	$13.87
Missing Data	$0.74	$1.42	$0.49	$0.78	$3.40	$1.41	$0.58	$1.11	$0.91	$0.38	$0.35	$0.50
Physician Total	**$228.40**	**$852.68**	**$122.03**	**$258.60**	**$1,579.86**	**$457.83**	**$122.37**	**$152.18**	**$2,170.62**	**$71.12**	**$67.10**	**$120.25**
Dental Services												
Dental	$10.10	$7.67	$4.97	$3.92	$0.80	$0.99	$1.25	$31.81	$38.47	$26.01	$34.10	$19.96
Missing Data	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Dental Total	**$10.10**	**$7.67**	**$4.97**	**$3.92**	**$0.80**	**$0.99**	**$1.25**	**$31.81**	**$38.47**	**$26.01**	**$34.10**	**$19.96**
Other Services												
Ambulance	$13.56	$5.51	$4.44	$4.89	$38.86	$14.19	$3.12	$2.25	$13.58	$1.45	$1.07	$3.98
Non-Emergency Transportation	$7.32	$22.99	$1.37	$1.21	$19.79	$0.46	$0.44	$0.41	$1.28	$0.26	$0.14	$1.50
DME	$30.58	$13.14	$4.51	$2.60	$136.93	$1.86	$3.00	$5.86	$13.12	$2.07	$2.70	$6.95
Glasses / Contacts	$0.64	$1.05	$0.79	$0.79	$0.02	$0.00	$0.01	$0.66	$1.39	$0.77	$1.20	$0.73
Other	$11.11	$5.83	$0.28	$0.06	$119.22	$0.14	$0.55	$4.83	$1.85	$0.36	$0.31	$2.18
Missing Data	$1.52	$1.08	$1.71	$1.59	$1.17	$1.66	$1.63	$0.13	$1.79	$1.85	$1.85	$1.74
Other Total	**$64.72**	**$49.61**	**$13.10**	**$11.12**	**$316.00**	**$18.32**	**$8.75**	**$14.14**	**$33.00**	**$6.76**	**$7.26**	**$17.08**
Grand Total w/o PBA pharmacy services	**$666.47**	**$2,523.64**	**$296.44**	**$743.15**	**$6,007.17**	**$1,867.62**	**$224.75**	**$508.83**	**$2,792.36**	**$157.57**	**$156.64**	**$308.78**

**Pharmacy services are not included in the display due to the pharmacy carve out for SFY 2026 capitation rates and known Gainwell data issues.*

Exhibit 9C
Mississippi Division of Medicaid
Summary of CY 2023 MississippiCAN Encounter Claims
Summary of Total Costs by Rate Cell

Member Months	719,929	1,038	501,768	108,557	5,313	67,416	232,841	88,226	11,130	2,754,615	298,064	4,788,897
						% of Total Allowed Cost						
Service Category	**Non-Newborn SSI / Disabled**	**Breast and Cervical Cancer**	**MA Adult**	**Pregnant Women**	**SSI / Disabled Newborn**	**Non-SSI Newborns 0 to 2 Months**	**Non-SSI Newborns 3 to 12 Months**	**Foster Care**	**MYPAC**	**MA Children**	**Quasi-CHIP**	**All MSCAN Rate Cells**
Inpatient Facility Services												
Medical	7.6%	1.3%	3.0%	0.2%	3.8%	1.3%	5.4%	1.0%	0.4%	1.4%	1.5%	3.7%
Surgical	11.1%	4.1%	6.3%	0.4%	10.0%	3.7%	7.4%	0.6%	0.5%	2.5%	2.1%	5.9%
Maternity / Deliveries	0.4%	0.0%	9.3%	49.9%	50.0%	66.2%	1.2%	0.2%	0.1%	0.7%	0.6%	10.8%
Psychiatric / Substance Abuse	5.2%	0.0%	1.6%	0.2%	0.0%	0.0%	0.0%	49.2%	16.2%	6.9%	7.5%	6.0%
Skilled Nursing Facility	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Missing Data	0.0%	0.0%	0.0%	0.1%	0.0%	0.1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Inpatient Facility Total	**24.3%**	**5.4%**	**20.2%**	**50.8%**	**63.8%**	**71.3%**	**14.0%**	**51.1%**	**17.2%**	**11.4%**	**11.8%**	**26.3%**
Outpatient Facility Services												
Emergency Room	4.8%	1.1%	8.5%	3.9%	1.0%	1.3%	11.4%	1.6%	0.8%	6.3%	4.6%	5.2%
Urgent Care	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Radiology / Pathology	4.7%	13.5%	6.9%	3.2%	0.7%	0.7%	6.3%	1.5%	0.6%	4.1%	3.7%	4.1%
Psychiatric / Alcohol & Drug Abuse	0.9%	0.0%	0.2%	0.0%	0.0%	0.0%	0.0%	2.4%	0.2%	2.0%	1.2%	1.0%
Pharmacy	7.8%	32.7%	4.6%	1.3%	0.6%	0.1%	1.1%	0.6%	0.2%	1.2%	2.0%	3.6%
Other	12.0%	11.0%	12.3%	4.0%	2.3%	1.0%	8.3%	3.8%	0.7%	9.0%	7.5%	8.8%
Missing Data	0.0%	0.1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Outpatient Facility Total	**30.2%**	**58.5%**	**32.6%**	**12.4%**	**4.6%**	**3.1%**	**27.1%**	**10.0%**	**2.5%**	**22.6%**	**19.0%**	**22.8%**
Physician Services												
IP Visits	2.2%	0.7%	1.1%	0.7%	19.4%	9.1%	4.3%	0.3%	0.1%	0.5%	0.4%	2.4%
IP Surgery	0.8%	0.4%	0.6%	0.1%	1.1%	0.3%	0.6%	0.1%	0.0%	0.2%	0.3%	0.5%
Office / Home Visits	7.4%	3.7%	12.1%	1.8%	1.3%	2.4%	19.5%	6.4%	1.6%	16.0%	15.6%	10.1%
Preventive Exams & Immunizations	1.1%	0.7%	5.0%	11.3%	0.5%	5.9%	16.9%	1.7%	0.4%	4.6%	3.2%	4.1%
Urgent Care Visits	0.1%	0.0%	0.5%	0.1%	0.0%	0.0%	0.4%	0.3%	0.1%	0.8%	0.8%	0.4%
ER Visits and Observation Care	1.4%	0.3%	2.6%	1.1%	0.3%	0.4%	3.4%	0.5%	0.3%	2.1%	1.5%	1.6%
OP Surgery	2.1%	2.7%	3.5%	0.4%	0.3%	0.1%	1.8%	1.0%	0.2%	2.5%	2.4%	2.0%
Physical Therapy	2.0%	0.5%	0.8%	0.1%	0.6%	0.0%	0.9%	2.1%	0.2%	2.5%	1.9%	1.7%
Psychiatric / Substance Abuse	7.3%	0.3%	3.3%	0.4%	0.0%	0.0%	0.0%	11.8%	51.8%	7.8%	8.8%	6.8%
Radiology / Pathology	2.5%	5.2%	5.9%	5.6%	0.6%	0.5%	5.1%	1.4%	0.4%	4.1%	4.0%	3.3%
Vision, Hearing, and Speech Exams	0.3%	0.1%	0.6%	0.2%	0.1%	0.0%	0.1%	0.4%	0.1%	1.0%	1.3%	0.5%
Maternity - Anesthesia	0.0%	0.0%	0.6%	3.8%	0.0%	0.0%	0.0%	0.0%	0.0%	0.1%	0.1%	0.3%
Maternity - Non-Anesthesia - Non-Deliveries	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Maternity - Non-Anesthesia - Ancillary	0.0%	0.0%	0.1%	0.4%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Maternity - Non-Anesthesia - Cesarean Delive	0.0%	0.0%	0.7%	3.6%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.3%
Maternity - Non-Anesthesia - Normal Deliverie	0.0%	0.0%	0.8%	4.8%	0.0%	0.0%	0.0%	0.0%	0.0%	0.1%	0.1%	0.4%
Other	6.8%	19.0%	2.8%	0.3%	2.1%	5.7%	1.2%	3.5%	22.5%	2.4%	2.3%	4.5%
Missing Data	0.1%	0.1%	0.2%	0.1%	0.1%	0.1%	0.3%	0.2%	0.0%	0.2%	0.2%	0.2%
Physician Total	**34.3%**	**33.8%**	**41.2%**	**34.8%**	**26.3%**	**24.5%**	**54.4%**	**29.9%**	**77.7%**	**45.1%**	**42.8%**	**38.9%**
Dental Services												
Dental	1.5%	0.3%	1.7%	0.5%	0.0%	0.1%	0.6%	6.3%	1.4%	16.5%	21.8%	6.5%
Missing Data	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Dental Total	**1.5%**	**0.3%**	**1.7%**	**0.5%**	**0.0%**	**0.1%**	**0.6%**	**6.3%**	**1.4%**	**16.5%**	**21.8%**	**6.5%**
Other Services												
Ambulance	2.0%	0.2%	1.5%	0.7%	0.6%	0.8%	1.4%	0.4%	0.5%	0.9%	0.7%	1.3%
Non-Emergency Transportation	1.1%	0.9%	0.5%	0.2%	0.3%	0.0%	0.2%	0.1%	0.0%	0.2%	0.1%	0.5%
DME	4.6%	0.5%	1.5%	0.3%	2.3%	0.1%	1.3%	1.2%	0.5%	1.3%	1.7%	2.3%
Glasses / Contacts	0.1%	0.0%	0.3%	0.1%	0.0%	0.0%	0.0%	0.1%	0.0%	0.5%	0.8%	0.2%
Other	1.7%	0.2%	0.1%	0.0%	2.0%	0.0%	0.2%	0.9%	0.1%	0.2%	0.2%	0.7%
Missing Data	0.2%	0.0%	0.6%	0.2%	0.0%	0.1%	0.7%	0.0%	0.1%	1.2%	1.2%	0.6%
Other Total	9.7%	2.0%	4.4%	1.5%	5.3%	1.0%	3.9%	2.8%	1.2%	4.3%	4.6%	5.5%
Grand Total w/o PBA pharmacy services	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**

**Pharmacy services are not included in the display due to the pharmacy carve out for SFY 2026 capitation rates and known Gainwell data issues.*

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

Change	Change Type	Effective Date	Impacted Rate Cells	Where Reflected in Rate Development
Hemophilia Population Carve-In	Population	January 1, 2024	All	Exhibit 2A
SFY 2025 Population Acuity Adjustment	Program	N/A	MA Adult, MA Children, Quasi-CHIP	Exhibit 2A
SSI Children - COE Change	Program	October 1, 2018 to May 31, 2022	SSI	Exhibit 1B
Gene Therapy Drug Coverage	Program	July 1, 2023	All	Exhibit 2A
Preventative and Diagnostic Dental Reimbursement Change	Reimbursement	July 1, 2022 and July 1, 2023	All	Exhibit 1B and Exhibit 2A
Restorative Dental Reimbursement Change	Reimbursement	July 1, 2022, July 1, 2023 and July 1, 2024	All	Exhibit 1B and Exhibit 2A
Home Health Agency (HHA) Fee Schedule Update	Reimbursement	October 1, 2022 and October 1, 2024	All	Exhibit 1B
Prescribed Pediatric Extended Care (PPEC) Fee Schedule Update	Reimbursement	October 1, 2022	All	Exhibit 1B
Private Duty Nursing Services (PDN) Fee Schedule Update	Reimbursement	October 1, 2022 and July 1, 2023	All	Exhibit 1B
Ambulatory Surgical Center (ASC) Fee Schedule Update	Reimbursement	October 1, 2022, October 1, 2023, January 1, 2024 and October 1, 2024	All	Exhibit 1B and Exhibit 2A
Behavioral Health Services (BHS) Fee Schedule Update	Reimbursement	July 1, 2023, and July 1, 2024	All	Exhibit 1B and Exhibit 2A
Autism Spectrum Disorder (ASD) Fee Schedule Update	Reimbursement	May 1, 2022, January 1, 2023, and March 3, 2025	All	Exhibit 1B and Exhibit 2A
Orthodontia Services Fee Schedule Update	Reimbursement	October 1, 2023	All	Exhibit 1B and Exhibit 2A
Psychiatric Residential Treatment Facility (PRTF) Fee Schedule Update	Reimbursement	July 1, 2022, January 1, 2024, and January 1, 2025	All	Exhibit 1B and Exhibit 2A
MYPAC Services Fee Schedule Update	Reimbursement	November 1, 2023	All Children's Rate Cells	Exhibit 1B and Exhibit 2A
Postpartum Coverage Extension	Reimbursement	July 1, 2023	Pregnant Women	Exhibit 2A
MYPAC Member Identification Change	Population	January 1, 2022	Non-Newborn SSI / Disabled, Foster Care, MYPAC, MA Children, Quasi-CHIP	Exhibit 1B
MYPAC Removal	Population	July 1, 2025	Non-Newborn SSI / Disabled, Foster Care, MYPAC, MA Children, Quasi-CHIP	Exhibit 2B

Exhibit 11A
Mississippi Division of Medicaid
CY 2023 to SFY 2026 Unit Cost Trends by Category of Service

		Percentage of CY 2023 Paid							CY 2023 to SFY 2026 Unit Cost Trend (Annualized)							
Rate Cell	Category of Service	BHS	ASC	ASD	PRTF	MYPAC	Ortho	All Other	CMHC	ASC	ASD	PRTF	MYPAC	Ortho	All Other	Composite
Non-Newborn SSI / Disabled	Inpatient Hospital Services - Maternity / Deliveries	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-0.93%	**-0.93%**
Non-Newborn SSI / Disabled	Inpatient Hospital Services - Psychiatric / Substance Abuse	0.0%	0.0%	0.0%	19.9%	0.0%	0.0%	80.1%	0.00%	0.00%	0.00%	2.33%	0.00%	0.00%	-0.93%	**-0.27%**
Non-Newborn SSI / Disabled	Inpatient Hospital Services - All Other	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-0.93%	**-0.93%**
Non-Newborn SSI / Disabled	Outpatient Hospital Services - Emergency Room	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	2.57%	**2.57%**
Non-Newborn SSI / Disabled	Outpatient Hospital Services - Pharmacy	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	1.59%	**1.59%**
Non-Newborn SSI / Disabled	Outpatient Hospital Services - All Other	4.6%	1.3%	0.0%	0.0%	0.0%	0.0%	94.1%	4.53%	3.97%	0.00%	0.00%	0.00%	0.00%	2.57%	**2.68%**
Non-Newborn SSI / Disabled	Physician Services - Maternity / Deliveries	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-1.05%	**-1.05%**
Non-Newborn SSI / Disabled	Physician Services - Psychiatric / Substance Abuse	88.6%	0.0%	5.5%	0.0%	0.9%	0.0%	5.0%	2.97%	0.00%	1.11%	0.00%	1.30%	0.00%	-1.05%	**2.66%**
Non-Newborn SSI / Disabled	Physician Services - All Other	0.8%	1.1%	0.1%	0.0%	0.1%	0.0%	97.9%	3.66%	4.05%	0.00%	0.00%	1.35%	0.00%	-0.66%	**-0.57%**
Non-Newborn SSI / Disabled	Dental - All Services	0.0%	0.0%	0.0%	0.0%	0.0%	11.4%	88.6%	0.00%	0.00%	0.00%	0.00%	0.00%	2.88%	0.00%	**0.34%**
Non-Newborn SSI / Disabled	All Other Services	1.4%	0.0%	0.0%	0.0%	0.0%	0.0%	98.6%	4.43%	0.00%	0.00%	0.00%	0.00%	0.00%	0.72%	**0.77%**
Breast and Cervical Cancer	Inpatient Hospital Services - Maternity / Deliveries	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-0.93%	**0.00%**
Breast and Cervical Cancer	Inpatient Hospital Services - Psychiatric / Substance Abuse	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-0.93%	**0.00%**
Breast and Cervical Cancer	Inpatient Hospital Services - All Other	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-0.93%	**-0.93%**
Breast and Cervical Cancer	Outpatient Hospital Services - Emergency Room	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	2.57%	**2.57%**
Breast and Cervical Cancer	Outpatient Hospital Services - Pharmacy	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	13.75%	**13.75%**
Breast and Cervical Cancer	Outpatient Hospital Services - All Other	0.0%	1.4%	0.0%	0.0%	0.0%	0.0%	98.6%	0.00%	4.62%	0.00%	0.00%	0.00%	0.00%	2.57%	**2.60%**
Breast and Cervical Cancer	Physician Services - Maternity / Deliveries	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-1.05%	**0.00%**
Breast and Cervical Cancer	Physician Services - Psychiatric / Substance Abuse	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	2.16%	0.00%	0.00%	0.00%	0.00%	0.00%	-1.05%	**2.16%**
Breast and Cervical Cancer	Physician Services - All Other	0.1%	1.8%	0.0%	0.0%	0.0%	0.0%	98.1%	-0.84%	2.59%	0.00%	0.00%	0.00%	0.00%	6.87%	**6.79%**
Breast and Cervical Cancer	Dental - All Services	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	**0.00%**
Breast and Cervical Cancer	All Other Services	0.9%	0.0%	0.0%	0.0%	0.0%	0.0%	99.1%	4.61%	0.00%	0.00%	0.00%	0.00%	0.00%	0.72%	**0.76%**
MA Adult	Inpatient Hospital Services - Maternity / Deliveries	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.76%	**0.76%**
MA Adult	Inpatient Hospital Services - Psychiatric / Substance Abuse	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.76%	**0.76%**
MA Adult	Inpatient Hospital Services - All Other	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.76%	**0.76%**
MA Adult	Outpatient Hospital Services - Emergency Room	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	2.81%	**2.81%**
MA Adult	Outpatient Hospital Services - Pharmacy	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	1.05%	**1.05%**
MA Adult	Outpatient Hospital Services - All Other	0.9%	1.9%	0.0%	0.0%	0.0%	0.0%	97.1%	4.36%	4.16%	0.00%	0.00%	0.00%	0.00%	2.81%	**2.85%**
MA Adult	Physician Services - Maternity / Deliveries	0.0%	0.1%	0.0%	0.0%	0.0%	0.0%	99.9%	0.00%	7.32%	0.00%	0.00%	0.00%	0.00%	-0.07%	**-0.06%**
MA Adult	Physician Services - Psychiatric / Substance Abuse	86.4%	0.0%	0.0%	0.0%	0.0%	0.0%	13.6%	1.50%	0.00%	0.00%	0.00%	0.00%	0.00%	-0.07%	**1.29%**
MA Adult	Physician Services - All Other	0.5%	2.1%	0.0%	0.0%	0.0%	0.0%	97.4%	3.77%	3.84%	0.00%	0.00%	0.00%	0.00%	0.01%	**0.11%**
MA Adult	Dental - All Services	0.0%	0.0%	0.0%	0.0%	0.0%	0.1%	99.9%	0.00%	0.00%	0.00%	0.00%	0.00%	3.57%	0.00%	**0.00%**
MA Adult	All Other Services	1.2%	0.0%	0.0%	0.0%	0.0%	0.0%	98.8%	4.39%	0.00%	0.00%	0.00%	0.00%	0.00%	1.07%	**1.11%**
Pregnant Women	Inpatient Hospital Services - Maternity / Deliveries	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.76%	**0.76%**
Pregnant Women	Inpatient Hospital Services - Psychiatric / Substance Abuse	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.76%	**0.76%**
Pregnant Women	Inpatient Hospital Services - All Other	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.76%	**0.76%**
Pregnant Women	Outpatient Hospital Services - Emergency Room	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	2.81%	**2.81%**
Pregnant Women	Outpatient Hospital Services - Pharmacy	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	1.05%	**1.05%**
Pregnant Women	Outpatient Hospital Services - All Other	0.2%	0.4%	0.0%	0.0%	0.0%	0.0%	99.5%	2.94%	4.74%	0.00%	0.00%	0.00%	0.00%	2.81%	**2.82%**
Pregnant Women	Physician Services - Maternity / Deliveries	0.0%	0.1%	0.0%	0.0%	0.0%	0.0%	99.9%	0.00%	5.81%	0.00%	0.00%	0.00%	0.00%	-0.07%	**-0.07%**
Pregnant Women	Physician Services - Psychiatric / Substance Abuse	84.2%	0.0%	0.0%	0.0%	0.0%	0.0%	15.8%	0.86%	0.00%	0.00%	0.00%	0.00%	0.00%	-0.07%	**0.71%**
Pregnant Women	Physician Services - All Other	0.2%	0.4%	0.0%	0.0%	0.0%	0.0%	99.4%	3.74%	4.67%	0.00%	0.00%	0.00%	0.00%	0.00%	**0.02%**
Pregnant Women	Dental - All Services	0.0%	0.0%	0.0%	0.0%	0.0%	1.9%	98.1%	0.00%	0.00%	0.00%	0.00%	0.00%	2.53%	0.00%	**0.05%**
Pregnant Women	All Other Services	0.4%	0.0%	0.0%	0.0%	0.0%	0.0%	99.6%	3.87%	0.00%	0.00%	0.00%	0.00%	0.00%	1.07%	**1.08%**
SSI / Disabled Newborn	Inpatient Hospital Services - Maternity / Deliveries	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	1.62%	**1.62%**
SSI / Disabled Newborn	Inpatient Hospital Services - Psychiatric / Substance Abuse	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	1.62%	**0.00%**
SSI / Disabled Newborn	Inpatient Hospital Services - All Other	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	1.62%	**1.62%**
SSI / Disabled Newborn	Outpatient Hospital Services - Emergency Room	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	4.11%	**4.11%**
SSI / Disabled Newborn	Outpatient Hospital Services - Pharmacy	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	2.42%	**2.42%**
SSI / Disabled Newborn	Outpatient Hospital Services - All Other	0.0%	0.1%	0.0%	0.0%	0.0%	0.0%	99.9%	-2.07%	9.97%	0.00%	0.00%	0.00%	0.00%	4.11%	**4.11%**
SSI / Disabled Newborn	Physician Services - Maternity / Deliveries	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-0.71%	**0.00%**
SSI / Disabled Newborn	Physician Services - Psychiatric / Substance Abuse	49.0%	0.0%	0.0%	0.0%	0.0%	0.0%	51.0%	-0.59%	0.00%	0.00%	0.00%	0.00%	0.00%	-0.71%	**-0.65%**
SSI / Disabled Newborn	Physician Services - All Other	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%	-1.62%	0.00%	0.00%	0.00%	0.00%	0.00%	-0.70%	**-0.70%**
SSI / Disabled Newborn	Dental - All Services	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	**0.00%**
SSI / Disabled Newborn	All Other Services	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%	4.48%	0.00%	0.00%	0.00%	0.00%	0.00%	0.33%	**0.33%**
Non-SSI Newborns 0 to 2 Months	Inpatient Hospital Services - Maternity / Deliveries	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	1.62%	**1.62%**
Non-SSI Newborns 0 to 2 Months	Inpatient Hospital Services - Psychiatric / Substance Abuse	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	1.62%	**0.00%**
Non-SSI Newborns 0 to 2 Months	Inpatient Hospital Services - All Other	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	1.62%	**1.62%**
Non-SSI Newborns 0 to 2 Months	Outpatient Hospital Services - Emergency Room	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	4.11%	**4.11%**
Non-SSI Newborns 0 to 2 Months	Outpatient Hospital Services - Pharmacy	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	2.42%	**2.42%**
Non-SSI Newborns 0 to 2 Months	Outpatient Hospital Services - All Other	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	4.11%	**4.11%**
Non-SSI Newborns 0 to 2 Months	Physician Services - Maternity / Deliveries	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-0.71%	**0.00%**
Non-SSI Newborns 0 to 2 Months	Physician Services - Psychiatric / Substance Abuse	46.2%	0.0%	0.0%	0.0%	0.0%	0.0%	53.8%	-0.90%	0.00%	0.00%	0.00%	0.00%	0.00%	-0.71%	**-0.79%**
Non-SSI Newborns 0 to 2 Months	Physician Services - All Other	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%	-1.24%	0.00%	0.00%	0.00%	0.00%	0.00%	-0.01%	**-0.01%**
Non-SSI Newborns 0 to 2 Months	Dental - All Services	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	**0.00%**
Non-SSI Newborns 0 to 2 Months	All Other Services	0.1%	0.0%	0.0%	0.0%	0.0%	0.0%	99.9%	5.04%	0.00%	0.00%	0.00%	0.00%	0.00%	0.33%	**0.33%**
Non-SSI Newborns 3 to 12 Months	Inpatient Hospital Services - Maternity / Deliveries	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-0.53%	**-0.53%**
Non-SSI Newborns 3 to 12 Months	Inpatient Hospital Services - Psychiatric / Substance Abuse	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-0.53%	**-0.53%**
Non-SSI Newborns 3 to 12 Months	Inpatient Hospital Services - All Other	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-0.53%	**-0.53%**
Non-SSI Newborns 3 to 12 Months	Outpatient Hospital Services - Emergency Room	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	3.62%	**3.62%**
Non-SSI Newborns 3 to 12 Months	Outpatient Hospital Services - Pharmacy	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	2.42%	**2.42%**
Non-SSI Newborns 3 to 12 Months	Outpatient Hospital Services - All Other	0.0%	1.1%	0.0%	0.0%	0.0%	0.0%	98.9%	0.00%	8.57%	0.00%	0.00%	0.00%	0.00%	3.62%	**3.67%**
Non-SSI Newborns 3 to 12 Months	Physician Services - Maternity / Deliveries	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.18%	**0.00%**
Non-SSI Newborns 3 to 12 Months	Physician Services - Psychiatric / Substance Abuse	30.8%	0.0%	0.0%	0.0%	0.0%	0.0%	69.2%	0.74%	0.00%	0.00%	0.00%	0.00%	0.00%	0.18%	**0.35%**
Non-SSI Newborns 3 to 12 Months	Physician Services - All Other	0.0%	0.6%	0.0%	0.0%	0.0%	0.0%	99.3%	-1.32%	8.82%	0.00%	0.00%	0.00%	0.00%	0.24%	**0.30%**
Non-SSI Newborns 3 to 12 Months	Dental - All Services	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	**0.00%**
Non-SSI Newborns 3 to 12 Months	All Other Services	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%	3.88%	0.00%	0.00%	0.00%	0.00%	0.00%	1.02%	**1.02%**
Foster Care	Inpatient Hospital Services - Maternity / Deliveries	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-0.53%	**-0.53%**
Foster Care	Inpatient Hospital Services - Psychiatric / Substance Abuse	0.0%	0.0%	0.0%	71.2%	0.0%	0.0%	28.8%	0.00%	0.00%	0.00%	1.99%	0.00%	0.00%	-0.53%	**1.28%**
Foster Care	Inpatient Hospital Services - All Other	0.0%	0.0%	0.0%	20.3%	0.0%	0.0%	79.7%	0.00%	0.00%	0.00%	1.18%	0.00%	0.00%	-0.53%	**-0.18%**
Foster Care	Outpatient Hospital Services - Emergency Room	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	3.62%	**3.62%**
Foster Care	Outpatient Hospital Services - Pharmacy	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	2.42%	**2.42%**
Foster Care	Outpatient Hospital Services - All Other	31.0%	1.9%	0.0%	0.0%	0.0%	0.0%	67.0%	4.30%	5.69%	0.00%	0.00%	0.00%	0.00%	3.62%	**3.87%**
Foster Care	Physician Services - Maternity / Deliveries	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.18%	**0.18%**
Foster Care	Physician Services - Psychiatric / Substance Abuse	77.8%	0.0%	2.1%	0.0%	14.0%	0.0%	6.2%	1.12%	0.00%	1.07%	0.00%	1.44%	0.00%	0.18%	**1.11%**
Foster Care	Physician Services - All Other	5.2%	1.4%	0.0%	0.0%	2.1%	0.0%	91.2%	2.46%	6.16%	0.00%	0.00%	1.47%	0.00%	0.35%	**0.57%**
Foster Care	Dental - All Services	0.0%	0.0%	0.0%	0.0%	0.0%	17.2%	82.8%	0.00%	0.00%	0.00%	0.00%	0.00%	2.90%	0.00%	**0.51%**
Foster Care	All Other Services	4.7%	0.0%	0.0%	0.0%	0.0%	0.0%	95.3%	4.07%	0.00%	0.00%	0.00%	0.00%	0.00%	1.02%	**1.17%**
MYPAC	Inpatient Hospital Services - Maternity / Deliveries	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-0.53%	**-0.53%**
MYPAC	Inpatient Hospital Services - Psychiatric / Substance Abuse	0.0%	0.0%	0.0%	24.5%	0.0%	0.0%	75.5%	0.00%	0.00%	0.00%	2.36%	0.00%	0.00%	-0.53%	**0.19%**
MYPAC	Inpatient Hospital Services - All Other	0.0%	0.0%	0.0%	3.7%	0.0%	0.0%	96.3%	0.00%	0.00%	0.00%	2.45%	0.00%	0.00%	-0.53%	**-0.42%**
MYPAC	Outpatient Hospital Services - Emergency Room	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	3.62%	**3.62%**
MYPAC	Outpatient Hospital Services - Pharmacy	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	2.42%	**2.42%**
MYPAC	Outpatient Hospital Services - All Other	11.0%	1.7%	0.0%	0.0%	0.0%	0.0%	87.3%	4.57%	4.99%	0.00%	0.00%	0.00%	0.00%	3.62%	**3.75%**
MYPAC	Physician Services - Maternity / Deliveries	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.18%	**0.18%**
MYPAC	Physician Services - Psychiatric / Substance Abuse	3.2%	0.0%	0.0%	0.0%	95.4%	0.0%	1.3%	1.53%	0.00%	1.08%	0.00%	1.79%	0.00%	0.01%	**1.76%**
MYPAC	Physician Services - All Other	0.7%	0.1%	0.0%	0.0%	86.3%	0.0%	12.9%	2.07%	6.25%	0.00%	0.00%	1.38%	0.00%	0.04%	**1.22%**
MYPAC	Dental - All Services	0.0%	0.0%	0.0%	0.0%	0.0%	21.1%	78.9%	0.00%	0.00%	0.00%	0.00%	0.00%	3.14%	0.00%	**0.68%**
MYPAC	All Other Services	5.9%	0.0%	0.0%	0.0%	0.0%	0.0%	94.1%	3.46%	0.00%	0.00%	0.00%	0.00%	0.00%	1.02%	**1.17%**
MA Children	Inpatient Hospital Services - Maternity / Deliveries	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-0.53%	**-0.53%**
MA Children	Inpatient Hospital Services - Psychiatric / Substance Abuse	0.0%	0.0%	0.0%	38.8%	0.0%	0.0%	61.2%	0.00%	0.00%	0.00%	2.69%	0.00%	0.00%	-0.53%	**0.74%**
MA Children	Inpatient Hospital Services - All Other	0.0%	0.0%	0.0%	0.5%	0.0%	0.0%	99.5%	0.00%	0.00%	0.00%	0.72%	0.00%	0.00%	-0.53%	**-0.52%**
MA Children	Outpatient Hospital Services - Emergency Room	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	3.62%	**3.62%**
MA Children	Outpatient Hospital Services - Pharmacy	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	2.42%	**2.42%**
MA Children	Outpatient Hospital Services - All Other	13.0%	2.7%	0.0%	0.0%	0.0%	0.0%	84.3%	4.47%	5.17%	0.00%	0.00%	0.00%	0.00%	3.62%	**3.77%**
MA Children	Physician Services - Maternity / Deliveries	0.0%	0.1%	0.0%	0.0%	0.0%	0.0%	99.9%	0.00%	4.00%	0.00%	0.00%	0.00%	0.00%	0.18%	**0.19%**
MA Children	Physician Services - Psychiatric / Substance Abuse	91.8%	0.0%	1.0%	0.0%	3.4%	0.0%	3.8%	1.19%	0.00%	1.15%	0.00%	1.22%	0.00%	0.18%	**1.15%**
MA Children	Physician Services - All Other	1.7%	1.9%	0.0%	0.0%	0.2%	0.0%	96.2%	3.18%	5.49%	0.00%	0.00%	1.32%	0.00%	0.26%	**0.42%**
MA Children	Dental - All Services	0.0%	0.0%	0.0%	0.0%	0.0%	18.8%	81.2%	0.00%	0.00%	0.00%	0.00%	0.00%	2.91%	0.00%	**0.56%**
MA Children	All Other Services	3.8%	0.0%	0.0%	0.0%	0.0%	0.0%	96.2%	4.40%	0.00%	0.00%	0.00%	0.00%	0.00%	1.02%	**1.15%**
Quasi-CHIP	Inpatient Hospital Services - Maternity / Deliveries	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-0.53%	**-0.53%**
Quasi-CHIP	Inpatient Hospital Services - Psychiatric / Substance Abuse	0.0%	0.0%	0.0%	38.9%	0.0%	0.0%	61.1%	0.00%	0.00%	0.00%	2.76%	0.00%	0.00%	-0.53%	**0.77%**
Quasi-CHIP	Inpatient Hospital Services - All Other	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-0.53%	**-0.53%**
Quasi-CHIP	Outpatient Hospital Services - Emergency Room	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	3.62%	**3.62%**
Quasi-CHIP	Outpatient Hospital Services - Pharmacy	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	2.42%	**2.42%**
Quasi-CHIP	Outpatient Hospital Services - All Other	8.7%	2.7%	0.0%	0.0%	0.0%	0.0%	88.6%	4.35%	4.80%	0.00%	0.00%	0.00%	0.00%	3.62%	**3.71%**
Quasi-CHIP	Physician Services - Maternity / Deliveries	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.18%	**0.18%**
Quasi-CHIP	Physician Services - Psychiatric / Substance Abuse	90.7%	0.0%	1.4%	0.0%	3.4%	0.0%	4.6%	0.96%	0.00%	1.12%	0.00%	1.37%	0.00%	0.18%	**0.94%**
Quasi-CHIP	Physician Services - All Other	2.2%	2.0%	0.0%	0.0%	0.4%	0.0%	95.4%	3.27%	4.62%	0.00%	0.00%	1.58%	0.00%	0.29%	**0.45%**
Quasi-CHIP	Dental - All Services	0.0%	0.0%	0.0%	0.0%	0.0%	25.6%	74.4%	0.00%	0.00%	0.00%	0.00%	0.00%	2.94%	0.00%	**0.77%**
Quasi-CHIP	All Other Services	4.0%	0.0%	0.0%	0.0%	0.0%	0.0%	96.0%	4.53%	0.00%	0.00%	0.00%	0.00%	0.00%	1.02%	**1.17%**

Exhibit 11B
Mississippi Division of Medicaid
CY 2022 to CY 2023 Unit Cost Trends by Category of Service

		Percentage of CY 2022 Paid										CY 2022 to CY 2023 Unit Cost Trend (Annualized)										
Rate Cell	**Category of Service**	**PPEC**	**PDN**	**BHS**	**ASC**	**ASD**	**HH**	**PRTF**	**MYPAC**	**Ortho**	**All Other**	**PPEC**	**PDN**	**BHS**	**ASC**	**ASD**	**HH**	**PRTF**	**MYPAC**	**Ortho**	**All Other**	**Composite**
Breast and Cervical Cancer	Inpatient Hospital Services - Maternity / Deliveries	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-1.83%	**0.00%**
Breast and Cervical Cancer	Inpatient Hospital Services - Psychiatric / Substance Abuse	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-1.83%	**0.00%**
Breast and Cervical Cancer	Inpatient Hospital Services - All Other	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-1.83%	**-1.83%**
Breast and Cervical Cancer	Outpatient Hospital Services - Emergency Room	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	2.30%	**2.30%**
Breast and Cervical Cancer	Outpatient Hospital Services - Pharmacy	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	2.00%	**2.00%**
Breast and Cervical Cancer	Outpatient Hospital Services - All Other	0.0%	0.9%	0.0%	10.5%	0.0%	1.9%	0.0%	0.0%	0.0%	86.6%	0.00%	15.00%	18.01%	24.66%	0.00%	28.71%	0.00%	0.00%	0.00%	2.30%	**5.28%**
Breast and Cervical Cancer	Physician Services - Maternity / Deliveries	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-0.10%	**0.00%**
Breast and Cervical Cancer	Physician Services - Psychiatric / Substance Abuse	0.0%	0.0%	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.00%	0.00%	6.07%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-0.10%	**6.07%**
Breast and Cervical Cancer	Physician Services - All Other	0.0%	0.0%	0.0%	7.5%	0.0%	0.0%	0.0%	0.0%	0.0%	92.5%	0.00%	0.00%	8.07%	4.20%	0.00%	0.00%	0.00%	0.00%	0.00%	0.68%	**0.94%**
Breast and Cervical Cancer	Dental - All Services	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	**0.00%**
Breast and Cervical Cancer	All Other Services	0.0%	0.0%	1.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	99.0%	0.00%	0.00%	3.96%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	1.50%	**1.53%**
SSI / Disabled Newborn	Inpatient Hospital Services - Maternity / Deliveries	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	3.34%	**3.34%**
SSI / Disabled Newborn	Inpatient Hospital Services - Psychiatric / Substance Abuse	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	3.34%	**3.34%**
SSI / Disabled Newborn	Inpatient Hospital Services - All Other	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	3.34%	**3.34%**
SSI / Disabled Newborn	Outpatient Hospital Services - Emergency Room	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	4.84%	**4.84%**
SSI / Disabled Newborn	Outpatient Hospital Services - Pharmacy	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	2.50%	**2.50%**
SSI / Disabled Newborn	Outpatient Hospital Services - All Other	0.0%	0.4%	0.0%	0.0%	0.0%	1.7%	0.0%	0.0%	0.0%	97.9%	0.00%	15.00%	0.00%	0.00%	0.00%	14.07%	0.00%	0.00%	0.00%	4.84%	**5.03%**
SSI / Disabled Newborn	Physician Services - Maternity / Deliveries	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-0.72%	**0.00%**
SSI / Disabled Newborn	Physician Services - Psychiatric / Substance Abuse	0.0%	0.0%	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.00%	0.00%	2.07%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-0.72%	**2.07%**
SSI / Disabled Newborn	Physician Services - All Other	4.3%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	95.7%	8.79%	0.00%	-3.17%	-2.01%	0.00%	0.00%	0.00%	0.00%	0.00%	-0.71%	**-0.31%**
SSI / Disabled Newborn	Dental - All Services	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	**0.00%**
SSI / Disabled Newborn	All Other Services	1.2%	15.4%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	83.4%	6.83%	11.58%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.58%	**2.35%**
Non-SSI Newborns 0 to 2 Months	Inpatient Hospital Services - Maternity / Deliveries	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	3.34%	**3.34%**
Non-SSI Newborns 0 to 2 Months	Inpatient Hospital Services - Psychiatric / Substance Abuse	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	3.34%	**0.00%**
Non-SSI Newborns 0 to 2 Months	Inpatient Hospital Services - All Other	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	3.34%	**3.34%**
Non-SSI Newborns 0 to 2 Months	Outpatient Hospital Services - Emergency Room	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	4.84%	**4.84%**
Non-SSI Newborns 0 to 2 Months	Outpatient Hospital Services - Pharmacy	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	2.50%	**2.50%**
Non-SSI Newborns 0 to 2 Months	Outpatient Hospital Services - All Other	0.0%	0.1%	0.0%	0.0%	0.0%	0.5%	0.0%	0.0%	0.0%	99.4%	0.00%	15.00%	0.00%	0.00%	0.00%	17.80%	0.00%	0.00%	0.00%	4.84%	**4.91%**
Non-SSI Newborns 0 to 2 Months	Physician Services - Maternity / Deliveries	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-0.72%	**0.00%**
Non-SSI Newborns 0 to 2 Months	Physician Services - Psychiatric / Substance Abuse	0.0%	0.0%	41.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	59.0%	0.00%	0.00%	9.58%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-0.72%	**3.50%**
Non-SSI Newborns 0 to 2 Months	Physician Services - All Other	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%	15.00%	0.00%	-2.66%	5.04%	0.00%	0.00%	0.00%	0.00%	0.00%	-0.39%	**-0.39%**
Non-SSI Newborns 0 to 2 Months	Dental - All Services	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	**0.00%**
Non-SSI Newborns 0 to 2 Months	All Other Services	0.0%	0.2%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	99.8%	0.00%	14.15%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.58%	**0.61%**
Foster Care	Inpatient Hospital Services - Maternity / Deliveries	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-1.04%	**-1.04%**
Foster Care	Inpatient Hospital Services - Psychiatric / Substance Abuse	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	59.1%	0.0%	0.0%	40.9%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	5.68%	0.00%	0.00%	-1.04%	**2.93%**
Foster Care	Inpatient Hospital Services - All Other	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-1.04%	**-1.04%**
Foster Care	Outpatient Hospital Services - Emergency Room	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	3.18%	**3.18%**
Foster Care	Outpatient Hospital Services - Pharmacy	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	2.50%	**2.50%**
Foster Care	Outpatient Hospital Services - All Other	0.0%	0.0%	31.0%	2.4%	0.0%	0.0%	0.0%	0.0%	0.0%	66.6%	0.00%	0.00%	3.61%	4.05%	0.00%	8.62%	0.00%	0.00%	0.00%	3.18%	**3.34%**
Foster Care	Physician Services - Maternity / Deliveries	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.53%	**0.53%**
Foster Care	Physician Services - Psychiatric / Substance Abuse	0.0%	0.0%	63.4%	0.0%	1.2%	0.0%	0.0%	30.8%	0.0%	4.7%	0.00%	0.00%	3.22%	0.00%	34.61%	0.00%	1.20%	1.53%	0.00%	0.53%	**2.95%**
Foster Care	Physician Services - All Other	4.0%	0.0%	4.5%	1.2%	0.0%	0.0%	0.0%	3.8%	0.0%	86.4%	11.49%	0.00%	1.96%	3.21%	0.00%	0.00%	1.20%	1.53%	0.00%	0.63%	**1.20%**
Foster Care	Dental - All Services	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	19.0%	81.0%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	2.50%	0.00%	**0.48%**
Foster Care	All Other Services	1.9%	25.8%	2.9%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	69.4%	10.53%	10.65%	3.93%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	2.03%	**4.47%**
MYPAC	Inpatient Hospital Services - Maternity / Deliveries	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-1.04%	**-1.04%**
MYPAC	Inpatient Hospital Services - Psychiatric / Substance Abuse	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	30.1%	0.0%	0.0%	69.9%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	5.50%	0.00%	0.00%	-1.04%	**0.93%**
MYPAC	Inpatient Hospital Services - All Other	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-1.04%	**-1.04%**
MYPAC	Outpatient Hospital Services - Emergency Room	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	3.18%	**3.18%**
MYPAC	Outpatient Hospital Services - Pharmacy	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	2.50%	**2.50%**
MYPAC	Outpatient Hospital Services - All Other	0.0%	0.0%	21.6%	1.3%	0.0%	0.0%	0.0%	0.0%	0.0%	77.1%	0.00%	0.00%	2.82%	1.59%	0.00%	0.00%	0.00%	0.00%	0.00%	3.18%	**3.08%**
MYPAC	Physician Services - Maternity / Deliveries	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.53%	**0.53%**
MYPAC	Physician Services - Psychiatric / Substance Abuse	0.0%	0.0%	3.8%	0.0%	0.0%	0.0%	0.0%	94.5%	0.0%	1.6%	0.00%	0.00%	3.85%	0.00%	26.02%	0.00%	1.20%	1.53%	0.00%	0.03%	**1.60%**
MYPAC	Physician Services - All Other	0.0%	0.0%	0.4%	0.0%	0.0%	0.0%	0.0%	91.3%	0.0%	8.3%	0.00%	0.00%	1.90%	3.97%	0.00%	0.00%	1.20%	1.53%	0.00%	0.05%	**1.41%**
MYPAC	Dental - All Services	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	21.7%	78.3%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	1.78%	0.00%	**0.39%**
MYPAC	All Other Services	0.0%	0.0%	3.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	97.0%	0.00%	0.00%	3.38%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	2.03%	**2.07%**

Exhibit 12
Mississippi Division of Medicaid
SFY 2026 MississippiCAN Capitation Rate Development
SFY 2026 MississippiCAN Expenditure Estimate

Rate Cell	*a* Projected SFY 2026 Member Months	*b* SFY 2026 Statewide Capitation Rates[1]	*c* MHAP-FSA PMPM	*d* Premium Tax on MHAP-FSA PMPM[2]	*e* MHAP-QIPP PMPM	*f* Premium Tax on MHAP-QIPP PMPM[2]	*g* TREAT PMPM	*h* Premium Tax on TREAT PMPM[2]	*i* MAPS PMPM	*j* Premium Tax on MAPS PMPM[2]	*k* MOMS PMPM	*l* Premium Tax on MOMS PMPM[2]	*m = sum of b through l* Total Rate at 1.0 Risk Score prior to Withhold	*n = a × m* MississippiCAN Estimated Cost	*o* FMAP / EFMAP[3]	*p = n × o* Federal Estimated Cost
Non-Newborn SSI / Disabled	740,802	$871.27	$295.73	$9.15	$148.97	$4.61	$4.85	$0.15	$5.66	$0.18	$1.21	$0.04	$1,341.81	$994,017,673	76.90%	$764,399,590
Breast and Cervical Cancer	598	$4,468.36	$1,499.24	$46.37	$148.97	$4.61	$4.85	$0.15	$5.66	$0.18	$1.21	$0.04	$6,179.64	$3,694,565	76.90%	$2,841,120
MA Adult	603,476	$375.66	$122.89	$3.80	$148.97	$4.61	$4.85	$0.15	$5.66	$0.18	$1.21	$0.04	$668.02	$403,131,839	76.90%	$310,008,384
Pregnant Women	221,974	$654.11	$290.76	$8.99	$148.97	$4.61	$4.85	$0.15	$5.66	$0.18	$1.21	$0.04	$1,119.52	$248,505,270	76.90%	$191,100,553
SSI / Disabled Newborn	5,867	$7,090.56	$4,166.57	$128.86	$148.97	$4.61	$4.85	$0.15	$5.66	$0.18	$1.21	$0.04	$11,551.66	$67,775,650	76.90%	$52,119,475
Non-SSI Newborns 0 to 2 Months	73,493	$2,382.32	$1,506.57	$46.60	$148.97	$4.61	$4.85	$0.15	$5.66	$0.18	$1.21	$0.04	$4,101.15	$301,404,275	76.90%	$231,779,888
Non-SSI Newborns 3 to 12 Months	232,659	$291.40	$71.74	$2.22	$148.97	$4.61	$4.85	$0.15	$5.66	$0.18	$1.21	$0.04	$531.02	$123,547,344	76.90%	$95,007,908
Foster Care	97,653	$724.03	$331.77	$10.26	$148.97	$4.61	$4.85	$0.15	$5.66	$0.18	$1.21	$0.04	$1,231.72	$120,281,124	76.90%	$92,496,184
MA Children	3,118,841	$217.63	$43.84	$1.36	$148.97	$4.61	$4.85	$0.15	$5.66	$0.18	$1.21	$0.04	$428.49	$1,336,401,259	76.90%	$1,027,692,568
Quasi-CHIP	379,285	$213.05	$39.76	$1.23	$148.97	$4.61	$4.85	$0.15	$5.66	$0.18	$1.21	$0.04	$419.70	$159,186,298	83.83%	$133,445,873
Total - All Rate Cells	**5,474,647**	**$389.94**	**$126.90**	**$3.92**	**$148.97**	**$4.61**	**$4.85**	**$0.15**	**$5.66**	**$0.18**	**$1.21**	**$0.04**	**$686.43**	**$3,757,945,297**	**77.19%**	**$2,900,891,544**
Total Expenditures - All Rate Cells		**$2,134,768,996**	**$694,749,941**	**$21,487,112**	**$815,576,017**	**$25,224,001**	**$26,549,485**	**$821,118**	**$31,002,486**	**$958,840**	**$6,603,083**	**$204,219**	**$3,757,945,297**			

[1] Capitation rates prior to quality withhold and VBP payments, excluding directed payments.
[2] Calculated using a premium tax of 3.00%.
[3] For SFY 2026, the FMAP is 76.90% and the EFMAP is 83.83%.

Exhibit 13A
Mississippi Division of Medicaid
SFY 2026 MississippiCAN Capitation Rate Development
High-Cost Pharmacy Risk Corridor
Illustrative Settlement Calculation

Rate Cell	*a* Illustrative Actual SFY 2026 Membership[1]	*b* SFY 2026 High-Cost Pharmacy Target PMPM	*c* Illustrative Actual SFY 2026 High-Cost Pharmacy Costs[2,3]	*d = c / a* Illustrative Actual SFY 2026 High-Cost Pharmacy PMPM
Non-Newborn SSI / Disabled	741,000	$17.39	$12,000,000	$16.19
Breast and Cervical Cancer	1,000	$0.00	$0	$0.00
MA Adult	603,000	$0.36	$0	$0.00
Pregnant Women	222,000	$0.00	$0	$0.00
SSI / Disabled Newborn	6,000	$0.22	$0	$0.00
Non-SSI Newborns 0 to 2 Months	73,000	$87.43	$7,000,000	$95.89
Non-SSI Newborns 3 to 12 Months	233,000	$0.00	$0	$0.00
Foster Care	98,000	$4.51	$500,000	$5.10
MA Children	3,119,000	$1.89	$5,000,000	$1.60
Quasi-CHIP	379,000	$0.36	$0	$0.00
Total	**5,475,000**	**$4.74**	**$24,500,000**	**$4.47**

Illustrative Actual Risk Corridor Eligible Costs	$24,500,000	*e = c*
Illustrative Target Risk Corridor Eligible Costs	$25,963,872	*f = a × b*
Difference ($)	($1,463,872)	*g = e - f*
Difference (%)	-5.64%	*h = g / f*

Risk Corridor Bands	*i* Percentage	*j = i × f* Dollars	*k = j × DOM %* Settlement
< -6%: 0% CCO / 100% DOM	0.00%	$0	$0
-6% to -3%: 50% CCO / 50% DOM	2.64%	$684,956	$342,478
-3% to 0%: 100% CCO / 0% DOM	3.00%	$778,916	$0
0% to 3%: 100% CCO / 0% DOM	0.00%	$0	$0
3% to 6%: 50% CCO / 50% DOM	0.00%	$0	$0
> 6%: 0% CCO / 100% DOM	0.00%	$0	$0

Total Risk Corridor Settlement Received (Paid) by DOM **$342,478**

[1] Illustrative values demonstrate projected enrollment mix. Actual values will use CCO-specific enrollment mix.
[2] PMPM calculation will be populated with actual SFY 2026 CCO-specific values.
[3] Includes all costs incurred during SFY 2026 eligible for the risk corridor, as outlined in the rate certification. Actual costs, but not target costs, will be populated with actual SFY 2026 CCO-specific experience.

Exhibit 13B
Mississippi Division of Medicaid
SFY 2026 MississippiCAN Capitation Rate Development
Illustrative MLR Development

	a	*b*	*c*	*d = b × c*	*e*	*f = d × (e × 2%) / (1 - 2%)*	*g*	*h*	*i*	*j*	*k*	*l = d + f + g + h + i + j + k*	*m*	*n = g + h + i + j + k + m*	*o = n / l*
Rate Cell	**Projected SFY 2026 Membership[1]**	**SFY 2026 Capitation Rates Net of Withhold**	**Illustrative Risk Score[1]**	**Risk Adjusted Premium Net of Withhold**	**% of Withhold Returned[1]**	**Withhold Returned PMPM**	**MHAP-FSA PMPM Gross of Premium Tax[1]**	**MHAP-QIPP Gross of Premium Tax[1]**	**MAPS Gross of Premium Tax[1]**	**TREAT Gross of Premium Tax[1]**	**MOMS Gross of Premium Tax[1]**	**Total Revenue PMPM**	**Projected SFY 2026 Medical Costs PMPM[2]**	**Projected Total Service Costs PMPM**	**Illustrative Target MLR**
Non-Newborn SSI / Disabled	740,802	$853.85	1.000	$853.85	100%	$17.43	$304.88	$153.58	$5.84	$5.00	$1.24	$1,341.81	$764.97	$1,235.52	92.1%
Breast and Cervical Cancer	598	$4,379.00	1.000	$4,379.00	100%	$89.37	$1,545.61	$153.58	$5.84	$5.00	$1.24	$6,179.64	$3,966.05	$5,677.33	91.9%
MA Adult	603,476	$368.15	1.000	$368.15	100%	$7.51	$126.69	$153.58	$5.84	$5.00	$1.24	$668.02	$323.93	$616.28	92.3%
Pregnant Women	221,974	$641.02	1.000	$641.02	100%	$13.08	$299.76	$153.58	$5.84	$5.00	$1.24	$1,119.52	$571.72	$1,037.14	92.6%
SSI / Disabled Newborn	5,867	$6,948.75	1.000	$6,948.75	100%	$141.81	$4,295.43	$153.58	$5.84	$5.00	$1.24	$11,551.66	$6,299.56	$10,760.66	93.2%
Non-SSI Newborns 0 to 2 Months	73,493	$2,334.68	1.000	$2,334.68	100%	$47.65	$1,553.17	$153.58	$5.84	$5.00	$1.24	$4,101.15	$2,109.67	$3,828.50	93.4%
Non-SSI Newborns 3 to 12 Months	232,659	$285.58	1.000	$285.58	100%	$5.83	$73.96	$153.58	$5.84	$5.00	$1.24	$531.02	$248.95	$488.56	92.0%
Foster Care	97,653	$709.55	1.000	$709.55	100%	$14.48	$342.03	$153.58	$5.84	$5.00	$1.24	$1,231.72	$633.95	$1,141.64	92.7%
MA Children	3,118,841	$213.28	1.000	$213.28	100%	$4.35	$45.20	$153.58	$5.84	$5.00	$1.24	$428.49	$183.30	$394.16	92.0%
Quasi-CHIP	379,285	$208.78	1.000	$208.78	100%	$4.26	$40.99	$153.58	$5.84	$5.00	$1.24	$419.70	$179.21	$385.87	91.9%
Total	**5,474,647**	**$382.14**	**1.000**	**$382.14**	**100%**	**$7.80**	**$130.83**	**$153.58**	**$5.84**	**$5.00**	**$1.24**	**$686.43**	**$336.63**	**$633.12**	**92.2%**
		$0.60													

[1] MLR calculation will be populated with actual SFY 2026 CCO-specific values.

[2] Includes all services incurred during SFY 2026 with payments made to providers as defined in Exhibit C of the CCO Contract, including fee-for-service payments, subcapitation payments, and settlement payments. CCO-specific target MLRs will be calculated with actual SFY 2026 CCO-specific values.

Exhibit 13C
Mississippi Division of Medicaid
SFY 2026 High Cost Pharmacy Risk Corridor Development

		Non-Newborn SSI / Disabled		Breast and Cervical Cancer		MA Adult		Pregnant Women		SSI / Disabled Newborn		Non-SSI Newborns 0 to 2 Months		Non-SSI Newborns 3 to 12 Months		Foster Care		MA Children		Quasi-CHIP	
		PMPM	Total	PMPM	Total	PMPM	Total	PMPM	Total	PMPM	Total	PMPM	Total	PMPM	Total	PMPM	Total	PMPM	Total	PMPM	Total
Step One: Remove cost of program changes from SFY 2026 risk corridor eligible PMPM																					
	Eligible Spend Rate Categories PMPM																				
	Outpatient Hospital - Pharmacy	$57.61		$1,661.09		$14.54		$8.77		$50.66		$2.85		$2.85		$3.16		$2.31		$3.57	
	Outpatient Hospital - Other	$139.24		$737.25		$67.98		$55.24		$228.08		$37.75		$39.86		$46.86		$29.17		$23.74	
	Physician - Other	$207.60		$1,316.64		$112.72		$156.05		$1,568.65		$508.13		$133.39		$117.94		$66.38		$59.04	
(a)	**Projected SFY 2026 Eligible Risk Corridor Spend[1]**	$404.45	$299,615,815	$3,714.98	$2,221,038	$195.24	$117,821,589	$220.05	$48,845,878	$36.20	$212,388	$548.72	$40,327,159	$176.10	$40,970,968	$167.96	$16,401,266	$97.86	$305,201,844	$86.34	$32,749,144
(b)	**Hemophilia Population Carve-In Eligible Spend[2]**	*$0.03*	*$20,403*	$0.00	$0	$0.00	$1,680	$0.00	$631	$0.00	$0	$0.00	$0	$0.00	$1	$0.00	$0	$0.00	$2,179	$0.00	$365
	Sickle Cell Disease Gene Therapy (Casgevy / Lyfgenia)																				
(c)	Gross Risk Corridor Eligible Costs	*$7.15*	*$5,300,000*	*$0.00*	*$0*	*$0.00*	*$0*	*$0.00*	*$0*	*$0.00*	*$0*	*$0.00*	*$0*	*$0.00*	*$0*	*$0.00*	*$0*	*$0.00*	*$0*	*$0.00*	*$0*
	Duchene Muscular Dystrophy Gene Therapy (Elevydis)																				
(d)	Gross Risk Corridor Eligible Costs	*$0.00*	*$0*	*$0.00*	*$0*	*$0.00*	*$0*	*$0.00*	*$0*	*$0.00*	*$0*	*$0.00*	*$0*	*$0.00*	*$0*	*$0.00*	*$0*	*$2.05*	*$6,400,000*	*$0.00*	*$0*
	Spinal Muscular Atrophy Gene Therapy (Zolgensma)																				
(e)	Gross Risk Corridor Eligible Costs	*$0.00*	*$0*	*$0.00*	*$0*	*$0.00*	*$0*	*$0.00*	*$0*	*$0.00*	*$0*	*$97.63*	*$7,175,116*	*$0.00*	*$0*	*$0.00*	*$0*	*$0.00*	*$0*	*$0.00*	*$0*
(f) = (a) - sum((b) to (e))	**Adjusted SFY 2026 Risk Corridor Eligible Spend**	**$397.27**	**$294,295,412**	**$3,714.98**	**$2,221,038**	**$195.24**	**$117,819,909**	**$220.05**	**$48,845,247**	**$36.20**	**$212,388**	**$451.09**	**$33,152,043**	**$176.10**	**$40,970,967**	**$167.96**	**$16,401,266**	**$95.80**	**$298,799,665**	**$86.34**	**$32,748,779**
Step Two: Using CY 2023 encounter data, estimate the percentage of eligible costs that will exceed the risk corridor threshold.																					
(g)	Applicable to Eligible Spend[3]	18.6%	18.6%	43.7%	43.7%	7.1%	7.1%	4.3%	4.3%	2.0%	2.0%	0.2%	0.2%	0.7%	0.7%	5.8%	5.8%	2.0%	2.0%	4.3%	4.3%
(h)	Historical Percentage of Claims Over Threshold[3]	14.0%	14.0%	0.0%	0.0%	2.6%	2.6%	0.0%	0.0%	30.4%	30.4%	0.0%	0.0%	0.0%	0.0%	46.0%	46.0%	0.0%	0.0%	9.5%	9.5%
(i) = (f) x (g) x (h)	**Anticipated SFY 2026 Risk Corridor Eligible Cost Over Threshold, Prior to Program Changes**	**$10.37**	**$7,685,316**	**$0.00**	**$0**	**$0.36**	**$215,050**	**$0.00**	**$0**	**$0.22**	**$1,265**	**$0.00**	**$0**	**$0.00**	**$0**	**$4.51**	**$440,467**	**$0.00**	**$0**	**$0.36**	**$134,650**
Step Three: Add the cost of new eligible covered services for SFY 2026 to Step Two. See Exhibit 2 and Exhibit 3B for the development of the risk corridor eligible spend associated with gene therapies in items (15) through (20).																					
	Sickle Cell Disease Gene Therapy (Casgevy / Lyfgenia)																				
(j)	*Risk Corridor Eligible Spend*	*$7.02*	*$5,200,000*	*$0.00*	*$0*	*$0.00*	*$0*	*$0.00*	*$0*	*$0.00*	*$0*	*$0.00*	*$0*	*$0.00*	*$0*	*$0.00*	*$0*	*$0.00*	*$0*	*$0.00*	*$0*
	Duchene Muscular Dystrophy Gene Therapy (Elevydis)																				
(k)	*Risk Corridor Eligible Spend*	*$0.00*	*$0*	*$0.00*	*$0*	*$0.00*	*$0*	*$0.00*	*$0*	*$0.00*	*$0*	*$0.00*	*$0*	*$0.00*	*$0*	*$0.00*	*$0*	*$1.89*	*$5,900,000*	*$0.00*	*$0*
	Spinal Muscular Atrophy Gene Therapy (Zolgensma)																				
(l)	*Risk Corridor Eligible Spend*	*$0.00*	*$0*	*$0.00*	*$0*	*$0.00*	*$0*	*$0.00*	*$0*	*$0.00*	*$0*	*$87.43*	*$6,425,116*	*$0.00*	*$0*	*$0.00*	*$0*	*$0.00*	*$0*	*$0.00*	*$0*
(m) = sum((i) to (l))	**Anticipated SFY 2026 Risk Score Eligible Cost Over Threshold, Including Program Changes**	**$17.39**	**$12,885,316**	**$0.00**	**$0**	**$0.36**	**$215,050**	**$0.00**	**$0**	**$0.22**	**$1,265**	**$87.43**	**$6,425,116**	**$0.00**	**$0**	**$4.51**	**$440,467**	**$1.89**	**$5,900,000**	**$0.36**	**$134,650**

[1] PMPM amounts tie to the final row of Exhibit 2A and Exhibit 2B.
[2] CY 2023 claims for members with hemophilia that transitioned from FFS to MSCAN on January 1, 2024 trended forward to SFY 2026.
[3] See Exhibit 13D for the development of the risk corridor eligible spend for each gene therapy.

Exhibit 13D
Mississippi Division of Medicaid
SFY 2026 High Cost Pharmacy Risk Corridor Development - Gene Therapy Supplemental Support

		Non-Newborn SSI / Disabled	Breast and Cervical Cancer	MA Adult	Pregnant Women	SSI / Disabled Newborn	Non-SSI Newborns 0 to 2 Months	Non-SSI Newborns 3 to 12 Months	Foster Care	MA Children	Quasi-CHIP
Sickle Cell Disease Gene Therapy (Casgevy / Lyfgenia)											
(a)	Expected Number of Therapies	2	0	0	0	0	0	0	0	0	0
(b)	Net Pharmacy Cost for Gene Therapy[1]	$5,300,000	$0	$0	$0	$0	$0	$0	$0	$0	$0
(c)	Applicable Inpatient Hospital Cost for Gene Therapy	$400,000	$0	$0	$0	$0	$0	$0	$0	$0	$0
(d) = (b) + (c)	*Total Gene Therapy Cost*	*$5,700,000*	*$0*	*$0*	*$0*	*$0*	*$0*	*$0*	*$0*	*$0*	*$0*
(e) = (d) / (a)	Total Cost per Therapy	$2,850,000	$0	$0	$0	$0	$0	$0	$0	$0	$0
(f)	Pharmacy RC Threshold per Member	$250,000	$0	$0	$0	$0	$0	$0	$0	$0	$0
(g) = max[(e) - (f), 0]	*RC Eligible Dollars per Member*	*$2,600,000*	*$0*	*$0*	*$0*	*$0*	*$0*	*$0*	*$0*	*$0*	*$0*
(h) = (g) x (a)	*Total RC Eligible Dollars*	*$5,200,000*	*$0*	*$0*	*$0*	*$0*	*$0*	*$0*	*$0*	*$0*	*$0*
Duchene Muscular Dystrophy Gene Therapy (Elevydis)											
(a)	Expected Number of Therapies	0	0	0	0	0	0	0	0	2	0
(b)	Net Pharmacy Cost for Gene Therapy[1]	$0	$0	$0	$0	$0	$0	$0	$0	$6,400,000	$0
(c)	Applicable Inpatient Hospital Cost for Gene Therapy	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
(d) = (b) + (c)	*Total Gene Therapy Cost*	*$0*	*$0*	*$0*	*$0*	*$0*	*$0*	*$0*	*$0*	*$6,400,000*	*$0*
(e) = (d) / (a)	Total Cost per Therapy	$0	$0	$0	$0	$0	$0	$0	$0	$3,200,000	$0
(f)	Pharmacy RC Threshold per Member	$0	$0	$0	$0	$0	$0	$0	$0	$250,000	$0
(g) = max[(e) - (f), 0]	*RC Eligible Dollars per Member*	*$0*	*$0*	*$0*	*$0*	*$0*	*$0*	*$0*	*$0*	*$2,950,000*	*$0*
(h) = (g) x (a)	*Total RC Eligible Dollars*	*$0*	*$0*	*$0*	*$0*	*$0*	*$0*	*$0*	*$0*	*$5,900,000*	*$0*
Spinal Muscular Atrophy Gene Therapy (Zolgensma)											
(a)	Expected Number of Therapies	0	0	0	0	0	3	0	0	0	0
(b)	Net Pharmacy Cost for Gene Therapy[1]	$0	$0	$0	$0	$0	$7,175,116	$0	$0	$0	$0
(c)	Applicable Inpatient Hospital Cost for Gene Therapy	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
(d) = (b) + (c)	*Total Gene Therapy Cost*	*$0*	*$0*	*$0*	*$0*	*$0*	*$7,175,116*	*$0*	*$0*	*$0*	*$0*
(e) = (d) / (a)	Total Cost per Therapy	$0	$0	$0	$0	$0	$2,391,705	$0	$0	$0	$0
(f)	Pharmacy RC Threshold per Member	$0	$0	$0	$0	$0	$250,000	$0	$0	$0	$0
(g) = max[(e) - (f), 0]	*RC Eligible Dollars per Member*	*$0*	*$0*	*$0*	*$0*	*$0*	*$2,141,705*	*$0*	*$0*	*$0*	*$0*
(h) = (g) x (a)	*Total RC Eligible Dollars*	*$0*	*$0*	*$0*	*$0*	*$0*	*$6,425,116*	*$0*	*$0*	*$0*	*$0*

[1] Reconciles to Exhibit 13C items (c) through (e).

Exhibit 14A
Mississippi Division of Medicaid
Procedure Codes for Non-Psychiatric Physician Visits

90000	90066	90541	90642
90001	90067	90542	90643
90002	90068	90543	90650
90003	90069	90544	90651
90004	90070	90545	90652
90005	90071	90546	90653
90006	90072	90547	90654
90007	90073	90548	92002
90008	90074	90549	92004
90009	90075	90550	92012
90010	90076	90551	92014
90011	90077	90552	99062
90012	90078	90553	99063
90013	90079	90554	99064
90014	90080	90555	99065
90015	90500	90556	99201
90016	90501	90557	99202
90017	90502	90558	99203
90018	90503	90559	99204
90019	90504	90560	99205
90020	90505	90561	99212
90040	90506	90562	99213
90041	90507	90563	99214
90042	90508	90564	99215
90043	90509	90565	99241
90044	90510	90566	99242
90045	90511	90567	99243
90046	90512	90568	99244
90047	90513	90569	99245
90048	90514	90570	99271
90049	90515	90571	99272
90050	90516	90572	99273
90051	90517	90573	99274
90052	90518	90574	99275
90053	90519	90575	99281
90054	90520	90576	99282
90055	90530	90577	99283
90056	90531	90578	99284
90057	90532	90579	99285
90058	90533	90580	99341
90059	90534	90600	99342
90060	90535	90605	99343
90061	90536	90610	99344
90062	90537	90620	99345
90063	90538	90630	99347
90064	90539	90640	99350
90065	90540	90641	

Exhibit 14B
Mississippi Division of Medicaid
Procedure Codes for Psychiatric Physician Visits

90791
90792
90832
90834
90837
90846
90847
90849
90853
90870
99201
99202
99203
99204
99205
99212
99213
99214
99215

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April 7, 2025

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

Re: Report09 State Fiscal Year 2026 CHIP Preliminary Rate Calculation and Certification - DRAFT

Dear Jennifer:

The Mississippi Division of Medicaid (DOM) has retained Milliman to develop the state fiscal year SFY 2026 capitation rate for the Children's Health Insurance Program (CHIP) population, effective July 1, 2025 to June 30, 2026.

The attached report documents the preliminary capitation rate for CHIP. Overall, the preliminary SFY 2026 capitation rate in this report is 4.3% higher than the SFY 2025 capitation rate issued on December 4, 2024.[1]

There are many considerations taken in the development of the SFY 2026 capitation rate to reflect impacts of COVID-19 and the unwinding of the continuous coverage requirement (CCR) in the Families First Coronavirus ACT (FFCRA). This includes consideration of the impacts of COVID-19 when setting prospective utilization and unit charge trends, as well as analyzing population acuity over time through a risk score-based analysis.

This preliminary report does not include adjustments related to policy or procedural changes that result from the 2025 state legislative session. If needed, we will amend the capitation rate accordingly in a subsequent release for these items.

❖ ❖ ❖ ❖ ❖

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

Sincerely,

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

Katarina N. Lorenz, FSA, MAAA
Consulting Actuary

JAB/KNL/bl

Attachments

[1] *"Report19 - SFY 2025 Preliminary CHIP Rate Calculation and Certification.pdf" dated December 4, 2024.*

DRAFT

MILLIMAN REPORT

State of Mississippi Division of Medicaid

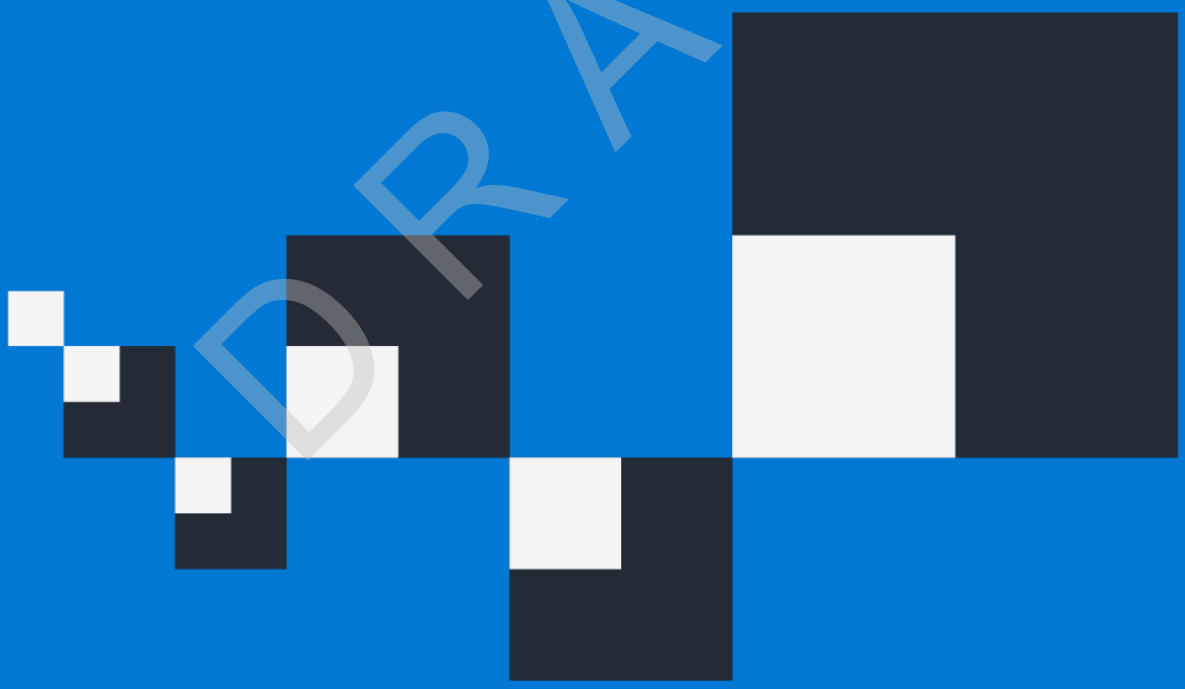
State Fiscal Year 2026 CHIP Preliminary Rate Calculation and Certification - DRAFT

April 7, 2025

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

Katarina N. Lorenz, FSA, MAAA
Consulting Actuary

DRAFT



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Milliman

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EXHIBIT 3 Non-Service Expense Allowance Development
EXHIBIT 4 Illustrative High-Cost Pharmacy Settlement
EXHIBIT 5 Service Category to Milliman *HCGs* Grouper Category Mapping
EXHIBIT 6 Historical PMPM Trend Summary
EXHIBIT 7 CY 2023 Databook
EXHIBIT 8 Enhanced Match Services – **INTENTIONALLY LEFT BLANK FOR DRAFT**

Expenditure Projection

EXHIBIT 9 CHIP Expenditure Projection

High-Cost Pharmacy Risk Corridor Support

EXHIBIT 10 High-Cost Pharmacy Risk Corridor Development

APPENDICES

Supporting Documentation

APPENDIX A Data Processing
APPENDIX B CHIP Actuarial Certification – **INTENTIONALLY LEFT BLANK FOR DRAFT**
APPENDIX C Data Reliance Letter – **INTENTIONALLY LEFT BLANK FOR DRAFT**

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I. SUMMARY AND DISCUSSION OF RESULTS

The Mississippi Division of Medicaid (DOM) retained Milliman to calculate and document the capitation rate for the Children's Health Insurance Program (CHIP) population effective for state fiscal year (SFY) 2026. This report documents the development of the preliminary capitation rate for the CHIP population. This report is structured as follows:

- Section I includes a high-level overview of the change in the capitation rate relative to the SFY 2025 capitation rate.
- Section II describes the methodology used to develop the SFY 2026 CHIP capitation rate.
- Appendix A contains additional information on the base period data sources and processing.
- Appendix B contains an Actuarial Certification for the CHIP program. ***This is intentionally blank for the draft report.***
- Appendix C documents our reliance on DOM for data and other assumptions in the development of the capitation rate. ***This is intentionally blank for the draft report.***

CATEGORIES OF SERVICE

Table 1 below shows the categories of service for the SFY 2026 capitation rate. Similar to the SFY 2025 capitation rate, we use a more granular category of service methodology to develop the SFY 2026 capitation rate. In this more granular methodology inpatient, outpatient, and physician services are further subset into more specific sub-categories of service.

Starting in July 2024, DOM entered into an arrangement with their Pharmacy Benefits Administrator (PBA) in which certain pharmacy claims are paid through the PBA. While these pharmacy services are not carved-out of managed care, the CCO is not at risk for these expenses. As such, we identified and removed the associated pharmacy claims from the base data for the purpose of developing the SFY 2026 capitation rate. Please see Appendix A for a further description of the associated pharmacy services.

Table 1
CHIP Capitation Rate Development
SFY 2026 Categories of Service

High Level Service Category	Detailed Service Category
Inpatient Hospital	Inpatient Hospital Services - Maternity / Deliveries
	Inpatient Hospital Services - Psychiatric / Substance Abuse
	Inpatient Hospital Services - All Other
Outpatient Hospital	Outpatient Hospital Services - Emergency Room
	Outpatient Hospital Services - Pharmacy
	Outpatient Hospital Services - All Other
Physician	Physician Services - Maternity / Deliveries
	Physician Services - Psychiatric / Substance Abuse
	Physician Services - All Other
Dental	Dental - All Services
Other	All Other Services

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CAPITATION RATE CHANGE SUMMARY

The per member per month (PMPM) preliminary capitation rate for SFY 2026 is $237.50.

The SFY 2026 CHIP capitation rate is 4.3% higher than the SFY 2025 capitation rate. Table 2 shows a summary of the main drivers of the rate change that make up this change to the capitation rate.

Table 2
Mississippi Division of Medicaid
Summary of SFY 2026 Rate Change by Component

Final SFY 2025 Capitation Rate	**$227.64**
Base Period Data Update	1.000
Restate CY 2023 to SFY 2025 Trends	1.015
SFY 2025 to SFY 2026 Trends	1.047
SFY 2026 Population Acuity Adjustment	0.978
Updated SFY 2026 Admin	1.004
Preliminary SFY 2026 Rate Change	**1.043**

The development of the SFY 2026 capitation rate is a ground-up approach where the base data and each assumption is evaluated separate from the SFY 2025 capitation rate. However, for the purposes of explaining the rate change from SFY 2025 to SFY 2026, we break apart the total rate change into sub-components as shown in Table 2 above. This demonstrates the impact of incrementally updating each rate component to better assess the impact each contributes to the overall rate change. Each component is described in more detail below.

- Base Period Data Update: CY 2022 claims data was used as the base period for SFY 2025 rate setting, whereas CY 2023 data was used for the SFY 2026 rate. The impact of updating the base period data was approximately net neutral including the associated impact of restating base data adjustments.

- Restate CY 2023 to SFY 2025 Trends: Utilization and unit cost trend assumptions from CY 2023 to SFY 2025 were restated based upon a review of more recent experience. The same trends are used for the entire projection time period, so updated trends reflect the revised trend assumptions selected for CY 2023 to SFY 2026, which may differ from those selected for SFY 2025 capitation rate setting. This trend restatement results in an increase to the CHIP capitation rate of 1.5%.

- SFY 2025 to SFY 2026 Trends: Claim costs were increased approximately 4.7% for anticipated utilization and unit charge increases from SFY 2025 to SFY 2026. Please see Section II for more information on trend assumptions included in the SFY 2026 capitation rate.

- SFY 2026 Population Acuity Adjustment: The continuous coverage requirement ended on March 31, 2023 and DOM started redeterminations in April 2023, with disenrollments of ineligible recipients starting in July 2023. Given the changes in enrollment, Milliman analyzed the acuity of the CHIP population over time using a risk score-based approach to evaluate acuity differences between CY 2023 and SFY 2026. This analysis resulted in no adjustment being applied for the SFY 2026 capitation rate. A similar analysis was also performed for SFY 2025 capitation rate setting. The impact of updating the population acuity adjustment from the adjustment applied in SFY 2025 to no adjustment for SFY 2026 is a decrease of approximately 2.2%, however a partially offsetting impact of the acuity change is likely included in the base data update which reflects the change from CY 2022 to CY 2023. Please see Section II for a further description of the population acuity analysis performed for SFY 2026.

- Update SFY 2026 Admin: Changes to administrative expenses on a PMPM basis result in an increase to the rate of approximately 0.4%, based upon CCO reported administrative expenses for CY 2023 trended to SFY 2026. A positive rate change in Table 2 indicates that the administrative costs increased as a percentage of the overall rate (i.e., administrative costs trended at a higher percentage than the overall rate). The overall PMPM for administrative expenses increased 3.9% from the SFY 2025 allowance, comprised of a fixed administrative expense increase from $6.78 PMPM in the SFY 2025 rate to $7.05 PMPM in the SFY 2026 rate, and variable administrative expense increase from $15.83 in the SFY 2025 rate to $16.44 in the SFY 2026 rate.

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DATA RELIANCE AND IMPORTANT CAVEATS

Milliman has developed certain models to estimate the values included in this report. The intent of the models was to estimate the SFY 2026 CHIP capitation rate. We reviewed the models, including their inputs, calculations, and outputs for consistency, reasonableness, and appropriateness to the intended purpose and in compliance with generally accepted actuarial practice and relevant actuarial standards of practice (ASOP).

The models rely on data and information as input to the models. We used CCO encounter data and CCO financial reporting for January 2023 to December 2023 with runout through August 2024, historical and projected reimbursement information, fee schedules, and other information from DOM, CHIP CCOs, Gainwell Technologies, Myers and Stauffer, and CMS to calculate the preliminary CHIP capitation rate shown in this report. If the underlying data used is inadequate or incomplete, the results will be likewise inadequate or incomplete. Please see Appendix A for a full list of the data relied upon to develop the SFY 2026 base data.

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

Our report is intended for the internal use of DOM to review the preliminary CHIP capitation rate for SFY 2026. The report and the models used to develop the values in this report may not be appropriate for other purposes. We anticipate the report will be shared with contracted CCOs, CMS and other interested parties. Milliman does not intend to service, and assumes no duty or liability to, other parties who receive this work. It should only be distributed and reviewed in its entirety. This capitation rate may not be appropriate for all CCOs. Any CCO considering participating in CHIP should consider their unique circumstances before deciding to contract under this rate.

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

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

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II. DEVELOPMENT OF CAPITATION RATE

This section of the report describes the development of the preliminary SFY 2026 CHIP capitation rate.

METHODOLOGY OVERVIEW

The methodology used to calculate the capitation rate can be outlined in the following steps:

1. Summarize financial reporting and encounter data for CY 2023 CHIP enrollees.
2. Trend CY 2023 adjusted experience to SFY 2026.
3. Apply adjustments for program changes.
4. Provide an allowance for non-service expenses.
5. Adjust for CCO specific risk scores.
6. Calculate risk corridor settlements.

Each of the above steps is described in detail below.

Step 1: Summarize Financial Reporting and Encounter Data for CY 2023 CHIP Enrollees

MEMBERSHIP

Member months in CY 2023 were summarized from the detailed CHIP eligibility data. These enrollment counts were validated against enrollment information provided by the CCOs. In total, the enrollment in the eligibility files is within 0.06% of enrollment as reported by the CCOs.

Row (a) of Exhibit 1 includes the CY 2023 member months included in base data development.

CLAIM DATA

The encounter data expenditures for both currently operating CCOs are combined to summarize CY 2023 claim experience for CHIP enrollees with runout through August 2024. Row (b) of Exhibit 1 includes the CY 2023 total claim costs from the encounter data. Row (c) converts the total costs to a PMPM basis.

All experience used to develop the base period data for the SFY 2026 capitation rate is on a net basis, excluding any member cost sharing, which varies by the income eligibility of the enrolled child's family.

- No copayments are charged to enrolled children in families with an annual income up to 150% FPL.
- Enrolled children in families with an annual income above 150% of the FPL are charged the following copayments:
  - Outpatient Health Care Professional Visit, $5.00.
  - Emergency Room Visit, $15.00.
- Annual out-of-pocket maximums for the following are in place:
  - Families with annual income from 151% to 175% FPL shall pay no more than $800.
  - Families with annual income above 175% FPL shall pay no more than $950.

No cost sharing is applied to preventive services, including immunizations, well childcare, routine preventive and diagnostic dental services, routine dental fillings, routine eye examinations, eyeglasses, or hearing aids. There is also no cost sharing for American Indian or Alaska Native children.

In addition, no cost sharing is charged on outpatient mental health and substance use disorder (SUD) visits for all income eligibility levels.

Exhibit 7 contains the databook summarizing the total paid amounts and paid PMPMs in the encounter data for CY 2023.

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Data Collection and Validation

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

As part of rate development, Milliman requests financial reporting data from each CCO. This financial reporting data is reconciled to each CCO's CY 2023 audited NAIC financial statement. After several rounds of questions to clarify, adjust, and confirm understanding of the reported financial information, Milliman compared the encounter data to the financial reporting data, together for paid claims and subcapitated claims. This comparison excludes any claims that were identified as missing from the processed encounter data. To align the financial templates and encounter data on a comparable basis, we performed this reconciliation exercise using CY 2023 data with run-out through August 2024.

Traditionally, claims runout in the encounter data is limited to align with the CCO submitted financial template data. However, when reconciling encounter data utilizing the available paid date fields, we observed material differences in the paid amounts when comparing encounter data (with runout through June 2024) to the paid data submitted by the CCOs. Therefore, we removed paid date limitations from the encounter data processing and are reconciling the encounter data with run-out through August 2024 to the paid amounts provided by the CCOs. A separate adjustment is then applied to reflect the CCO reported incurred but not reported (IBNR) values. Additional details on the calculation of the IBNR adjustment are discussed in more detail below.

DOM transitioned to a new data vendor during CY 2022. In the process of reviewing the CY 2023 data from the new data vendor, Gainwell, we noted several issues, including duplicate claims. We are still working with DOM and Gainwell to determine a possible resolution for this issue. Therefore, this base data report includes an adjustment to calibrate encounters to CCO reported financial levels at a high-level service category level. This adjustment is discussed in more detail below.

Encounter to Financial Adjustment

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

- Overall, the paid amounts in the encounters exceed the paid amounts shown in the CCO financial reporting for the CHIP population. Table 3 shows that encounter data is 0.02% higher than financial data.
- At a category of service level, there was a greater variance between encounter data and financial reporting, particularly for the Dental service category, where encounter data is higher than reported costs in the financial templates. Therefore, when calculating and applying the financial to encounter data adjustments we applied separate adjustments for inpatient and dental services. All other services receive the same adjustment.

Table 3
Mississippi Division of Medicaid
SFY 2026 CHIP Capitation Rate Development
Comparison of Financial and Encounter Data

Difference of Encounters and Financials (% of Encounters)	
OP / Physician / Other Services	1.72%
IP Services	-11.20%
Dental Services	6.64%
All Services	-0.02%

Encounter data for both CCOs historically participating in the CHIP program is combined to summarize CY 2023 claim experience for CHIP enrollees. The financial reporting expenditures for all CCOs were combined to perform the encounter validation outlined above, as well as to develop the following adjustments to apply to the encounter data:

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

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To reflect differences between claims in the financial reporting and the encounter data, the financial to encounter data adjustment is applied on row (d) of Exhibit 1. Given duplicate claims and other encounter data issues noted by Gainwell and DOM, this adjustment calibrates overall encounter claims to levels reported in the financial templates.

Missing Data Adjustment

A separate adjustment was made to account for payments made by the CCOs that are not reflected in the detailed encounter data or cannot be reasonably applied to a specific claim (e.g., provider bonuses or settlements). These claim amounts are not included in the detailed encounter data after the processing outlined in Appendix A.

Each CCO provided separate financial reporting to support and validate the amounts reported for claims not appearing in encounters. The detailed financial reporting provided by the CCOs included splits by service category, which were used to allocate missing data on Exhibit 1.

Overall, the base data is increased by 0.2% on a PMPM basis for missing data.

The detailed missing data adjustments for each service category are shown in Exhibit 1 in row (e).

IBNR Adjustment

The adjustment for IBNR claims uses the best estimate IBNR claims provided by each of the CCOs in their financial reporting. This adjustment reflects a claims runout date of June 30, 2024 as reported by the CCOs in their financial template submissions. Although the encounter data is not limited to the same runout date, we do separately reconcile the encounter claims to the paid amounts reported by the CCOs.

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

- Data, including IBNR estimates, was reported on a quarterly basis by each CCO. We reviewed the reported IBNR by quarter to determine that there was a reasonable pattern throughout the year (i.e., IBNR amounts held for Q1 2023 were significantly lower than Q4 2023).
- IBNR estimates among the CCOs were reviewed to validate that they were approximately the same as a percentage of total claims, where appropriate.
- IBNR estimates by category of service are approximately the same as a percentage of total claims as IBNR adjustments applied to the CHIP data in prior years after accounting for differences in runout period between years.

Overall, the base data increased by 0.3% on a PMPM basis for IBNR claims.

The IBNR adjustment is shown in Exhibit 1 in row (f).

Non-Covered Services

The value of expanded services offered to plan members that were not CHIP covered services during the base data period are excluded from the base data. In CY 2023, these services are non-emergency transportation services offered by one CCO. The costs of expanded services were excluded from paid claims in CCO financial reporting. These services are equivalent to approximately 0.02% of total reported CHIP CY 2023 service costs. Corresponding amounts were removed from the encounter data, as reported by the impacted CCO.

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

Third Party Liability Recoveries

The CCOs provided Milliman with a summary of recoveries for TPL payments related to claims incurred in CY 2023 and recovered through December 2024. Using CY 2023 data, Milliman reviewed the portion of total CY 2023 recoveries. We removed the total TPL amounts as a percentage of total paid claims across all service categories from the CY 2023 base data. These TPL recoveries amounted to a 0.3% reduction to CY 2023 base data. We do not have information to apply this estimate at a category of service level, and therefore, apply a uniform adjustment for the estimate of TPL recoveries.

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

Adjusted CY 2023 PMPM Costs

Total CY 2023 base period PMPM costs are shown in Exhibit 1 row (i).

Step 2: Trend CY 2023 Adjusted Experience to SFY 2026

Starting with the base data developed in Step 1, we apply trend adjustments to project the base period costs to SFY 2026. Below, we describe each trend adjustment shown on Exhibit 2. The adjustments for non-pharmacy and pharmacy services for which the CCOs are responsible (physician administered drugs) are developed using different methodologies and are therefore described separately in this section.

Non-Pharmacy Trend Overview

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

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

- Encounter data and financial reporting experience for CHIP members to analyze PMPM and utilization trends by major service categories. Exhibit 6 includes a historical trend summary for the CHIP program from CY 2021 through June 2024. This includes encounter data from the two CCOs that have provided CHIP services over the time period shown and has been normalized for the following to put it on a consistent basis across time:
  - IBNR from the financial templates was added to the encounter data to review PMPM trends on a completed basis.
  - Estimates of the impact of the following material program or reimbursement changes were removed for the applicable time periods. These changes are accounted for in separate adjustments in this report, and therefore, should not be included in data analyzed for trends.
    - Financial to encounter adjustments
    - Provider settlements
  - No adjustments were made to account for population acuity changes over time.
- Experience from similar programs in other states.
- Anticipated reimbursement changes for Medicaid FFS, as well as commercial plans, as the CHIP provider contracts are a mix of being tied to the Medicaid FFS fee schedules and alternative methodologies.

In addition, we reviewed CY 2023 and emerging CY 2024 experience reported by the CCOs for changes in PMPM costs as the continuous coverage requirement unwind occurred.

Utilization and unit charge adjustments are shown in rows (c) and (d), respectively, on Exhibit 2.

Physician Administered Drug Utilization and Unit Cost Trends

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

- ***CHIP-Specific Data*** – We analyzed completed January 2023 to July 2024 experience by drug type for pharmacy claims administered in a medical setting, also referred to in this report as PADs.

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

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

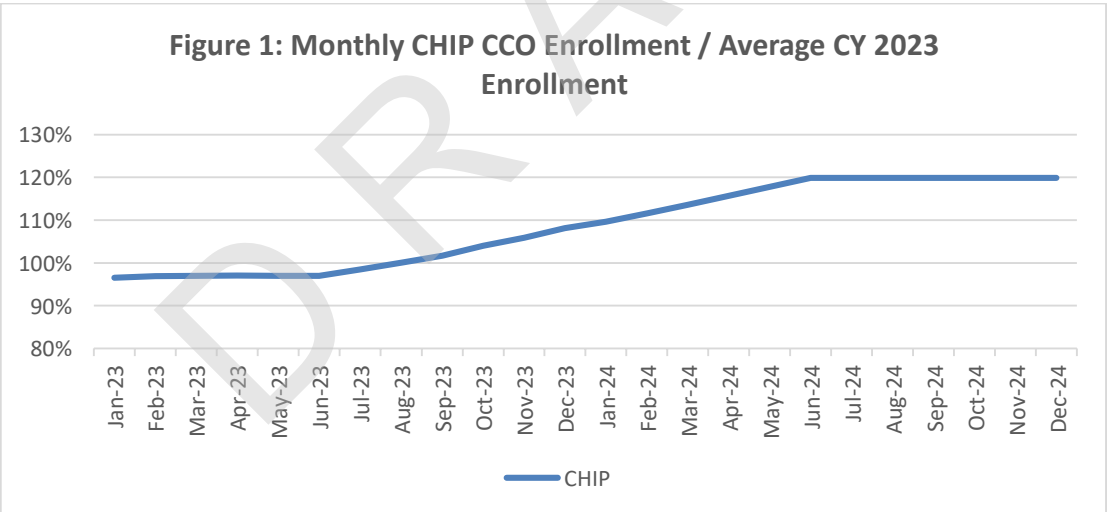
Based on our analyses, we estimate annualized utilization and unit cost trends of 1.81%, respectively, from CY 2023 to SFY 2026.

Step 3: Apply Program Change Adjustments

For SFY 2026, there are no currently expected program or reimbursement changes expected for CHIP relative to the base period of CY 2023.

Population Acuity Adjustment

The continuous coverage requirement ended on March 31, 2023, and DOM initiated Medicaid eligibility redeterminations in April 2023, with disenrollments of ineligible recipients starting in July 2023 and continuing over the next 12 months. Since the beginning of the continuous coverage requirement unwinding period, we have seen steady CHIP enrollment increases throughout CY 2023 and into CY 2024. Figure 1 shows this change in monthly enrollment compared to the average enrollment in CY 2023 for the CHIP population (e.g., a ratio of 110% indicates that month's enrollment is 10% higher than the average enrollment during the CY 2023 base data).



To evaluate whether there is a change in acuity due to population changes between the CY 2023 base period data and the population we expect to be enrolled during SFY 2026, we performed a risk score-based acuity analysis. We calculated risk scores for two distinct time frames:

1. CY 2023 (April 2022 through March 2023 diagnoses and CY 2023 enrollment).

2. December 2024 (October 2023 through September 2024 diagnoses and December 2024 enrollment used as a proxy for the population enrolled during SFY 2026).

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To develop the risk scores described above, we used the MississippiCAN and CHIP custom risk weights for SFY 2025, as described in a previous letter.[2] As outlined there, when creating the Mississippi custom cost weights, we removed the associated pharmacy claims from the member-level cost calculations used as the basis for our regression analysis. Pharmacy claims remain in the diagnosis data for the development of risk scores for flagging conditions via relevant NDC codes; however, diagnosis periods were selected to avoid the May through September 2023 timeframe due to known pharmacy related data issues. Given the large changes in membership between CY 2023 and December 2024 we only looked at members that were able to be "scored," meaning they had at least six months of enrollment during the diagnosis period. As shown in Table 4 below, the scored percentages are not materially different between the two time periods.

We compared the average risk scores for December 2024 enrollment compared to the average risk score in CY 2023. This supported making no adjustment for the CHIP population given the population in CY 2023 has a very similar risk score to that expected for SFY 2026. The results of our analysis are shown in Table 4 below.

Table 4
Mississippi Division of Medicaid
SFY 2026 CHIP Capitation Rate Development
Population Acuity Adjustment

	CY 2023 - Scored Members			December 2024 - Scored Members					
Cap Cell	Average Monthly Membership	Scored %	Average Risk Score	Members	Scored %	Average Risk Score	Membership Change	Risk Score Change	Final Acuity Adjustment
	A	B	C	D	E	F	G = D / A	H = F / C	I[1]
CHIP	41,600	95.9%	1.031	50,414	95.5%	1.029	1.212	0.999	1.000

[1] The final acuity adjustment in column I is the rounded risk score change in column H.

Step 4: Provide an Allowance for CCO Non-Service Expenses

Administrative Expenses, Premium Tax, and Targeted Margin

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

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

The non-service expense allowance for the SFY 2026 capitation rate is comprised of a flat PMPM for fixed administrative costs and a percentage of revenue for variable administrative costs. We also included explicit adjustments of 1.80% of revenue for target margin and 3.00% for the Mississippi premium tax, for a total non-service expense allowance of 14.69%. Table 5 displays the allowance included in the CHIP rate for non-service expenses.

Table 5
Mississippi Division of Medicaid
Non-Service Expenses

	% of Revenue	PMPM
Fixed Costs[1]	2.97%	**$7.05**
Variable Costs[2]	**6.92%**	$16.44
Premium Tax[2]	**3.00%**	$7.13
Margin[2]	**1.80%**	$4.28
Total	14.69%	$34.89

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

[2] *Wentworth13 – July 2024 MSCAN Risk Weight Development.pdf, dated October 31, 2024."*

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The administrative expense allowance for SFY 2026 was developed by trending the adjusted CY 2022 PMPM costs reported by the CCOs, excluding any PBA related costs, and supporting the SFY 2025 administrative cost assumption. We reviewed updated financial template data supplied by the CCOs for CY 2023 and were not able to collect sufficient documentation to support the large increases reported by several of the CCOs. Therefore, this data was not directly used in calculating the SFY 2026 administrative expense assumptions. We additionally reviewed data on benchmark administrative costs for Medicaid programs nationwide to validate that the assumed administrative costs are sufficient for the CHIP program.

Adjusted CY 2022 administrative expenses were trended by an annual trend of 3.9% from CY 2022 to SFY 2026. The 3.9% annual trend is a blend of actual employment cost index (ECI) data from CY 2022 through CY 2024 showing a trend of 4.1% annually and an assumed 3.6% annual trend from CY 2024 to SFY 2026. The future 3.6% trend assumption is consistent with the average ECI annual change from CY 2018 through CY 2023. The ECI data reflects expected changes in wages and other services that comprise a majority of administrative costs. In addition, we reviewed the CMS Medicare Economic Index (MEI) that includes actual changes through June 2024 and forecasted quarterly changes afterwards. The MEI from CY 2022 through SFY 2026 has an annualized change of 3.7%, similar to our analysis with the ECI data.

The final overall projected administrative cost PMPM (for fixed and variable expenses) is $23.49 for the CHIP program in SFY 2026 as shown in columns (b) and (d) of Exhibit 3.

The margin of 1.80% of revenue is applied in column (e) of Exhibit 3 and premium tax of 3.00% of revenue is applied in column (g) of Exhibit 3 for costs included in the capitation rate.

Step 5: Adjust For CCO-Specific Risk Score

CHIP Risk Adjustment

Similar to SFY 2025, the CHIP capitation rate will be further adjusted for each CCO using the combined Chronic Illness and Disability Payment System and Medicaid Rx risk adjuster (CDPS + Rx). The CDPS + Rx risk adjuster will be used to adjust for the acuity differences between the enrolled populations of each CCO. Risk adjustment will be budget-neutral to DOM. This risk sharing mechanism is developed in accordance with generally accepted actuarial principles and practices.

To establish these risk scores, the CDPS + Rx risk adjuster will be run with risk weights consistent with services covered in CHIP for the given time period. These risk weights are Mississippi specific developed from a combination of MississippiCAN children and CHIP populations, to increase the population used to develop the model. In the application of the risk adjustment model, a beneficiary must have at least six months of eligibility in the data year to be scored. If a beneficiary does not have enough data, they will receive a score based on demographic information, such as age and gender. We will monitor the percentage of CCO enrollees who are not scored and adjust the methodology if necessary.

We also plan to evaluate the significance of regional variation when updating the risk weights for SFY 2026.

Risk Score Timing

For the SFY 2026 rate setting period DOM plans to contract with three CCOs, compared to the two CCOs operating the program historically. However, it is currently planned that one existing CCO will exit the program and two new CCOs will join. Therefore, we expect that risk adjustment will be applied retroactively for SFY 2026 while enrollment stabilizes for each of the CCOs. We will monitor emerging enrollment as it becomes available and provide timing updates on this process as available.

Step 6: Calculate Risk Corridor Settlements

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

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High-Cost Pharmacy Risk Corridor

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 state is continuing the high-cost pharmacy risk corridor started in SFY 2024, subject to CMS approval. The risk corridor is applicable to total drug spend and related costs due to administration and monitoring for specified products of $250,000 or more per year at a member level.

The SFY 2026 CHIP capitation rate does not include any projected costs for CGTs at this time, but the risk corridor will provide protection for the CCOs if any such treatments are provided during SFY 2026.

The capitation rate includes a $0.52 PMPM estimate of the costs that will be covered in the high-cost pharmacy risk corridor specific to the CHIP program. This target is based on estimates of total costs that will exceed the threshold of $250,000 per member, using historical data. The actual costs from the CCOs will be compared to the estimated cost for the settlement calculations.

Table 6 summarizes the share of gains and losses relative to the estimated high-cost pharmacy costs for each party.

Table 6
Mississippi Division of Medicaid
Proposed High-Cost Pharmacy Risk Corridor Parameters

CCO Gain / Loss	CCO Share of Gain / Loss in Corridor	DOM Share of Gain / Loss in Corridor
Less than -6.0%	0%	100%
-6.0% to -3.0%	50%	50%
-3.0% to +3.0%	100%	0%
+3.0% to +6.0%	50%	50%
Greater than +6.0%	0%	100%

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

- Estimated high-cost pharmacy costs are calculated separately for the CHIP program based on the expected mix of high-cost products.
- Actual high-cost pharmacy costs for the CHIP program will include payments made for the following:
  - All drugs billed as medical claims with a HCPCS code that starts with the letter "J."
  - Inpatient stays for the administration and monitoring for select gene therapies and other select products. The estimated pharmacy costs included in the high-cost risk corridor include the following; however, DOM will monitor and revise the list of approved products if additional products are covered by DOM for use during SFY 2026.
    - Lyfgenia
    - Casgevy
    - Zynteglo
- The timing of the risk corridor settlements will occur during the initial and final settlements for the program-wide risk corridor. The high-costs pharmacy risk corridor will be calculated independent of the larger program-wide risk corridor.
  - The initial settlement will occur after the contract year is closed, using six months of runout.
  - The final settlement will occur once the MLR audit has been completed. MLR audits are usually completed 12 to 18 months after the close of the SFY.

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The 85% minimum MLR provision (Federal MLR definition) in the CCO contract will apply after the risk corridor settlement calculation.

Other Program Considerations

Minimum MLR

The program includes a minimum MLR requirement of 85% of revenue. The sum of medical expenses and HCQI expenses must meet or exceed 85% of revenue. Revenue for premium taxes is excluded from the MLR calculation. If the 85% threshold is not met, CCOs return revenue to DOM until the threshold is met.

Withholds

There are no withholds associated with the CHIP capitation rate.

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EXHIBITS 1 THROUGH 10

(Provided in Excel Format Only)

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APPENDIX A

Data Processing

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APPENDIX A

Encounter Data Processing

A number of data sources are used to develop the base data for the SFY 2026 CHIP capitation rate:

- Medicaid eligibility data
- CCO encounter data
- CCO financial data

CY 2023 encounter data forms the primary base data for the SFY 2026 capitation rate. This section of the report outlines the Medicaid eligibility and CCO encounter data sources and steps to process the data.

ELIGIBILITY

DOM's MMIS vendor provided detailed eligibility data for CY 2023. We relied upon the 'CHP' lock in code for each eligibility span to include individuals enrolled in the CHIP program in the base period.

ENCOUNTER DATA

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

For all service categories we used CY 2023 encounter data with runout through August 2024.

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

CCO encounters are rigorously vetted by Myers and Stauffer as part of their reconciliation of encounters against CCOs' cash disbursement journals (CDJs). As part of this reconciliation, Myers and Stauffer identifies encounter claims that are duplicates, voids, or replacements for other encounter claims. Myers and Stauffer shares these findings with CCOs at a claim level to ensure they are accurately determining the final, non-duplicated version of each paid claim. As a result of their analysis, Myers and Stauffer is able to reconcile closely to the CCOs' CDJs (historically within 0.6% on a paid basis). We use summaries provided by Myers and Stauffer to identify final, non-duplicative claims consistent with their CDJ reconciliation.

Lastly, the encounter data is run through Milliman's *Health Cost Guidelines*™ (*HCG*s) grouper to map the encounter data into detailed categories of service. These categories of service are then rolled up into 11 high level categories of service used for rate development.

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

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

Removal of Pharmacy Benefit Administered Claims

Starting in July 2024, DOM entered into an arrangement with their Pharmacy Benefits Administrator (PBA) in which certain pharmacy claims are paid through the PBA. While these pharmacy services are not carved-out of managed care, the CCO will not be at risk for these expenses. As such, we identified and removed the associated pharmacy claims from the CY 2023 base data for the purpose of developing SFY 2026 capitation rates. These claims were identified and removed using the follow logic:

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

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APPENDIX A

ENCOUNTER DATA PROCESSING

FINANCIAL REPORTING DATA

For base data development, each CCO submitted a financial report reconciled to their organization's audited CY 2023 financial statements for Mississippi. The report submitted for CY 2023 includes earned premium, claim experience with run out through June 2024, best estimate IBNR claim amounts, subcapitated arrangements, non-service expenses, and membership. The reported membership was close in total to the MMIS enrollment, so we utilized the MMIS enrollment for rate development.

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

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APPENDIX B

Actuarial Certification of the SFY 2026 CHIP Capitation Rate

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APPENDIX C

Data Reliance Letter

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Caveats and Limitations
Mississippi Division of Medicaid
READ BEFORE PROCEEDING

Milliman has developed certain models to estimate the values included in this report. The intent of the models was to estimate the SFY 2026 CHIP capitation rate. We reviewed the models, including their inputs, calculations, and outputs for consistency, reasonableness, and appropriateness to the intended purpose and in compliance with generally accepted actuarial practice and relevant actuarial standards of practice (ASOP).

The models rely on data and information as input to the models. We used CCO encounter data and CCO financial reporting for January 2023 to December 2023 with runout through August 2024, historical and projected reimbursement information, fee schedules, and other information from DOM, CHIP CCOs, Gainwell Technologies, Myers and Stauffer, and CMS to calculate the preliminary CHIP capitation rate shown in these exhibits. If the underlying data used is inadequate or incomplete, the results will be likewise inadequate or incomplete. Please see Appendix A for a full list of the data relied upon to develop the SFY 2026 base data.

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

Our exhibits are intended for the internal use of DOM to review the preliminary CHIP capitation rate for SFY 2026. The exhibits and the models used to develop the values in these exhibits may not be appropriate for other purposes. We anticipate the exhibits will be shared with contracted CCOs, CMS and other interested parties. Milliman does not intend to service, and assumes no duty or liability to, other parties who receive this work. It should only be distributed and reviewed in its entirety. This capitation rate may not be appropriate for all CCOs. Any CCO considering participating in CHIP should consider their unique circumstances before deciding to contract under this rate.

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

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

Exhibit 1
Mississippi Division of Medicaid
All Regions SFY 2026 CHIP Capitation Rate Development
CY 2023 Encounter Data

		Category of Service											
Calculation Step	**PMPM Development**	**Inpatient Hospital - Maternity / Deliveries**	**Inpatient Hospital - Psychiatric / Substance Abuse**	**Inpatient Hospital - Other**	**Outpatient Hospital - Emergency Room**	**Outpatient Hospital - Pharmacy**	**Outpatient Hospital - Other**	**Physician - Maternity / Deliveries**	**Physician - Psychiatric / Substance Abuse**	**Physician - Other**	**Dental**	**Other**	**Total**
a	CY 2023 Member Months	521,644	521,644	521,644	521,644	521,644	521,644	521,644	521,644	521,644	521,644	521,644	
b	Total Paid Dollars	$677,468	$4,573,665	$4,621,255	$6,264,128	$3,779,776	$17,952,445	$61,809	$4,523,539	$31,507,994	$16,248,992	$2,793,721	**$93,004,791**
c = b / a	CY 2023 PMPM Costs	$1.30	$8.77	$8.86	$12.01	$7.25	$34.42	$0.12	$8.67	$60.40	$31.15	$5.36	**$178.29**
d	Encounter to Financial Adjustment	1.066	1.066	1.066	1.017	1.017	1.017	1.017	1.017	1.017	0.888	1.017	**1.000**
e	Missing Data	1.001	1.000	1.003	1.002	1.000	1.003	1.001	1.000	1.003	1.000	1.003	**1.002**
f	IBNR Adjustment	1.009	1.009	1.009	1.002	1.002	1.002	1.002	1.002	1.002	1.000	1.002	**1.003**
g	Non-Covered Services	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	0.994	**1.000**
h	TPL Adjustment	0.997	0.997	0.997	0.997	0.997	0.997	0.997	0.997	0.997	0.997	0.997	**0.997**
i = Product of c through h	Adjusted CY 2023 PMPM Costs	$1.39	$9.41	$9.53	$12.24	$7.37	$35.08	$0.12	$8.82	$61.61	$27.59	$5.42	**$178.58**

Exhibit 2
Mississippi Division of Medicaid
All Regions SFY 2026 CHIP Capitation Rate Development
Projection Assumptions
All Children

		Category of Service											
Calculation Step	**PMPM Development**	**Inpatient Hospital - Maternity / Deliveries**	**Inpatient Hospital - Psychiatric / Substance Abuse**	**Inpatient Hospital - Other**	**Outpatient Hospital - Emergency Room**	**Outpatient Hospital - Pharmacy**	**Outpatient Hospital - Other**	**Physician - Maternity / Deliveries**	**Physician - Psychiatric / Substance Abuse**	**Physician - Other**	**Dental**	**Other**	**Total**
a	SFY 2026 Member Months	674,247	674,247	674,247	674,247	674,247	674,247	674,247	674,247	674,247	674,247	674,247	**674,247**
b	Adjusted CY 2023 PMPM Costs	$1.39	$9.41	$9.53	$12.24	$7.37	$35.08	$0.12	$8.82	$61.61	$27.59	$5.42	**$178.58**
c	Utilization Trend Factors CY 2023 to SFY 2026	1.025	1.077	1.025	1.000	1.046	1.077	1.025	1.077	1.050	1.051	1.051	**1.053**
d	Charge Trend Factors CY 2023 to SFY 2026	1.103	1.103	1.103	1.184	1.046	1.184	1.000	1.000	1.002	1.077	1.077	**1.077**
e = Product of b through d	Projected SFY 2026 PMPM Costs	$1.58	$11.17	$10.78	$14.48	$8.06	$44.70	$0.12	$9.49	$64.88	$31.21	$6.14	**$202.61**

Exhibit 3
Mississippi Division of Medicaid
SFY 2026 CHIP Capitation Rate Development
Non-Service Expense Allowance Development

	a	*b*	*c*	*d = c × i*	*e*	*f = e × i*	*g*	*h = g × i*	*i = (a + b) / (1 - c - e - g)*	*j = a / i*
Rate Cell	**SFY 2026 PMPM Cost**	**Fixed Non-Service Expense Load**	**Non-Service Percentage**	**Non-Service PMPM**	**Margin Percentage**	**Margin PMPM**	**Premium Tax Percentage**	**Premium Tax PMPM**	**Total**	**Illustrative Target MLR[1]**
All Children	$202.61	$7.05	6.92%	$16.44	1.80%	$4.28	3.00%	$7.13	$237.50	85.3%

[1] Includes all services incurred during SFY 2026 with payments made to providers as defined in Exhibit C of the CCO Contract, including fee-for-service payments, subcapitation payments, and settlement payments. CCO-specific target MLRs will be calculated with actual SFY 2026 CCO-specific values.

Exhibit 4
Mississippi Division of Medicaid
SFY 2026 CHIP Capitation Rate Development
High-Cost Pharmacy Risk Corridor
Illustrative Settlement Calculation

Rate Cell	*a* Illustrative Actual SFY 2026 Membership[1]	*b* SFY 2026 High-Cost Pharmacy Target PMPM[2]	*c* Illustrative Actual SFY 2026 High-Cost Pharmacy Costs[3]	*d = c / a* Illustrative Actual SFY 2026 High-Cost Pharmacy PMPM
CHIP	522,000	$0.52	$250,000	$0.48

Illustrative Actual Risk Corridor Eligible Costs	$250,000	*e = c*
Illustrative Target Risk Corridor Eligible Costs	$273,928	*f = b x a*
Difference ($)	($23,928)	*g = e - f*
Difference (%)	-8.74%	*h = g / f*

Risk Corridor Bands	*i* Percentage	*j = i × f* Dollars	*k = j × CCO %* Settlement
< -6%: 0% CCO / 100% DOM	2.74%	$7,492	$7,492
-6% to -3%: 50% CCO / 50% DOM	3.00%	$8,218	$4,109
-3% to 0%: 100% CCO / 0% DOM	3.00%	$8,218	$0
0% to 3%: 100% CCO / 0% DOM	0.00%	$0	$0
3% to 6%: 50% CCO / 50% DOM	0.00%	$0	$0
> 6%: 0% CCO / 100% DOM	0.00%	$0	$0
Total Risk Corridor Settlement Received (Paid) by DOM			**$11,601**

[1] Illustrative values demonstrate projected enrollment. Actual values will use CCO-specific enrollment.
[2] PMPM calculation will be populated with actual SFY 2026 CCO-specific values.
[3] Includes all costs incurred during SFY 2026 eligible for the risk corridor, as outlined in the rate certification. Actual costs, but not target costs, will be populated with actual SFY 2026 CCO-specific experience.

Exhibit 5
Mississippi Division of Medicaid
SFY 2026 CHIP Capitation Rate Development
Service Category to Milliman *HCGs* Grouper Category Mapping

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

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

Exhibit 6
Mississippi Division of Medicaid
CHIP Historical Completed Non-Pharmacy PMPM Costs and Trends

PMPM Costs by Month[1]

Month	Member Months	Inpatient Hospital Services	Outpatient Hospital Services	Physician Services	Dental Services	Other Services	Non-Pharmacy Total
January 2021	48,285	$23.38	$36.69	$52.62	$25.81	$4.08	$142.58
February 2021	48,204	$12.49	$34.30	$46.01	$21.91	$4.12	$118.83
March 2021	48,026	$27.35	$41.28	$55.96	$32.00	$4.97	$161.57
April 2021	47,885	$20.15	$45.64	$58.69	$27.71	$5.57	$157.75
May 2021	47,833	$19.45	$46.80	$51.80	$21.93	$4.28	$144.27
June 2021	47,666	$27.80	$47.55	$53.78	$27.75	$4.66	$161.53
July 2021	46,953	$21.76	$50.93	$62.31	$29.03	$5.00	$169.03
August 2021	45,982	$24.29	$51.14	$79.99	$24.28	$4.46	$184.17
September 2021	45,128	$22.05	$45.79	$67.52	$26.50	$4.60	$166.45
October 2021	43,501	$28.40	$50.03	$66.38	$25.87	$4.80	$175.48
November 2021	42,894	$16.88	$52.20	$68.26	$26.86	$4.52	$168.71
December 2021	42,528	$14.03	$47.36	$64.40	$24.18	$4.09	$154.07
CY 2021[4]	**46,240**	**$21.50**	**$45.81**	**$60.64**	**$26.15**	**$4.60**	**$158.70**
January 2022	42,279	$17.70	$42.54	$75.04	$25.75	$4.40	$165.43
February 2022	42,002	$22.70	$39.23	$62.26	$26.82	$4.91	$155.91
March 2022	41,866	$14.14	$45.65	$64.13	$30.99	$5.51	$160.42
April 2022	41,869	$18.81	$45.95	$59.85	$27.46	$5.59	$157.67
May 2022	41,727	$22.70	$45.56	$60.67	$25.09	$5.28	$159.30
June 2022	41,822	$32.78	$45.59	$57.90	$31.53	$5.45	$173.26
July 2022	41,798	$17.58	$46.31	$59.20	$30.56	$5.56	$159.21
August 2022	41,527	$24.00	$51.61	$79.19	$32.87	$5.66	$193.33
September 2022	41,399	$24.30	$54.84	$74.04	$33.07	$5.83	$192.08
October 2022	41,242	$16.39	$53.54	$80.17	$30.55	$5.65	$186.31
November 2022	41,421	$15.48	$54.87	$84.22	$29.76	$5.35	$189.67
December 2022	41,716	$16.40	$49.06	$62.11	$28.30	$5.60	$161.46
CY 2022	**41,722**	**$20.25**	**$47.89**	**$68.23**	**$29.40**	**$5.40**	**$171.17**
January 2023	42,003	$21.04	$51.65	$76.45	$34.11	$5.65	$188.90
February 2023	42,181	$15.01	$48.45	$73.47	$30.78	$5.76	$173.47
March 2023	42,208	$22.47	$55.60	$76.90	$36.16	$5.35	$196.48
April 2023	42,241	$17.79	$58.15	$68.67	$29.56	$4.03	$178.20
May 2023	42,211	$15.55	$56.84	$66.82	$31.04	$4.60	$174.85
June 2023	42,208	$22.24	$51.72	$60.98	$33.67	$5.47	$174.08
July 2023	42,828	$25.64	$52.56	$64.94	$34.27	$6.15	$183.56
August 2023	43,479	$24.79	$57.21	$84.55	$34.08	$6.38	$207.00
September 2023	44,271	$22.70	$59.05	$72.02	$28.66	$5.99	$188.42
October 2023	45,019	$23.90	$60.36	$79.53	$33.20	$6.30	$203.28
November 2023	46,133	$18.27	$65.63	$81.67	$30.19	$4.95	$200.70
December 2023	46,862	$13.33	$67.41	$77.78	$25.30	$4.75	$188.57
CY 2023[3]	**43,470**	**$20.23**	**$57.05**	**$73.65**	**$31.75**	**$5.45**	**$188.13**
January 2024	47,174	$20.07	$54.80	$67.78	$29.85	$6.38	$178.88
February 2024	48,063	$23.87	$54.02	$77.86	$29.45	$5.28	$190.48
March 2024	49,100	$27.73	$55.71	$66.02	$26.61	$5.09	$181.17
April 2024	50,019	$19.78	$62.89	$75.07	$26.38	$5.70	$189.82
May 2024	50,936	$20.44	$55.68	$65.88	$24.45	$5.74	$172.18
June 2024	51,915	$26.01	$53.76	$58.23	$24.39	$5.60	$168.00
Q1-Q2 2024[3]	**49,535**	**$22.99**	**$56.14**	**$68.47**	**$26.86**	**$5.63**	**$180.09**

Annual PMPM Trends

CY 2021 to CY 2022	-5.8%	4.6%	12.5%	12.4%	17.5%	7.9%
CY 2022 to CY 2023	-0.1%	19.1%	7.9%	8.0%	0.9%	9.9%
CY 2023 to YTD 2024	13.6%	-1.6%	-7.0%	-15.4%	3.4%	-4.3%
CY 2021 to YTD 2024 (Annualized)	2.5%	7.7%	4.5%	1.0%	7.7%	4.7%

[1] CHIP PMPM figures have been adjusted for: financial to encounter adjustments, and IBNR.

[2] CY 2022 is assumed to be fully complete with no explicit IBNR adjustment.

[3] CY 2021, CY 2023, and YTD 2024 IBNR as reported by CCOs in financial templates.

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

Exhibit 7
Mississippi Division of Medicaid
Summary of CY 2023 CHIP Encounter Claims
CHIP Rate Cell

Member Months	521,644

	Total Costs	PMPM Costs
Inpatient Facility		
Medical	$1,361,218	$2.61
Surgical	$3,260,037	$6.25
Maternity / Deliveries	$677,468	$1.30
Psychiatric / Substance Abuse	$4,573,665	$8.77
Skilled Nursing Facility	$0	$0.00
Missing Data	$14,436	$0.03
Inpatient Facility Total	**$9,886,824**	**$18.95**
Outpatient Facility		
Emergency Room	$6,264,128	$12.01
Urgent Care	$954	$0.00
Radiology / Pathology	$5,129,802	$9.83
Psychiatric / Alcohol & Drug Abuse	$512,785	$0.98
Pharmacy	$3,779,776	$7.25
Other	$12,308,904	$23.60
Missing Data	$60,745	$0.12
Outpatient Facility Total	**$28,057,095**	**$53.79**
Physician		
IP Visits	$415,108	$0.80
IP Surgery	$323,752	$0.62
Office / Home Visits	$12,840,676	$24.62
Preventive Exams & Immunizations	$3,378,889	$6.48
Urgent Care Visits	$811,585	$1.56
ER Visits and Observation Care	$1,402,692	$2.69
OP Surgery	$3,321,402	$6.37
Physical Therapy	$1,731,777	$3.32
Psychiatric / Substance Abuse	$4,523,539	$8.67
Radiology / Pathology	$3,781,840	$7.25
Vision, Hearing, and Speech Exams	$1,333,109	$2.56
Maternity - Anesthesia	$24,435	$0.05
Maternity - Non-Anesthesia - Non-Deliveries	$4,157	$0.01
Maternity - Non-Anesthesia - Ancillary	$1,236	$0.00
Maternity - Non-Anesthesia - Cesarean Deliveries	$8,465	$0.02
Maternity - Non-Anesthesia - Normal Deliveries	$23,517	$0.05
Other	$2,167,166	$4.15
Missing Data	$103,849	$0.20
Physician Total	**$36,197,191**	**$69.39**
Dental		
Dental	$16,248,992	$31.15
Missing Data	$0	$0.00
Dental Total	**$16,248,992**	**$31.15**
Other		
Ambulance	$715,651	$1.37
Non-Emergency Transportation	$16,527	$0.03
DME	$1,291,281	$2.48
Glasses / Contacts	$608,971	$1.17
Other	$161,290	$0.31
Missing Data	$7,201	$0.01
Other Total	**$2,800,922**	**$5.37**
Grand Total w/o PBA pharmacy services	**$93,191,023**	**$178.65**

**Pharmacy services are not included in the display due to the pharmacy carve out for SFY 2026 capitation rates and known Gainwell data issues.*

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Exhibit 9
Mississippi Division of Medicaid
SFY 2026 CHIP Capitation Rate Development
CHIP Expenditure Projection

Eligibility Category	*a* Projected SFY 2026 Exposures	*b* SFY 2026 Capitation Rates	*c = a * b* CHIP Estimated Cost	*d = c * 83.83%* Federal Estimated Cost[1]
All Children	674,247	$237.50	$160,133,686	$134,240,069

[1] For SFY 2026 the EFMAP is 83.83%.

Exhibit 10
Mississippi Division of Medicaid
SFY 2026 High Cost Pharmacy Risk Corridor Development

		PMPM	Total
Step One: Remove cost of program changes from SFY 2026 risk corridor eligible PMPM			
	Eligible Spend Rate Categories PMPM		
	Outpatient Hospital - Pharmacy	$8.06	
	Outpatient Hospital - Other	$44.70	
	Physician - Other	$64.88	
(a)	**Projected SFY 2026 Pharmacy Spend[1]**	**$117.63**	**$79,314,888**
Step Two: Using CY 2023 encounter data, estimate the percentage of eligible costs that will exceed the risk corridor threshold.			
(b)	Percentage of Projected Spend in (a) Attributable to J-Codes[3]	3.8%	3.8%
(c)	Historical Percentage of J-Code Claims Over Threshold[3]	11.8%	11.8%
(d) = (a) x (b) x (c)	**Anticipated SFY 2026 Risk Corridor Eligible Cost Over Threshold, Prior to Program Changes**	**$0.52**	**$353,822**

[1] PMPM amounts tie to the final row of Exhibit 2.

Exhibit B: External Quality Review

External Quality Review (EQR) is a requirement under Title XIX of the Social Security Act, Section 1932(c)(2) for states to obtain an independent, external review body to perform an annual review of the quality of services furnished under state contracts with managed care organizations, including but not limited to the evaluation of quality outcomes, timeliness, network adequacy and access to services. The requirements for EQR are further outlined in 42 C.F.R. Parts 433 and 438: External Quality Review of Medicaid Managed Care Organizations. EQR is defined by 42 C.F.R. § 438.320 and refers to the analysis and evaluation of aggregated information on timeliness, access, and quality of health care services furnished to Members. The EQR will consist of the mandatory activities, and may include the optional activities, described in 42 C.F.R. § 438.358.

The results of the EQR are made available, upon request, to interested parties such as participating health care providers, Members and potential Members of the Contractor, beneficiary advocacy groups, and members of the general public. This is one of many tools that facilitates achieving continuous quality improvement in the delivery of care, health care outcomes, and timeliness of care, access to services, quality and utilization management systems, and program oversight. The Division requires that the Contractor:

1. Actively participate in planning and developing the measures to be utilized with the Division and the EQRO. The Contractor's Quality Leadership Team will be given an opportunity to provide input into the measures to be utilized.

2. Accurately, completely and within the required time frame identify eligible Members and network providers to the EQRO.

3. Ensure the appropriate technical specifications (CHIPRA, HEDIS, and the Division) are used for the calculation of each performance measure.

4. Correctly identify and report the numerator and denominator for each measure.

5. Actively encourage and require Providers, including Subcontractors, to provide complete and accurate Provider Medical Records within the time frame specified by the EQRO.

6. Demonstrate how the results of the EQR are incorporated into the Contractor's overall Quality Management Program and demonstrate progressive improvements during the term of the Contract.

7. Implement a process to ensure that all deficiencies identified during the EQR are addressed and corrections made.

8. Develop a monitoring strategy for assessing the quality of encounter data.

9. Provide information to the EQRO as requested to fulfill the requirements of the mandatory and optional activities required in 42 C.F.R. Parts 433 and 438.

10. Ensure that data, clinical records, and workspace located at the Contractor's work site are available to the independent review team and to the Division, upon request.

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MISSISSIPPI DIVISION OF
MEDICAID

Exhibit C: Medical Loss Ratio (MLR) Requirements

The Contractor is required to prepare a Medical Loss Ratio (MLR) Report in accordance with the provisions of Exhibit C. The Contractor is also required to rebate a portion of the Capitation Payment to the Division in the event the Contractor does not meet the ninety-one-and-three-tenths percent (91.3%) for MSCAN or eighty-five percent (85.0%) for CHIP minimum MLR standard. This Exhibit describes requirements for the following:

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 these 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, and the Managed Care Final Rule published November 13, 2020, with effective dates of December 14, 2020, and July 1, 2021.

A. Reporting Requirements

A.1. General Requirements

For each MLR Reporting Quarter and Year, the Contractor must submit to the Division a report which complies with the requirements that follow concerning Capitation Payments received, and expenses related to MississippiCAN and CHIP Members [42 CFR 438.8(a)] (referred to hereafter as MLR Report). A run-out period of 180 days is required for 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. This information must be reported on an accrual basis.

The Division reserves the right to require any further reporting or data from the Contractor necessary for the Division to adequately assess the Contractor's MLR Report.

A.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.

A.3. Premium Revenue

A Contractor must report to the Division the total Premium Revenue received from the Division for each MLR Reporting Year. Premium Revenue includes, but is not limited to, all monies paid by the Division to the Contractor for providing benefits and services as defined in the terms of the Contract and is inclusive of Capitation Payments, Capitation Premium Withhold amounts earned, State Directed Payments, Health Insurer Fee reimbursement, Risk Corridor adjustments, and any other Medicaid Managed Care Program Revenues but is exclusive of any Value-Based Payment Incentive Program receipts or amounts received from the DOM PBA. (Note: Other revenues may be inclusive of payments made for services such as high-cost drugs paid outside the capitation rate.)

A.4. Additional Reporting

During each MLR Reporting Quarter and 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 MLR Report:

a. Total incurred claims

b. Expenditures on health care quality improvement activities

c. Expenditures related to activities compliant with 42 C.F.R. § 438.8(e) (4)

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. Supplemental Adjustments

j. Supporting schedules/documentation for any adjustments made to items a-i.

k. 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)

l. The Calculated MLR

m. Any remittance owed to the State (Annual MLR Report only)

n. A comparison of the information reported in the MLR Report to the Audited Financial Statement (Annual MLR Report only)

o. A description of the aggregation method used

p. The number of Member Months

A.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.

A.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. Reimbursement for Clinical Services Provided to Members

The MLR Report must include direct claims paid to or received by Providers (including under capitated contracts with Network Providers), whose services are covered by the Subcontract for clinical services or supplies covered by the Division's Contract with the Contractor. Reimbursement for clinical services as defined in this section is referred to as "incurred claims." (Note: Services covered under the Contract are inclusive of services paid through the capitation rate or separately reimbursed by the Division, but are exclusive of Value-Based Incentive Program distributions or payments to the DOM PBA.)

1. Specific requirements include:

    a. Unpaid claims liabilities for the MLR Reporting Year, including claims reported that are in the process of being adjusted or claims incurred but not reported;

    b. Withholds from payments made to network providers;

    c. Claims that are recoverable for anticipated coordination of benefits;

    d. Claims payments recoveries received as a result of subrogation;

    e. Incurred but not reported claims based on past experience, and modified to reflect current conditions, such as changes in exposure or claim frequency or severity;

    f. Changes in other claims-related reserves; and

    g. Reserves for contingent benefits and the medical claim portion of lawsuits.

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

2. Amounts that must be deducted from incurred claims include:

    a. Overpayment recoveries received from Network Providers;

    b. If applicable, prescription drug rebates received and accrued by the Contractor;

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 that are tied to clearly-defined, objectively measurable, and well-documented clinical or quality improvement standards that apply to providers; (Please refer to Contract section 6.7 for additional contractual requirements to be considered allowable incurred claims for MLR reporting purposes.)

    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 ofthe 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 prior to the paymentof 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 subsequent 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 457.1201 (as applicable) 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. Incurred claims paid by Contractor that are later assumed by another entity must be reported by the assuming entity for the entire MLR reporting year and no incurred claims for that MLR reporting year may be reported by Contractor.

e. Amounts identified during the analysis of third-party subcontractors asspecified in Section J;

f. If applicable, Spread Pricing amounts paid to a pharmacy benefit manager (PBM); and

g. The amount of reinsurance premiums that exceed the reinsurance recoveries,as these are non-claims costs.

C. Activities that Improve Health Care Quality

C.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(a) and (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.

C.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;

v. 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) Identifying and addressing Social Determinants of Health as identified through screening;

(d) Quality reporting and documentation of care in non-electronic format;

(e) Health information technology to support these activities;

vi. Accreditation fees directly related to quality of care activities;

vii. 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 42 C.F.R. § 158.130.

viii. 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 ensure appropriate care that will, in all likelihood, avoid readmission to the hospital;

(b) Ensuring that proper referrals are made and followed up with pursuant to the requirements outlined in Section 7, Care Management, of this Contract;

(c) Patient-centered education and counseling;

(d) Personalized post-discharge reinforcement and counseling by an appropriate health care professional;

(e) Any quality reporting and related documentation in non- electronic form for activities to prevent hospital readmission; and

(f) Health information technology to support these activities.

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ix. 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.

x. 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 should be allowed as a quality improvement activity

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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.

xi. 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.

C.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 that otherwise meet the definitions for quality improvement activities, but that 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 that 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 donot 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 paragraphs 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 definition and purposes described above and 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, theallocation methodology and statistics utilized for any allocation. 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, theallocation 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. If indirect and/or overhead expenses cannot be separately identified from the portion directly attributable to QIA functions, the entirety of the QIA claimed expenditures will be disallowed in the MLR. 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. When QIA is outsourced versus provided in-house, the same principles for determination of QIA costs is necessary, requiring the exclusion of the vendor's indirect costs and profits from the MLR calculation. The Contractor is required to obtain this costing information from the vendor and to make the appropriate MLR adjustments. Please reference the guidance provided in PPACA regulation, as well as the remainder of this section when determining reportable QIA expense.

D. Activities Related to External Quality Review

D.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.

D.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 42. C.F.R § 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 42 C.F.R. § 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 42 C.F.R. § 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 42 C.F.R. § 438.204(g).

D.3. Optional Activities

The EQR may also use information derived during the preceding twelve (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.

D.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

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 and/or CHIP meaningful use requirements, and that 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:

1. 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;

2. 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;

3. Providing technical assistance to support adoption and meaningful use of certified electronic health records technologies;

4. 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;

5. Tracking whether a specific class of medical interventions or a bundle of related services leads to better patient outcomes;

6. 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;

7. 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

8. Provision of electronic health records, patient portals, and tools to facilitate patient self-management.

F. Non-Claims Cost

F.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).

F.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 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).

F.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 the Contractor;

b. any penalties or fines assessed against the 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 that 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 the State Plan.

G. State Directed Payments

The MLR Report will include all state directed payments paid pursuant to 42 CFR § 438.6(c) to include payments received by the Contractor reported as Capitation Revenue on the MLR Report for dates of service within the Rating Period, including any adjustments. The same amounts reported in the denominator as capitation revenues for all state directed payments shall be reported in the numerator as medical expenses.

H. Allocation of Expenses

Each expense must be reported under only one type of expense, unless a portion of the expense fits under the definition of or criteria for one type of expense and the remainder fits into a different type of expense, in which case the expense must be pro-rated between types of expenses. Expenditures that benefit multiple contracts or populations, or contracts other than those being reported, must be reported on a pro rata basis.

I. Description of Methods Used to Allocate Expenses

The report required must include a detailed description of the methods used to allocate expenses, including incurred claims, quality improvement expenses, Federal and state taxes and licensing or regulatory fees, and other non-claims costs, both direct and indirect allocated 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.

1. 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;

2. 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

3. 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.

4. The Contractor must notify the Division of any significant changes in allocation methodologies and submit a brief impact analysis for Mississippi Medicaid resulting from these changes, prior to submission of the MLR reports.

J. Third Party Subcontractors

Third party Subcontractors or vendors providing claims adjudication activity services to enrollees are required to supply all underlying data to the Contractor within 180 days of the end of the MLR reporting period or within 30 calendar 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.

J.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 the 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).

The Contractor must require any third party vendor providing claims adjudication activities to provide all underlying data associated with MLR reporting to the Contractor within 180 calendar days of the end of the MLR reporting year or within thirty (30) calendar days of being requested by the Contractor, whichever comes sooner, regardless of current contractual limitations, to calculate and validate the accuracy of MLR reporting.

J.2 Management Fee Arrangement

The Contractor is required to report to the Division the total expenses incurred by the management organization for the plan. These costs should be adjusted for any non-allowable activities. In the absence of specific State guidance, the Contractor should refer to other Federal regulations concerning the identification of non-allowable costs.

K. Maintenance of Records

The Contractor must maintain and retain, and require Subcontractors to retain, as applicable, for a period of no less than ten (10) years, in accordance with 42 C.F.R. §§ 438.3(u) and 457.1201 (as

applicable), and make available to the Division upon request the data used to allocate expenses reported, together with all supporting information required to determine that the methods identified and reported as required under this Exhibit C were accurately implemented in preparing the MLR Report.

L. Formula for Calculating Medical Loss Ratio

1. Medical Loss Ratio

   a. The 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 Quarter or 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.

      iii. The total amount of the denominator for Contractor which is later assumed by another entity must be reported by the assuming entity for the entire MLR reporting year and no amount under this paragraph for that year may be reported by the Contractor.

   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 the 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 must be in accordance with rules 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 is "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 Medical Loss Ratio Standards established below are Not Met

a. General Requirement
For each MLR Reporting Year, the Contractor must provide a rebate to the Division if the Contractor's MLR does not meet or exceed the ninety-one-and-three-tenths percent (91.3%) minimum requirement for MSCAN and the eighty-five percent (85.0%) minimum requirement for CHIP.

b. Amount of Rebate
For each MLR Reporting Year, the Contractor must rebate to the Division the difference between the total amount of Adjusted Premium Revenue received by the Contractor from the Division multiplied by the required minimum MLR of ninety-one-and-three-tenths percent (91.3%) for MSCAN and eighty-five percent (85.0%) for CHIP 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 the Contractor fails to pay any rebate owing to the Division in accordance within the time period 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.

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Exhibit D: Member Grievance and Appeal Process

A. Grievances and Appeals Generally

The Contractor's Member Grievance and Appeal procedures shall meet the following requirements:

1. Resolving Grievances and Appeals expeditiously by Contractor personnel at a decision-making level with authority to require corrective action.

2. Providing for separate tracks for administrative and utilization management Grievances and Appeals.

3. Describing procedures for the submission and resolution of a Grievance or Appeal as well as procedures for MississippiCAN Member to request a State Fair Hearing and for CHIP Members to request an Independent External Review.

4. Maintaining written documentation of each Grievance or Appeal, and the actions taken by the Contractor.

5. Distributing a written description and educating Network Providers of the Contractor's Grievance, and Appeal process and how Providers can submit a Grievance or Appeal for a Member, or on their own behalf.

6. Making available reasonable assistance in completing forms and taking other procedural steps. This includes, but is not limited to, providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability.

7. Designating a specific individual as the Contractor's MississippiCAN Member Grievances and Appeals coordinator with the authority to administer the policies and procedures for resolution of a Grievance or Appeal, to review patterns/trends in Grievances and Appeals, and to initiate corrective action.

8. Designating a specific individual as the Contractor's CHIP Member Grievances and Appeals coordinator with the authority to administer the policies and procedures for resolution of a Grievance or Appeal, to review patterns/trends in Grievances and Appeals, and to initiate corrective action.

9. Ensuring that the individuals who make decisions on Grievances or Appeals are not involved in any previous level of review or decision-making or subordinates of any

individual who was involved in a previous level of review or decision-making. The Contractor shall also ensure that health care professionals with appropriate clinical expertise shall make decisions for the following:

a. An Appeal of an Adverse Benefit Determination that is based on lack of medical necessity;

b. An Adverse Benefit Determination that is upheld in an Expedited Resolution; and

c. A Grievance or Appeal that involves clinical issues.

10. Ensuring that individuals who make decisions on Grievances or Appeals take into account all comments, documents, records, and other information submitted by the Member or their representative without regard to whether such information was submitted or considered in the initial Adverse Benefit Determination.

11. Ensuring that punitive or retaliatory action is not taken against a Member or service Provider that files a Grievance or an Appeal, or a Provider that supports a Member's Grievance or Appeal.

12. Ensuring that there is a link between the Grievance and Appeal processes and the Quality Management and Utilization Management programs.

13. Designating and training sufficient staff to be responsible for receiving, processing, and responding to Grievances and Appeals in accordance with the requirements in this Exhibit and Contract.

14. Conducting an additional Provider office visit within forty-five (45) calendar days when a Grievance and/or Appeal threshold has been met against a specific Provider that relates to the Provider's office.

15. The following parties have a right to file a Grievance and Appeal on behalf of the Member:

a. The legal guardian of the Member for a minor or an incapacitated adult,

b. A representative of the Member as designated in writing to the Contractor, or

c. A service Provider acting on behalf of the Member and with the Member's written consent.

16. All notices sent to Members must comply with 42 C.F.R. § 438.404(a).

Notices indicating the resolution of Grievances must be in writing and must meet the language and format requirements of 42 C.F.R. § 438.10(c) and (d) to ensure ease of understanding.

17. Notices indicating the resolution of Appeals must be in writing and must meet the language and format requirements of 42 C.F.R. § 438.10(c) and (d) to ensure ease of understanding.

18. Notices to MississippiCAN Members must explain the following:

    a. Adverse Benefit Determination the Contractor has taken or intends to take (e.g., resolution of the Grievance or Appeal).

    b. Reasons for the Adverse Benefit Determination (e.g., findings and conclusions based on the investigation, all information considered in investigating the Grievance or Appeal).

    c. Member's right to request a State Fair Hearing.

    d. Procedures for exercising State Fair Hearing rights.

    e. Member's right to have benefits continue pending resolution of the State Fair Hearing, how to request that benefits be continued, and circumstances under which the Member may be required to pay the costs of these services.

19. Notices to CHIP Members must explain the following:

    a. Adverse Benefit Determination the Contractor has taken or intends to take (e.g., resolution of the Grievance or Appeal).

    b. Reasons for the Adverse Benefit Determination (e.g., findings and conclusions based on the investigation, all information considered in investigating the Grievance or Appeal).

    c. Member's right to request an Independent External Review.

    d. Procedures for exercising Independent External Review rights.

e. Member's right to have benefits continue pending resolution of the Independent External Review, how to request that benefits be continued, and circumstances under which the Member may be required to pay the costs of these services.

B. Grievance

A Grievance is an expression of dissatisfaction, regardless of whether identified by the Member as a "Grievance," received by any employee of the Contractor orally or in writing about any matter or aspect of the Contractor or its operation, other than a Contractor Adverse Benefit Determination as defined in this Contract. A Grievance includes, but is not limited to, the quality of care or services provided, aspects of interpersonal relationships such as rudeness or a Provider or an employee, or failure to respect the Members rights.

A Member or Authorized Representative may file a Grievance either orally or in writing with the Contractor at any time after the event causing the dissatisfaction.

Within five (5) calendar days of receipt of the Grievance, the Contractor shall provide the grievant with written notice that the Grievance has been received and the expected date of its resolution. For telephonic Grievances received, the Contractor may provide the grievant with verbal notice of expected date of resolution. If requested by the Member or the Member's representative, a written resolution will be provided.

The investigation and final Contractor resolution process for Grievances shall be completed within thirty (30) calendar days of the date the Grievance is received by the Contractor, or as expeditiously as the Member's health condition requires, whichever is sooner, and shall include a resolution letter to the grievant.

The Contractor may extend by up to fourteen (14) calendar days if the Member requests the extension, or the Contractor determines that there is need for additional information and the extension is in the Member's interest. For any extension not requested by the Member, the Contractor shall give the Member written notice of the reason for the extension within two (2) calendar days of the decision to extend the time frame.

Upon resolution of the Grievance, the Contractor shall mail a resolution letter to the Member. This resolution letter may not take the place of the acknowledgment letter referred above, unless the resolution of the Grievance has been completed and can be communicated to the Member in the same correspondence acknowledging receipt of the Grievance.

C. Appeal

An Appeal is a request for review by the Contractor of an Adverse Benefit Determination.

A Member or Member's Representative may file an Appeal with the Contractor either orally or in writing of an Adverse Benefit Determination within sixty (60) calendar days of receiving the Contractor's notice of Adverse Benefit Determination. The Contractor shall consider the Member, Member's Representative, or estate representative of a deceased Member as parties to the Appeal.

The Contractor has thirty (30) calendar days from the date the initial verbal or written Appeal is received by the Contractor to resolve the Appeal, or as expeditiously as the Member's health condition requires, whichever is sooner. The Contractor shall appoint at least one (1) person to review the Appeal who was not involved in the initial decision and who is not the subordinate of any person involved in the initial decision. Within this same thirty (30) calendar daytime frame, the Contractor shall provide written notice to the Member and/or Provider, if the Provider filed the Appeal.

Within ten (10) calendar days of receipt of the Appeal, the Contractor shall provide the grievant with written notice that the Appeal has been received and the expected date of its resolution. The Contractor shall confirm in writing receipt of verbal Appeals unless the Member or the service Provider requests an Expedited Resolution.

The Contractor shall have a process in place that ensures that a verbal or written inquiry from a Member seeking to appeal an Adverse Benefit Determination is treated as an Appeal (to establish the earliest possible filing date for the Appeal). A verbal Appeal shall be followed by a written Appeal that is signed by the Member. The Contractor shall use its best efforts to assist Members as needed with the written Appeal and may continue to process the Appeal.

The Contractor may extend the thirty (30) calendar day time frame by fourteen (14) calendar days if the Member requests the extension, or the Contractor determines that there is need for additional information and the extension is in the Member's interest. For any extension not requested by the Member, the Contractor shall give the Member written notice of the extension and the reason for the extension within two (2) calendar days of the decision to extend the time frame.

The Contractor shall provide the Member or the Member's representative a reasonable opportunity to present evidence of the facts or law, in person as well as in writing.

The Contractor shall provide the Member or the representative the opportunity, before and during the Appeals process, to examine the Member's case file, including medical or clinical records (subject to HIPAA requirements), and any other documents and records considered

during the Appeals process. The Contractor shall include as parties to the Appeal the Member and Member's representative, or the legal representative of a deceased Member's estate.

The Contractor shall continue the Member's benefits if all of the following are met:

1. Member or the authorized representative files a timely Appeal of the Adverse Benefit Determination. "Timely files" means the Member files for continuation of benefits on or before

    a. Within ten (10) calendar days of the Contractor's Notice of Adverse Benefit Determination, or

    b. The intended effective date of the Contractor's proposed Adverse Benefit Determination;

2. The Appeal involves the termination, suspension, or reduction of a previously authorized course of treatment;

3. The services were ordered by an authorized service Provider;

4. The time period covered by the original authorization has not expired; and

5. Member requests extension of the benefits.

C.1 Continuation of Benefits for MississippiCAN and CHIP Members

The Contractor shall continue the Member's benefits while the Contractor's Appeal in accordance with 42 C.F.R. § 438.420; § 438.402(c)(1)(ii) and (c)(2)(ii); and § 438.408(d)(2). Continuation of benefits by the Contractor shall occur if the following criteria are met:

6. Member or the authorized representative files a timely Appeal with the Contractor of the Adverse Benefit Determination. "Timely files" means the Member files for continuation of benefits on or before the later of the following:

    a. Within ten (10) calendar days of the Contractor's Notice of Adverse Benefit Determination, or

    b. The intended effective date of the Contractor's proposed Adverse Benefit Determination;

7. The Contractor must continue the member's benefits if all of the following occur:

    a. The member files the request for an appeal timely in accordance with § 438.402(c)(1)(ii) and (c)(2)(ii);

    b. The Appeal involves the termination, suspension, or reduction of a previously authorized course of treatment;

    c. The services were ordered by an authorized service Provider;

    d. The time period covered by the original authorization has not expired; and

    e. Member requests extension of the benefits.

8. Pending CCO Appeal, a State Fair Hearing (MSCAN), or Independent External Review (CHIP):

    At the Member's request, if the Contractor continues or reinstates the Member's benefits while the Appeal, State Fair Hearing, or Independent External Review is pending, the benefits must be continued until one of the following occurs:

1. The Member withdraws the Appeal or request for a State Fair Hearing/Independent External Review.

2. The Member fails to request a State Fair Hearing/Independent External Review, and continuation of benefits within ten (10) calendar days after the Contractor sends the notice of an adverse resolution to the Member's Appeal.

3. The Division or Independent External Reviewer issues a final decision adverse to the Member.

Accordingly, the Contractor shall ensure compliance with this requirement, including but not limited to, revision of applicable member and provider letters, manuals, and policies.

If the final resolution of the Appeal is adverse to the Member, that is, the Adverse Benefit Determination is upheld, the Contractor may recover the cost of the services furnished to the Member while the Appeal was pending, to the extent that services were furnished solely because of the requirements of this section and in accordance with the policy in 42 C.F.R. § 431.230(b).

If the Contractor or the Division reverses a decision to deny, limit, or delay services, and these services were not furnished while the Appeal was pending, the Contractor shall authorize or provide the disputed services promptly and as expeditiously as the Member's health condition requires, but no later than seventy-two (72) hours from the date it receives notice reversing the determination. If the Contractor or the Division of Medicaid reverses a decision to deny, limit, or delay services and the Member received the disputed services while the Appeal was pending, the Contractor shall pay for these services.

Should the Contractor fail to adhere to notice and timing requirements, the Member is deemed to have exhausted the Contractor's Appeals process, and the Member may initiate appeal to the Division or Independent External Reviewer.

D. Expedited Resolution of Appeals

An Expedited Resolution of Appeals is an expedited review by the Contractor of an Adverse Benefit Determination.

The Contractor shall establish and maintain an expedited review process for Appeals when the Contractor determines that allowing the time for a standard resolution could seriously jeopardize the Member's life, health, or ability to attain, maintain, or regain maximum function. Such a determination is based on:

1. A request from the Member;
2. A Provider's support of the Member's request;
3. A Provider's request on behalf of the Member; or
4. The Contractor's independent determination.

The Contractor shall ensure that the expedited review process is convenient and efficient for the Member.

The Contractor shall resolve the Appeal within seventy-two (72) hours of receipt of the request for an expedited Appeal. In addition to written resolution notice, the Contractor shall also make reasonable efforts to provide and document verbal notice.

The Contractor may extend the time frame by up to fourteen (14) calendar days if the Member requests the extension, or the Contractor demonstrates to the Division that there is need for additional information and the extension is in the Member's interest. For any extension not

requested by the Member, the Contractor shall give the Member written notice of the reason for the delay.

The Contractor shall ensure that punitive action is not taken against a Member or a service Provider who requests an Expedited Resolution or supports a Member's expedited Appeal. The Contractor shall provide an Expedited Resolution if the request meets the definition of an expedited Appeal in response to a verbal or written request from the Member or service Provider on behalf of the Member.

The Contractor shall inform the Member of the limited time available to present evidence and allegations in fact or law.

If the Contractor denies a request for an Expedited Resolution of an Appeal, it shall:

1. Transfer the Appeal to the thirty (30) calendar day-time frame for standard resolution, in which the thirty (30) calendar day period begins on the date the Contractor received the original request for Appeal; and

2. Make reasonable efforts to give the Member prompt verbal notice of the denial and follow up with a written notice within two (2) calendar days.

The Contractor shall document in writing all verbal requests for Expedited Resolution and shall maintain the documentation in the case file.

E. MississippiCAN Members Only: State Fair Hearing

A hearing conducted by the Division of Medicaid or its Subcontractor in accordance with 42 C.F.R. Part 431, Subpart E.

A Member or Authorized Representative may request a State Fair Hearing if he or she is dissatisfied with an Adverse Benefit Determination that has been taken by the Contractor within one hundred twenty (120) calendar days of the notice of appeal resolution by the Contractor. The Member must exhaust all Contractor-level Appeal procedures prior to requesting a State Fair Hearing with the Division of Medicaid.

For Member Appeals, the Contractor is responsible for providing to the Division and to the Member an Appeal summary describing the basis for the denial. For standard Appeals, the Appeal summary must be submitted to the Division and Member upon the Division's request, in the time and manner specified. For expedited Appeals, (that meet criteria set forth in 42 C.F.R. § 438.410 the Appeal summary must be emailed to an address specified the Division and/or uploaded to a File Transfer Protocol (FTP) site specified by the Division and overnight mailed to

the Member, as expeditiously as the Member's health condition requires, but no later than four (4) business hours after the Division informs the Contractor of the expedited Appeal. The Division may require that the Contractor attend the hearing either via telephone or in person. The Contractor is responsible for absorbing any telephone/travel expenses incurred. These records shall be made available to the Member upon request by either the Member, the Member's representative, or the Member's legal counsel. In addition, the Division will provide the Member with a hearing process that shall adhere to 42 C.F.R. Part 438, Subpart F and 42 C.F.R. Part 431, Subpart E.

Failure of the Contractor to comply with the State Fair Hearing requirements of the State and Federal Medicaid law in regard to an Adverse Benefit Determination taken by the Contractor or to appear and present evidence will result in an automatic ruling in favor of the Member.

The Member must exhaust all Contractor-level Grievance and Appeal procedures prior to requesting a State Fair Hearing with the Division.

Any Adverse Benefit Determination or Appeal that is not resolved wholly in favor of the Member by the Contractor may be Appealed by the Member or the Member's Authorized Representative to the Division for a State Fair Hearing conducted in accordance with 42 C.F.R. Part 431, Subpart E. Adverse Benefit Determinations include reductions in service, suspensions, terminations, and denials. Furthermore, the Contractor's denial of payment for Mississippi Medicaid-covered services and failure to act on a request for services within required time frames may also be appealed. Appeals must be requested in writing by the Member or the Member's representative within one hundred twenty (120) calendar days of the Member's receipt of notice of an Adverse Benefit Determination unless an acceptable reason for delay exists. An acceptable reason shall include but not be limited to situations or events where:

1. Appellant was seriously ill and was prevented from contacting the Contractor;

2. Appellant did not receive notice of the Contractor's decision;

3. Appellant sent the request for Appeal to another government agency in good faith within the time limit; and

4. Unusual or unavoidable circumstances prevented a timely filing.

The Contractor shall comply with the Division's State Fair Hearing decision. The Division's decision in these matters shall be final and shall not be subject to Appeal by the Contractor.

F. CHIP Members Only: Independent External Review

A review of any Adverse Benefit Determination conducted by the State or a contractor other than the contractor responsible for the matter subject to external review shall be in accordance with 42 C.F.R. §457.1150.

A Member or Authorized Representative may request an Independent External Review if he or she is dissatisfied with an Action or Adverse Benefit Determination that has been taken by the Contractor within one hundred twenty (120) calendar days of the notice of Appeal resolution by the Contractor. The Member must exhaust all Contractor level Appeal procedures prior to requesting an Independent External Review.

For Member Appeals, the Contractor is responsible for providing to the Member an Appeal summary describing the basis for the denial. For standard Appeals, the Appeal summary must be submitted to the Member at least ten (10) calendar days prior to the date of the review. For expedited Appeals, (that meet criteria set forth in 42 C.F.R. § 438.410 the Appeal summary must be faxed or overnight mailed to the Member, as expeditiously as the Member's health condition requires, but no later than four (4) business hours after the Independent External Review Vendor informs the Contractor of the expedited Appeal.

The Contractor shall educate its Members of their right to Appeal directly to the Independent External Review Vendor. The Member must exhaust all Contractor level Grievance and Appeal procedures prior to requesting an Independent External Review with the Vendor.

Any Adverse Action, Adverse Benefit Determination or Appeal that is not resolved wholly in favor of the Member by the Contractor may be Appealed by the Member or the Member's Authorized Representative to the Contractor for an Independent External Review conducted in accordance with 42 C.F.R. § 457.1150. Adverse Action and Adverse Benefit Determination include reductions in service, suspensions, terminations, and denials. Furthermore, the Contractor's denial of payment for Mississippi Medicaid covered services and failure to act on a request for services within required time frames may also be appealed. Appeals must be requested in writing by the Member or the Member's representative within one hundred twenty (120) calendar days of the Member's receipt of notice of Adverse Action or Adverse Benefit Determination unless an acceptable reason for delay exists. An acceptable reason shall include, but not be limited to, situations or events where:

1. Appellant was seriously ill and was prevented from contacting the Contractor;

2. Appellant did not receive notice of the Contractor's decision;

3. Appellant sent the request for Appeal to another government agency in good faith within the time limit; and

4. Unusual or unavoidable circumstances prevented a timely filing.

The Contractor shall comply with the Independent External Review decision. The Independent External Review Vendor's decision shall be completed within thirty (30) calendar days of the date the appeal is received by the Contractor, or as expeditiously as the Member's health

condition requires, whichever is sooner. The decisions made in these matters shall be final and shall not be subject to Appeal by the Contractor.

G. Remedies

Failure to comply with requirements of this section will subject the Contractor to sanctions, termination, and/or and liquidated damages permitted by 42 C.F.R. Part 438, Subpart I and as enumerated in Section 14, Remedies, and Exhibit G, Liquidated Damages.

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MISSISSIPPI DIVISION OF
MEDICAID

Exhibit E: Non-Emergency Transportation (NET) Requirements

The Contractor, in its delivery of NET services, shall comply with all requirements enumerated in Part 201 of the Division's Administrative Code. NET services are covered for MississippiCAN Members under this Contract. NET services are not covered for CHIP Members under this Contract.

The Contractor shall administer and provide NET services to Members, including but not limited to the establishment of a network of NET Providers, and authorization, coordination, scheduling, management, and reimbursement of NET service requests.

The Contractor is required to provide NET services according to Division policies. The Division will provide assistance as needed with interpretation and clarification of Division policy and will notify the Contractor as changes are made that affect the NET Program.

The Contractor will be responsible for reimbursing NET Providers. The Contractor is not required to reimburse for unauthorized NET services.

The Contractor shall name a designated representative to the NET program and meet with the Division quarterly regarding transportation services throughout the term of the Contract to discuss and resolve administrative and operational issues. During the meeting, the Contractor is responsible for providing updates and additional information to the Division as requested. The meeting shall not be held in coordination with other monthly meetings between the Division and the Contractor. The meeting must be solely dedicated to the NET program. Meetings may be conducted in person, by teleconference or by videoconference.

The Contractor shall develop written policies and procedures that describe how the Contractor, in the delivery of NET services, shall comply with the requirements of the Agreement, including this Exhibit. The Contractor shall provide to the Division NET program staff with an electronic version of all written policies and procedures upon request. The policies and procedures must be specific to the Mississippi NET program.

A. NET Service Requests

Requests for NET Services may be made by Members; their family members, guardians or representatives; and by Mississippi Medicaid Providers. The Contractor shall screen all NET requests to determine each of the following requirements:

1. The Member's eligibility for NET Services;

2. The Member's medical need that requires NET Services;

3. The Member's lack of access to Available Transportation. The Contractor shall require the Member to verbally certify the lack of access to Available Transportation;

4. That the medical service for which NET Service is requested is a Mississippi Medicaid Covered Medical Service for the Member and rendered by an enrolled Mississippi Medicaid provider;

5. The most economical Mode of Transportation appropriate to meet the medical needs of the Member, based on the Member's mobility status and personal capabilities on the date of service. Reasons for approval of a Mode of Transportation that is not the most economical must be documented in detail;

6. The nearest appropriate Provider to the Member.

7. Necessity of attendant or assistance request. The Contractor may require a medical certification statement from the Member's Provider in order to approve Door-to-Door Service or Hand-to-Hand Service.

One (1) adult attendant may accompany the Member during transport. An attendant must be qualified to provide the type of assistance certified as medically necessary by the Member's attending healthcare provider prior to transport. For Members with minor children, if the Member is the sole caregiver of minor child/children at the time of the scheduled appointment, the Contractor shall authorize transport of the additional minor child/children. If the Member is a minor child, an adult caregiver must accompany the Member/child. The Contractor is not responsible for providing car seats for a Member or a Member's minor child/children, nor should the Contractor transport a child without a necessary car seat.

The Contractor shall maintain detailed procedures for screening all NET request types and submit to the Division upon request. The Contractor shall maintain a procedure for ensuring transport of Members and their minor child/children at the time of the scheduled appointment. The procedure must specifically address how the Contractor works with NET Providers regarding transport of additional passengers who are not covered under this Contract.

The Contractor shall develop and maintain a system of conditional edits to determine whether a Members is eligible for the transportation requested, based upon eligibility information to be provided by the Division and/or the Division's Fiscal Agent.

Included in the Contract for informational purposes:

Not all Mississippi Medicaid enrollees are eligible for NET Services. The following eligibility groups are not eligible for NET transportation: Family Planning Waiver, QMB, QWDI, SLMB, QI-1. The Contractor is not responsible for NET Services rendered to beneficiaries residing in Long Term Care (LTC) facilities including Nursing Facilities (NF), and Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID).

The Contractor is not responsible for arranging the transportation of the remains of a Member who expires while receiving medical treatment. If a Member expires while in transit, the Contractor's NET Provider should contact the nearest law enforcement agency for instructions.

The Contractor shall provide written informational material concerning how to request NET Service and shall educate Members, their family members, guardians or representatives and Providers on how to request NET Services when a Member needs transportation services. The Contractor shall instruct Members, their family members, guardians or representatives, and Providers that requests for NET Services must be made at least three (3) business days before the NET Service is needed. Because scheduling issues will occasionally occur, the Contractor must develop processes for handling urgent trips, high risk trips, last minute requests from Members, their family members, guardians or representatives and Mississippi Medicaid Providers; scheduling changes; and NET Providers who do not arrive for scheduled pick-ups. Trips considered "high risk" include but are not limited to the following types of requests: mental health, cardiac, pulmonary, chemotherapy/radiation, diabetic complications, dialysis, hospital visitation by parent/guardian/caregiver to any inpatient critical care unit, high risk pregnancy, newborn check, prenatal appointment, transplant patient (service must be related to the transplant), life sustaining wound care, and vision threatening eye injury.

The Contractor shall provide additional education to Members, their family members, guardians or representatives, and Providers who habitually request transportation less than three (3) business days in advance of the appointment date. The information shall be made available to the Division upon request.

B. Notification of Arrangements

If possible, the Contractor shall inform the Member or the Member's representative of the transportation arrangements during the phone call requesting the NET Service. Otherwise, the Contractor shall inform the Member or Member's representative by a later phone call, facsimile, or letter.

C. Prior Authorizations and Denials

If the Contractor receives a request for NET services that meets one of the denial reasons listed below, the Contractor shall deny the request and record the reason(s) for the denial in its information system on the same business day. The Contractor shall generate and mail denial letters to Members no later than the next business day following the date the denial decision was made. The denial letter shall notify the Members of the right to Appeal the denial. If the denial was not made during the telephone call from the Member requesting the NET services, the Contractor must also contact the Member via telephone to inform them of the denial and the right to Appeal. All costs of generating and sending denial notices and making denial notice telephone calls shall be borne by the Contractor. In the event a Member does not have sufficient information to arrange the transport and has to hang up and call back at a later time, the initial phone call with incomplete information will not be considered a trip denial for reporting purposes.

Denial reasons include:

1. The Member is not eligible for NET Services on the date of service;
2. The Member does not have a medical need that requires NET services;
3. The medical service for which NET service is requested is not a covered medical service;
4. The Member has access to available transportation;
5. Transportation to the medical service for which NET Service is requested is covered under another Program;
6. The request was for post-transportation Authorization and was not received timely or did not meet established criteria;
7. The medical appointment is not scheduled or was not kept;
8. The Contractor cannot confirm that the Member had a medical appointment;
9. The Contractor cannot accommodate the request as the trip was not requested timely;
10. The Contractor requested additional documentation that was not received timely;
11. The Member refuses the appropriate mode of transportation; or
12. The Member refuses the NET Provider assigned to the trip and another appropriate NET Provider is not available.

D. Scheduling and Dispatching Trips

The Contractor shall receive requests for NET Services, screen each request, and, if authorized, schedule and assign the trip to an appropriate NET Provider. The Contractor shall authorize and schedule routine NET services within three (3) business days after receipt of the request for ninety-eight percent (98%) of all requests. Contractor shall authorize and schedule routine NET services of all requests within ten (10) business days after receipt of a request for one hundred percent (100%). The Contractor shall report these requirements, as well as those enumerated as follows, to the Division via a monthly Deliverable report.

1. The Contractor shall ensure:

    a. The average monthly Member waiting time for pick-up at their originating site (example: home) does not exceed fifteen (15) minutes based on the scheduled time of pick-up for each NET Provider.

    b. The average monthly Member waiting time for pick-up (scheduled pick-up) from their medically necessary covered service (example: appointment, pharmacy, screening, doctors visit) does not exceed thirty (30) minutes for each NET Provider.

    c. The average monthly Member waiting time for pick-up (will-call pick-up) from their medically necessary covered service (example: appointment, pharmacy, screening, doctors visit) does not exceed sixty (60) minutes for each NET Provider. A will-call is defined as a Member's call to request the return ride or "will-call" trip.

    d. The average monthly Member waiting time for pick-up from their hospital discharge does not exceed three (3) hours from the time the Contractor is notified of the discharge for each NET Provider. The Contractor shall contact an appropriate NET Provider so that pick-up occurs within three (3) hours after notification of a hospital discharge.

    e. That Members arrive on time at pre-arranged times for appointments and are picked up on time at pre-arranged times for the return trip if the Covered Medical Service follows a reliable schedule. The pre-arranged times may not be changed by the NET Provider or driver without prior permission from the Contractor.

2. The Contractor and a NET Provider may group Members and trips to promote efficiency and cost effectiveness. The Contractor may contact Providers in this process.

3. The Contractor shall notify the NET Provider of the assignment at least two (2) business days prior to the trip, if possible, and at minimum one (1) business day prior to the trip, with the exception of urgent or high-risk trips and shall timely assign the trip to another NET Provider if necessary.

4. The Contractor shall report the above requirements to the Division via a monthly deliverable report.

If the Contractor requires additional information to authorize a request, the Contractor shall place the request on hold and shall request the additional information within twenty-four (24) hours after receipt of the request. The Contractor shall specify the date by which the additional information must be submitted. Timely requests by the Contractor for additional information shall stay the authorization period. If the Contractor does not receive additional information by the date specified by the Contractor, the Contractor shall deny the request except NET services to an appointment for chemotherapy, dialysis, and high-risk pregnancy. In those instances, the Contractor shall authorize Single Trips and pursue receipt of necessary information to authorize a Standing Order.

E. Appropriate Modes of Transportation

The following modes of transportation are to be used in NET Brokerage Program:

1. **Ambulatory**

    a. Basic Vehicle: transportation by means of a motorized vehicle used for the transportation of passengers whose medical condition does not require use of a wheelchair, hydraulic lift, stretcher, medical monitoring, medical aid, medical care or medical treatment during transport. This does not include private automobiles and does not include transportation through the volunteer driver program.

    b. Commercial Carrier (Ground): transportation by means of passenger train (such as Amtrak) or buses (such as Greyhound).

    c. Fixed Route (Public Transit): transportation by means of a public transit vehicle that follows an advertised route on an advertised schedule, does not deviate from the route or the schedule and picks up passengers at designated stops.

    d. Gas Mileage Reimbursement: Gas reimbursement for Member trips. Transportation by means of private automobile (vehicle owned by the Member, relative or other

individual). This mode of transportation does not include transportation provided by the volunteer driver program.

e. Volunteer Driver: transportation by means of motor vehicle owned and operated by an individual. The volunteer driver must at a minimum meet all credentialing and insurance requirements, timeliness standards, report accidents and incidents, accept/deny trip assignments, comply with policies outlined in the Contractors volunteer driver agreement and submit claims to the Contractor.

2. Other

a. Enhanced Vehicle (Wheelchair/Stretcher): transportation by means of a motorized vehicle equipped specifically with certified wheelchair lifts or other equipment designed to carry persons in wheelchairs or other mobility devices, or is equipped specifically for the transportation of passengers who cannot sit upright and are required to remain in a lying position during transport. Enhanced Vehicles can only be used to transport passengers who do not require medical monitoring, medical aid, medical care or medical treatment during transport. This does not include Private Auto.

b. Non-Emergency (Ground) Ambulance: transportation by means of a motorized vehicle equipped specifically for the transportation of a passenger whose medical condition requires transfer by stretcher with medical supervision. The passenger's condition may also require the use of medical equipment, monitoring, aid, care or treatment, including the administration of drugs or oxygen, during the transport. The Contractor is not responsible for scheduling or reimbursement of nonemergency ground ambulance hospital to hospital transports.

3. Air

a. Commercial Carrier (Air): transportation by means of scheduled airline services

b. Fixed-Wing Non-Emergency Air Ambulance: transportation by means of a fixed-wing aircraft used for chartered air transportation of sick or injured persons who require medical attention during transport.

The Contractor is encouraged to maximize the utilization of fixed-route transportation whenever more economical and appropriate. The Contractor shall be familiar with schedules of fixed-route transportation in communities where it is now available and in areas where it becomes available during the term of the Contract. The Contractor shall distribute or arrange for the distribution of fixed-route passes to Members for whom fixed-route transportation is the most appropriate mode of transportation.

The furthest distance a Member may be required to walk to or from a fixed-route transportation stop is one quarter (1/4) mile. If the Contractor determines that fixed-route transportation is an appropriate mode of transportation for a Member, but the Member requests a different mode of transportation, the Contractor may require the Member to verify his or her mobility limitations, including but not limited to requiring the Member to supply documentation from his or her physician. The Contractor shall consider the following when determining whether to allow an exception:

1. The Member's ability to travel independently, including the age of the Member, and any permanent or temporary debilitating physical or mental condition that precludes use of fixed-route transportation;

2. The availability of the fixed-route transportation in the Member's area or community, including the accessibility of the location to which the Member is traveling and whether the Member must travel more than one quarter (1/4) of a mile to or from the fixed-route transportation stop;

3. Inclement weather conditions (including extreme heat or cold) or other pertinent factors that make use of fixed-route transportation unfeasible;

4. The compatibility of the fixed-route transportation schedule with the Member's appointment times for the covered medical service. The schedule of the fixed-route transportation should allow the Member to arrive at the drop off location no more than sixty (60) minutes prior to the scheduled appointment time, and will allow the Member forty-five (45) minutes after the estimated time the appointment will end to arrive at the pick-up location; and

5. Any special needs of the Member that requires the coordination of services with other providers.

F. Trip Types

Single Trip Requests: The Contractor shall require that requests for NET Service to a single appointment are made via a toll-free telephone number or web-based reservation system.

Standing Order Trip Requests: The Contractor shall establish procedures to handle trip requests so that Members are not required to continually make arrangements for repetitive appointments. The Contractor shall include in its procedure to recertify the need of a Standing Order with the Medical Provider at least every ninety (90) days. These orders may be accepted via phone, fax or a web-based reservation system.

One-way transport following Emergency Transports: In limited situations, a Member may be transported by emergency medical ground ambulance to a medical facility. Upon discharge, if the Member can be transported to his/her residence via an ambulatory vehicle or wheelchair accessible vehicle, the Contractor shall make the appropriate arrangements for the one-way transport for the Member and up to one (1) attendant (Emergency transportation is not the responsibility of the Contractor).

Commercial Carrier (Air) Transports: In limited situations, a Member may be transported by Commercial Carrier (Air). The Contractor shall establish procedures to handle trip requests, including but not limited to making the appropriate arrangements, purchasing the tickets, and distributing the tickets to the Member. The Contractor is only responsible for purchasing tickets for the Member receiving medical services and up to one (1) adult attendant. The Contractor shall use the most cost-efficient arrangements possible with reasonable allowances for choosing a flight that would reduce the number of transfers, and/or reduce travel time and/or choosing an appropriate departure/arrival time based on the needs of the Member. All tickets purchased for commercial air travel must be coach seating.

Fixed-Wing Air Ambulance Transports: Fixed-Wing Air Ambulance services are covered by Mississippi Medicaid based on criteria detailed in the Mississippi Administrative Code and outlined in the RFQ.

G. Network of NET Providers

The Contractor shall establish, maintain, and monitor a network of NET Providers supported by written agreements that is sufficient to provide adequate access to all services covered under the Contract for all Members eligible to receive NET services, including those with limited English proficiency or physical or mental disabilities. The Contractor is responsible for negotiating reimbursement with qualified transportation entities. The Contractor shall provide a gas mileage reimbursement program, volunteer driver program, and a fixed-route public transportation program as a form of access to transportation. The Contractor is encouraged to develop innovative and creative strategies to ensure increased access to transportation for Members.

The Contractor shall ensure that policies and procedures for provider selection and retention are submitted to the Division upon request. The Contractor shall submit to the Division, upon request, the NET Provider in Network, the number of vehicles by type that each NET provider operates, and the geographic areas in which the NET Provider operates. The Contractor shall maintain contingency plans for unexpected peak transportation demands and back-up plans for instances when a vehicle is excessively late or is otherwise unavailable for service and provide the plans to the Division upon request. The Contractor shall secure NET Providers for bariatric transportation by geographic areas of coverage.

The Contractor shall establish and maintain a good working relationship with NET Providers, Mississippi Medicaid Providers, and professional associations. The Contractor shall maintain a plan for establishing and maintaining a good working relationship with NET Providers, Mississippi Medicaid Providers, and professional associations and submit the plan to the Division upon request. The Contractor shall not discriminate in the participation, reimbursement, or indemnification of any NET Provider who is acting within the scope of his or her license or certification under applicable State law, solely based on that license or certification. If the Contractor declines to include individual or groups of NET Providers in its NET Provider network, it must give the affected NET Providers written notice of the reason for its decision.

The Contractor shall identify, recruit, and negotiate contracts with NET Providers, including all Modes of Transportation, sufficient to meet the needs of Members. The Contractor shall secure sufficient NET Provider resources (numbers and types of vehicles and drivers) under contracts so that the failure of any NET Provider to perform will not impede the ability of the Contractor to provide NET Services in accordance with the requirements of the Contract.

The Contractor is prohibited from establishing or maintaining contracts with NET Providers that are not eligible to be a Medicaid Provider under applicable state and federal law. The Contractor shall terminate a service agreement with a NET Provider when substandard performance is identified or when the NET Provider has failed to take satisfactory corrective action within a reasonable time period or if the NET Provider becomes ineligible to serve as a Medicaid Provider during the life of the service agreement. The Division reserves the right to direct the Contractor to terminate any service agreement with a NET Provider when the Division determines it to be in the best interest of the State. The Contractor shall notify the Division in writing of its intention to terminate a NET Provider contract and the reasons for such termination at least fifteen (15) days prior to termination. Volunteer Drivers, Gas Mileage Reimbursement, Fixed-Route (Public Transit), Commercial Carrier (Ground), Commercial Carrier (Air), and Fixed-Wing Nonemergency Air Ambulance are not considered contracted NET Providers. Basic Vehicle, Enhanced Vehicle (Wheelchair/Stretcher) and Non-Emergency (Ground) Ambulance are considered contracted NET Providers.

NET Provider Contracts

The Contractor shall receive advance written approval from the Division for the model contract the Contractor intends to use with NET Providers. The model contract shall address, at a minimum, the following items:

1. Identification of the NET Provider;
2. Payment administration and timely payment;
3. Modes of transportation;

4. Geographic coverage area(s);
5. Attendant services;
6. Telephone and vehicle communication systems;
7. Information systems;
8. Scheduling;
9. Dispatching;
10. Pick-up and delivery standards;
11. Urgent and High-Risk Trip requirements;
12. Driver qualifications;
13. Expectations for Door-to-Door, Hand-to-Hand, Curb-to-Curb;
14. Driver conduct;
15. Driver manifests delivery;
16. Vehicle requirements;
17. Back-up service;
18. Quality assurance;
19. Non-compliance with standards;
20. Training for drivers;
21. Confidentiality of Information;
22. Specific provisions, which in the instance of uncured default by the Contractor, the agreement, if terminated, will pass to the Division or its agent for continued provision of NET Services. All terms, conditions and rates established by the agreement shall remain in effect until or unless renegotiated with the Division or its agent subsequent to default action or unless otherwise terminated by the Division at its sole discretion;
23. Indemnification and hold harmless language to protect the State of Mississippi and the Division;
24. Evidence of insurance for vehicle and driver;
25. Submission of documentation as required by the Division; and
26. The procedures for appeal and dispute resolution.

H. Vehicle Requirements

See Mississippi Administrative Code, Title 23, Part 201, Rule 2.7 Vehicle Requirements.

I. Driver Requirements

See Mississippi Administrative Code, Title 23, Part 201, Rule 2.6 Driver Requirements.

Contractor Driver Requirements

The Contractor must ensure NET Providers employ drivers in accordance with or exceeding local, State, and Federal requirements and the Mississippi Administrative Code. The Contractor

must supply NET Providers with a copy of the driver requirements and inspect the NET Provider employee records prior to the Operations Start Date and at least every six (6) months thereafter. The Contractor must maintain records of biannual inspections and make them available to the Division via a quarterly Deliverable report.

J. Trip Monitoring

The Contractor shall require that the NET Providers' drivers to maintain daily trip logs containing, at a minimum: date of service, driver's name, driver's signature, Member's name, Member's signature, Vehicle Identification Number (VIN) or other identifying number on file, NET Provider's name, request tracking number, mode of transportation authorized, scheduled arrival time in military time, actual arrival time in military time, actual drop off time in military time, miles driven per odometer, destination and/or Medicaid Provider information, and other relevant notes.

Fixed-route transportation is excluded from this requirement. The Contractor shall require NET Providers to make the trip logs available to the Contractor or the Division upon request, within five (5) business days.

K. Validation Checks

The Contractor's payment procedures shall ensure that NET Provider claims for reimbursement match authorized trips and that the trips actually occurred. The Contractor shall validate that transportation services paid for under the Contract are properly authorized and rendered. The Contractor shall perform validation checks on at least Six Percent (6%) NET service requests in a month, both prior to the authorization of the request and after the services are rendered, as specified below.

The Division, at its sole discretion, may require validation checks of trips to specific services. The Contractor shall conduct pre-transportation validation checks prior to authorizing the request for no fewer than three percent (3%) of the NET services requests received in a month. The Contractor shall contact the Provider and verify that the Member has an appointment for a covered medical service. The Contractor shall not verify the medical necessity of an appointment. If the Contractor verifies with the Provider that no appointment exists, or that the service is not a covered medical service, the Contractor shall record in its computer system the reason for the failed validation check, and the Contractor shall deny the request. If a pre-transportation validation check cannot be completed because the call to the Provider resulted in a busy signal or no answer, the Contractor shall flag the request for a post-transportation validation check, and the attempt at validation shall not be counted toward the three percent (3%) requirement.

The Contractor shall conduct post-transportation validation checks on no fewer than three percent (3%) of the NET services requests received in a month. The Contractor shall contact the Provider and verify that the Member had an appointment for a covered medical service. The Contractor shall verify that the Member received a covered medical service. The Contractor shall not verify the necessity of the transportation or of the medical service, but only that the service occurred. If the Contractor verifies with the Provider that there was no appointment, that the appointment was not kept or that the service was not a covered medical service, the Contractor shall record in its computer system the reason for the failed validation check. If a post-transportation validation check cannot be completed because the call to the Provider resulted in a busy signal or no answer after three (3) attempts, the Contractor shall enter into its system information that will alert the Member Services Call Center staff that any future requests to this specific Provider shall be validated before it can be authorized.

The Contractor shall perform pre-transportation and post-transportation validation checks for three percent (3%) of fixed route transportation requests.

The Contractor shall report all validation check findings to the Division, by NET Provider, via a quarterly Deliverable report.

L. Remedies

Failure to comply with requirements of this section will subject the Contractor to sanctions, termination, and/or and liquidated damages permitted by 42 C.F.R. Part 438, Subpart I and as enumerated in Section 14, Remedies, and Exhibit G, Liquidated Damages.

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Exhibit F: Quality Management

A. Quality Management Generally

The Division will monitor the Quality Management (QM) of the Contractor and retains the right of advance written approval of all QM activities. The Contractor must design its QM program to assure and improve upon the accessibility, availability and quality of care provided for Mississippi Coordinated Care Members. The Contractor's QM programs must, at a minimum:

1. Contain a written program description, work plan, and program evaluation that meet requirements outlined in the Contract that focus on the areas of importance as identified by the Contract in collaboration with the Division.

2. Be based on and actively evaluate claims data, Member demographic information, Member and Provider surveys and other data, as applies, and to use these data for the identification of prevalent medical conditions and barriers to care to be targeted for quality improvement.

3. Continuously evaluate the effectiveness of its activities and make adjustments to the program or to various methodologies or approaches based on these evaluations. Evaluations should include a analysis, in a format proposed by the Contractor and approved by the Division, performed at least every six months and submitted to the Division.

4. Contain written policies and procedures that meet the requirements outlined in the Contract and monitor internal compliance with these policies and procedures.

5. Maintain a structure and actively ensure that the program is implemented and overseen by professionals with adequate and appropriate experience in QM.

The Contractor must submit to the Division for approval an improvement plan, as determined by the Division, and within time frames established by the Division, to resolve any performance or quality of care deficiencies identified by the Division. The Division must approve the improvement plan. Failure by the Contractor to comply with requirements and improvement actions requested by the Division may result in the application of liquidated damages or other available remedies.

B. Quality Management Standards

B.1. Scope

The scope of the QM program must be comprehensive in nature and improve health outcomes and satisfaction for the Members. This includes but is not limited to assessment of access to care,

barriers to care, quality of care, cost effectiveness of care, Social Determinants of Health, Care Management, and continuity of services. At a minimum, the Contractor's QM programs, must:

1. Adhere to current Federal, State, and Division rules and regulations.

2. Be developed and implemented by professionals with adequate and appropriate experience in QM.

3. Ensure that all QM activities and initiatives undertaken by the Contractor are chosen based upon claims data, Member demographic information, Member and Provider surveys, Medical Record review data and other data as applies.

4. Contain policies and procedures for all functions of the QM program. The policies and procedures must include ongoing review of the program provided by the Contractor ensuring that all demographic groups and special needs populations are addressed. The Contractor must submit to the Division for approval all policies and procedures prior to initial implementation and upon all changes.

5. Contain a detailed written program description, which must be approved by the Contractor's Governing Body and the Division prior to implementation and on an ongoing basis as the program description is modified. The program description must address all standards, requirements and objectives established by the Division and describe the goals, objectives and structure of the Contractor's QM program; at a minimum, it must be updated and submitted to the Division annually. The written program description must include:

    a. Standards and mechanisms to monitor Members to receive timely accessibility of primary care, specialty care, in accordance with time frames outlined in Section 6.2, Provider Network Requirements, of this Contract.

    b. Mechanisms for assessment, analysis and reporting of the quality of care provided through the Contractor including, but not limited to:

        i. Primary care and Patent-Centered Medical Homes;
        ii. Preventive care;

        iii. Acute and/or chronic conditions;

        iv. Care Management and care coordination, including coordination of behavioral health/substance use disorder and physical health services, as

well as use of closed-loop referrals and community-based organization partnerships;

v. Continuity of care;

vi. Behavioral Health Services/Substance Use Disorder;

vii. Inpatient hospitalization; and

viii. Social Determinants of Health.

c. Assessment of the timely, accurate, complete collection and/or analysis of Member and Provider surveys.

d. Assessment of outcomes of partnerships with community-based organizations.

6. The Contractor must submit to the Division for approval the detailed Annual Work Plan, approved by the Contractor's Governing Body prior to implementation, including:

a. Timetable;

b. Individual(s) accountable for each task;

c. Target dates for start dates;

d. Target dates for completion of all phases of all QM activities;

e. Updates at minimum on a quarterly basis;

f. Plan-Do-Study-Act (PDSA) assessments on a quarterly basis;

g. Annual submission, which must include prospective QM initiatives for the year;

h. Data collection methods and analysis target dates;

i. Evaluation and reporting of findings to the Division;

j. Implementation of improvement actions where applicable; and

k. Status of each activity.

7. The Annual QM Program Evaluation will include:

    a. Studies and activities undertaken;

    b. Rationales and methodologies for activities and studies undertaken;

    c. Results of activities;

    d. Subsequent improvement actions;

    e. An analysis of claims data, Member demographic information, Member and Provider surveys and other data as applicable; and

    f. Quarterly analysis and re-measurement of barriers to care and the quality of care provided to Members.

8. Include mechanisms and processes that ensure that related and relevant operational components, activities and initiatives from the QM program are communicated and integrated into activities and initiatives undertaken by other departments within the Contractor's organization, delegated Subcontractors, and Care Management programs.

9. Include procedures for informing Providers about the written QM program, and for securing cooperation with the QM program with all PCPs/PCMHs and community-based services.

10. Include procedures for feedback and interpretation of findings from analysis of quality data to PCPs/PCMHs, Care Management staff, community-based organizations, and Members and their family members.

11. Include mechanisms and processes that allow for the development and implementation of specific improvement actions in response to identified barriers and quality of care concerns within the QM program or the communication of the findings to the Division.

12. Cooperate and coordinate with State initiatives. The Contractor must participate in State health initiatives. This may include, but is not limited to:

    a. Provider outreach and education;

    b. Member outreach and education;

    c. Quality studies; and

d. Participation in workgroups.

B.2 Organizational Structure

The organizational structures of the Contractor must ensure that there is adequate support of the Contractor's Annual Quality Management Work Plan. The Contractor may determine that one (1) Governing Body will oversee all the Quality Management activities.

1. The Governing Body must:

    a. Formally designate an entity, such as the Quality Management Committee (QMC), to have the accountability for and oversight of all aspects of the Mississippi Coordinated Care Program and evaluation of the effectiveness of the population served.

    b. Regularly receive written reports on the QM program activities that describe actions taken, progress in meeting objectives and improvements made. The Governing Body reviews, on at least an annual basis, the written program description, work plan and program evaluation of the QM program activities.

    c. Document actions taken by the Governing Body in response to findings from QM program activities and supply them to the Division upon request.

    d. Delegate a liaison that is directly accountable to the Division, the Governing Body and the QMC for all QM activities and initiatives.

2. The Quality Management Committee (QMC):

    a. Operates under policies and procedures that describe the role, structure, and function of the QMC that:

        i. Demonstrate that the QMC has oversight responsibility and input, including review and approval, for all QM program activities;

        ii. Ensure membership on the QMC and active participation by individuals, representative of the composition of the PCPs; and
        iii. Document actions taken by the QMC in response to findings from QM program activities and supply them to the Division upon request;

b. Meets at least quarterly, and otherwise as needed;

c. Opportunity must be provided for Members to offer suggestions for changes in policies and procedures and how these suggestions will be communicated with the Division; and

d. Opportunity must be provided to the Provider Network to offer suggestions for changes in policies and procedures and how these suggestions will be communicated to the Division.

3. The Contractor must have sufficient material resources, and staff with the education, experience, and training to effectively implement the written QM program and related activities.

4. The Contractor must submit to the Division for approval the organizational chart and job descriptions prior to implementation.

B.3 Monitoring, Measurement, and Evaluation

The QM program must include and implement methodologies that allow for the objective and systematic monitoring, measurement, and evaluation of the quality, appropriateness of care, and services provided to Members through quality of care studies and related activities, with a focus on identifying and pursuing opportunities for continuous and sustained improvement. The QM program must include professionally developed practice guidelines and standards of care that are written in measurable and accepted professional formats, based on scientific evidence, applicable to PCPs/PCMHs for the delivery of certain types or aspects of health care, and regularly reviewed and updated.

1. The QM program must include clinical and/or quality indicators in the form of written, professionally developed, objective, and measurable variables of a specified clinical or health services delivery area that are reviewed by the Contractor over a period of time to screen delivered health care and/or monitor the process or outcome of care delivered in that clinical area.

2. Practice guidelines and clinical indicators must be measurable and address the health care needs of the populations served by the Contractor. The clinical areas addressed must include but are not limited to:

    a. Adult preventive care;

b. Pediatric and Adolescent preventive care with a focus on Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services for the applicable MississippiCAN population;

c. Well-Baby and Well-Child Care services for the CHIP population;

d. Division-defined clinical areas;

e. Care Management Related Clinical Outcomes and Performance;

f. Behavioral health/Substance Use Disorder;

g. Maternity/Perinatal;

h. Inpatient discharge planning; and

i. Provider Preventable Conditions.

3. The QM program must provide practice guidelines, clinical indicators, and Medical Record keeping standards to all Providers and appropriate Subcontractors. The Contractor must also provide this information to Members upon request.

4. The QM program must have policies and procedures for implementing and monitoring improvement plans. These policies and procedures must include the following:

    a. Person(s) or body responsible for making the final determinations regarding quality problems; and

    b. Types of actions to be taken, such as:

        i. Education;

        ii. Follow-up monitoring and re-evaluation;

        iii. Changes in the Contractor's processes, structures, and forms;

        iv. Informal counseling;

        v. Assessment of the effectiveness of the actions taken; and

        vi. Reporting of issues to the Division.

5. The QM program must include methodologies that allow for the identification, tracking, verification, and analysis of outpatient quality of care concerns, Member quality of care Grievances, and quality of care referrals from other sources. The Contractor must report findings from this analysis of quality of care concerns, Grievances, and quality of care referrals to the Division, with a discussion of how these findings will inform the Contractor's quality improvement work plan and how the Contractor will address these concerns. The Contractor will include this information in the QM Program Evaluation.

6. The QM program must contain procedures for the completion of Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Member satisfaction surveys, and the Contractor must conduct this survey annually. The Contractor must report findings from this survey to the Division, with a discussion of how the findings from the survey will inform the Contractor's quality improvement work plan and effect changes to the program description.

7. The QM program must contain procedures for completion of a Provider satisfaction survey of the PCPs/PCMHs and must conduct this survey at least annually. The Contractor must report findings from this survey to the Division, with a discussion of how the findings from the survey will inform the Contractor's quality improvement work plan and effect changes to the program description.

B.4 Disease and Health Management

The Contractor must develop and implement mechanisms for integration of disease and health management programs that rely on prevention of complications as well as treatment of chronic conditions for Members identified through clinical and financial analysis of claims data provided by the Division, detailed Comprehensive Health Assessments, Member demographic information, and utilization patterns for preventive, secondary and tertiary care.

B.5 Accountability

The Contractor must have formal accountability for the QM program. If the Contractor delegates this responsibility, the Contractor must:

1. Have a detailed written description and work plan, approved by the Division, of the delegated activities, the delegate's accountability for these activities, and the frequency of reporting to the Contractor and the Division.

2. Have written procedures approved by the Division for monitoring and evaluating the implementation of the delegated functions and for verifying the actual quality of care being provided.

3. Document evidence to be submitted to the Division, of continuous and ongoing evaluation of delegated activities, including of quality improvement plans, quality meeting minutes, and regular specified reports.

4. Make available to the Division, and its authorized representatives, any and all records, documents and data detailing its oversight of delegated QM program functions.

5. Ensure that delegated entities make available to the Division, and its authorized representatives, any and all records, documents, and data detailing the delegated QM program functions undertaken by the entity of behalf of the Contractor.

6. Ensure the delegated entity adheres to the standards of the current Contract.

B.6 Written Policies and Procedures

The Contractor must have written policies and procedures for record keeping on all of the Contractor activities.

1. The Contractor must ensure that these records are accurate, timely, and readily accessible and permit prompt and systematic retrieval of information. Written policies and procedures must contain standards for records that promote maintenance of records in a legible, current, detailed, organized, and comprehensive manner that permits effective quality review.

2. The Division and/or its authorized Agents (i.e., any individual, corporation, or entity employed, contracted, or subcontracted with the Division) must be afforded prompt access to all records in any and all formats. All record copies are to be forwarded to the requesting entity within fifteen (15) calendar days of such request and at no expense to the requesting entity. The Division is not required to obtain written approval from a Member before requesting a Member's record from the Contractor or any other agency.

B.7 Documentation

The Contractor must maintain systems that document implementation of the written QM program descriptions. The Contractor must document that it is monitoring the quality of care across all services, all treatment modalities, and all sub-populations according to its written QM program description.

B.8 PCP/PCMH Oversight

The Contractor must have standards and mechanisms to oversee the PCPs/PCMHs and report findings to the Division.

1. The Contractor must oversee that the PCPs/PCMHs are adhering to:

    a. Federal, State and Division rules and regulations;

    b. PCP/PCMH requirements;

    c. Members' rights; and

    d. Clinical and preventive guidelines of the program.

2. The Contractor must submit to the Division for approval the initial versions and any revisions made to the following documents that relate to the QM program:

    a. Table of Organization including job descriptions;

    b. Employee tools to include scripts, algorithms and criteria;

    c. Program Descriptions;

    d. Work Plans;

    e. Program Evaluations;
    f. Performance Improvement Projects;

    g. Focused Studies; and

    h. Other documents related to the QM program, as designated by the Division.

3. The Division may request additional information from the Contractor to assist in the determination of Contract compliance. To the extent possible, the Division shall provide reasonable advance notice of such reports. These may include:

    a. Committee Meeting Minutes;

    b. Work Plan Updates;

    c. Contractor Documentation;

    d. Ad Hoc Reports and Information;

e. Contractor Demonstrations; and

f. Access to materials and the ability to observe onsite evaluations.

B.9 Value-Based Purchasing

The Contractor must comply with all standards enumerated in the Mississippi Division of Medicaid Value-Based Purchasing Work Plan upon is publication and any updates to the document thereafter.

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Exhibit G: Liquidated Damages

A. As stated in Section 14, Remedies, of this Contract, the Division reserves the right to assess actual or liquidated damages upon the Contractor's noncompliance with any provision of this Contract. The parties agree that the Contractor shall pay the Division liquidated damages in the amounts as stated in the table below and other such liquidated damages as are a reasonable estimate of the loss to be incurred. Unless a different amount is specifically set forth below, the Division may, at its sole discretion, assess liquidated damages between one dollar ($1.00) and one million dollars ($1,000,000.00) for each failure that occurs or remains uncorrected.

B. The Division's declination to assess liquidated damages in one or more of the instances described below or in the Contract will in no event waive the right of the Division to assess additional liquidated damages or actual damages or to asses liquidated damages for a future action giving rise to a previously declined liquidated damage.

C. With the exception of Member Encounter Data submissions, the Division will utilize the following guidelines to determine whether a report is correct and complete for the purposes of liquidated damages: Reports must be 1) timely, 2) reflect application of instructions, 3) include questions and notations when contractor is unsure, 4) complete, 5) includes usable data to assess the service, operation, and program. The Division may provide additional requirements and guidelines at its discretion.

D. For the purposes of Exhibit G, "deficient" means that a report is inaccurate and/or incomplete.

E. Liquidated damages for late Deliverables shall begin on the first calendar day the Deliverable is late. The Division shall notify the Contractor of any deliverables that are incorrect or deficient and provide a date certain by which the Contractor shall make any corrections and/or cure any deficiencies. In the event the deliverable remains incorrect or deficient following the deadline to correct imposed by the Division, liquidated damages shall begin on the first calendar day after the deadline.

F. The collection of liquidated damages by the Division shall be made without regard to any appeal rights the Contractor may have pursuant to this Contract. However, in the event an appeal by the Contractor results in a decision in favor of the Contractor, any such funds withheld by the Division will be returned to the Contractor without interest.

G. The assessment of any actual or liquidated damages will be offset against the subsequent monthly payments to the Contractor or through demand to the Contractor for payment. Assessment of any actual or liquidated damages does not waive any other remedies available to the Division pursuant to this Contract or State or Federal law. If liquidated damages are

known to be insufficient, then the Division has the right to pursue actual damages and/or any other available remedies via law or equity.

H. If it is determined that the Contractor would have been able to meet the Contract requirements listed below but for the Division's failure to perform as provided in this Contract, the Contractor shall not be liable for damages resulting from the Division failure.

Category 1: General - GEN

Reference #	Service/Component	Performance Standard	Measurement Period	Measurement Assessment	Liquidated Damages
GEN #1	General	Failure by the Contractor to meet the Performance Measure targets established by the Division.	For the Term of the Contract	Per measure, per reporting period	The Division may assess up to a 1% reduction in Capitation Payments for the reporting period of the measure if the Contractor is found out of compliance.
GEN #2	General	The Contractor must not engage in misrepresentation or falsification of information to the Division, any governmental entity, any provider, and/or any Member or potential Member.			The Division may assess liquidated damages of up to $25,000 for each failure to comply. Repeated instances may result in grounds for Termination.
GEN #3	Section 16.4, Access to Records and throughout this Contract.	The Contractor must grant timely access to records (as defined by the Secretary in regulations) upon reasonable request to any person (including an organization, agency, or other entity, but excluding a Member) or to the Inspector General of the Department of Health and Human Services for the purpose of audits, investigations, evaluations or other statutory functions of the Inspector General of the Department of Health and Human Services, the Division, or any other duly authorized representative.	For the Term of the Contract	Per incident, per day of noncompliance	In addition to any other penalties that may be prescribed by law, the Division may asses a penalty of $15,000 for each day of the failure to make accessible all books, documents, papers, Provider records, Medical Records, financial records, data, surveys, and computer databases (collectively referred to as "records"). In addition, the Division may terminate the Contract.
GEN #4	Section 13.2.1, Subcontracting Conditions	1In the event that the Contractor terminates the Subcontractor or the Subcontractor ends its relationship with the Contractor, the Contractor will give notice to the Division within one (1) business day of termination and include information about the Contractor's plan to ensure continuity of services affected by the loss of the Subcontractor.	For the Term of the Contract	Each day of noncompliance	The Division may assess up to $5,000 per day of noncompliance.
GEN #5	Section 13.2.3, Division Approval Process	The Contractor must obtain written approval from the Division of a Subcontractor prior to initiating a	For the Term of the Contract	Per incident	The Division may assess liquidated damages in an amount up to $10,000 for each day that the Subcontractor

		Contract for services from that Subcontractor.			was in effect without the Division's approval.

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Additional General Liquidated Damages

Deliverables and Reporting

For each day that a Deliverable not otherwise particularly enumerated in this Exhibit is late or deficient, the Contractor may be liable to the Division for liquidated damages in an amount per calendar day per Deliverable as specified in the table below for Deliverables not otherwise specified in the above table. Liquidated damages have been designed to escalate by duration and by occurrence over the term of this Contract.

Occurrence per Report	Daily Amount for Days 1–14	Daily Amount for Days 15–30	Daily Amount for Days 31–60	Daily Amount for Days 61 and Beyond
1–3	$750	$1,200	$2,000	$3,000
4–6	$1,000	$1,500	$3,000	$5,000
7–9	$1,500	$2,000	$4,000	$6,000
10–12	$2,000	$3,000	$5,000	$8,000
13 and Beyond	$4,000	$7,000	$9,500	$12,000

Responsiveness to Division Requests

If the Contractor fails to meet the requirements of Section 1.10, Responsiveness to Division Requests, the Division may assess liquidated damages in an amount per calendar day per request as specified in the table below. Liquidated damages have been designed to escalate by duration and by occurrence over the term of this Contract. Liquidated damages under this table shall begin on the first day the contract requirement is not met, including but not limited to, the first day the Division request is not acknowledged or completed as required or in the required timeframe.

Occurrence	Daily Amount for Days 1–14	Daily Amount for Days 15–30	Daily Amount for Days 31–60	Daily Amount for Days 61 and Beyond
1–3	$750	$1,200	$2,000	$3,000
4–6	$1,000	$1,500	$3,000	$5,000
7–9	$1,500	$2,000	$4,000	$6,000
10–12	$2,000	$3,000	$5,000	$8,000
13 and Beyond	$4,000	$7,000	$9,500	$12,000

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Category 2: Readiness Review/Implementation Period – RR/IP

Reference #	Service/Component	Performance Standard	Measurement Period	Measurement Assessment	Liquidated Damages
RR/I #1	Section 15.9, Readiness Review	The Contractor must be operational no later than the agreed upon Operational Start Date. The Division will determine when the Contractor is operational based on the requirements in of this Contract.	Operational Start Date	Each day of noncompliance, per service area of the noncompliance.	The Division may assess up to $10,000 per calendar day of noncompliance, per service area for each day beyond the Operational Start Date that the Contractor is not operational, including all systems.
RR/IP #2	Section 6.2.5, Patient-Centered Medical Homes Section 7, Care Management Section 8, Quality Management Section 8.8, Value-Based Purchasing	The Contractor must submit to the Division the following plans for review, no later than 90 calendar days after the contract award date: • Patient-Centered Medical Homes • Care Management • Quality Management • Value-Based Purchasing	90 Calendar Days after Award of the Contract	Each day of noncompliance, per plan	The Division may assess up to $10,000 per calendar day of noncompliance, per plan, for each day a deliverable is not submitted or is late or deficient.
RR/IP #3	Section 5.5, Provider Directory	Final versions of the Provider Directory must be submitted to the Division no later than 90 calendar days prior to the Operational Start Date	90 Calendar Days prior to the Operational Start Date	Each day of noncompliance, per directory	The Division may assess up to $5,000 per calendar day of noncompliance for each day the deliverable is not submitted or is late or deficient.
RR/IP #4	Throughout the Contract	Final versions of any other plan, document, or other item required prior to the operationalization of the Contract must be submitted to the Division in the time and manner required by the Division.	As stated by the Division.	Each day of noncompliance, per item	The Division may assess up to $2,500 per calendar day of noncompliance for each day the deliverable is not submitted or is late or deficient.

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Category 3: Performance Standards – PS

Reference #	Service/Component	Performance Standard	Measurement Period	Measurement Assessment	Liquidated Damages
PS #3	Section 4, Covered Services and Benefits	The Contractor must meet the Prior Authorization performance standards for the completion timelines for review determinations.	For the Term of the Contract	Per incident, per business day	The Division will assess liquidated damages in the amount of $250 per business day for each failure to meet the performance standard.
PS #4	Section 4, Covered Services and Benefits	The Contractor must meet the Prior Authorization performance standards for timely notification of prior authorization determinations.	For the Term of the Contract	Per incident, per business day	The Division will assess liquidated damages in the amount of $100 per business day for each failure to meet the notification timeline standard.
PS #5	Section 4, Covered Services and Benefits	Decisions to deny a Service Authorization request or to authorize a service in an amount, duration, or scope that is less than requested must be made by a physician pursuant to Miss. Code Ann. § 41-83-31	For the Term of the Contract	Per incident	The Division will assess liquidated damages in the amount of $10,000 per incident for each failure to meet this standard.
PS #6	Exhibit E, Non-Emergency Transit (NET)	The Contractor shall authorize and schedule routine NET services for ninety-eight percent (98%) of all requests within three (3) business days from the date of the request.	For the Term of the Contract	Per incident, per month	If the Contractor fails to achieve these targets, the Contractor will be assessed liquidated damages up to $10,000 per monthly period.
PS #7	Exhibit E, Non-Emergency Transit (NET)	The Contractor shall authorize and schedule routine NET services for one hundred percent (100%) of all requests within ten (10) business days after receipt of a request.	For the Term of the Contract	Per incident, per month	If the Contractor fails to achieve these targets, the Contractor will be assessed liquidated damages up $10,000 per monthly period.
PS #8	Section 9.2.8, Physician Incentive Plans	The Contractor must comply with the standards set out in this Contract regarding Physician Incentive Plans.	For the Term of the Contract	Per incident	The Division may assess liquidated damages of up to $25,000 for each failure to comply.
PS #9	Section 8.3, External Quality Review Exhibit B: External Quality Review	The Contractor shall address any deficiencies or contract variances identified by the External Quality Review Organization (EQRO) on a schedule to be determined by the Division.	For the Term of the Contract	Per deficiency or variance	The Division may assess liquidated damages in the amount of $5,000. The Division may also pursue other available remedies for deficiencies or contract variances that are not addressed to the satisfaction of the Division.

Category 4: Administrative Matters - AM

Reference #	Service/Component	Performance Standard	Measurement Period	Measurement Assessment	Liquidated Damages
AM #1	Section 1.13.1, Key Personnel	The Contractor must ensure that Key Personnel positions do not remain vacant for greater than ninety (90) calendar days.	For the Term of the Contract	Per incident	The Division may assess up to $5,000 per calendar day for each incident of non-compliance, per position.
AM #2	Section 1.13.1 Key Personnel	The Contractor must submit to the Division for prior approval the proposed replacement for Key Personnel positions at least fifteen (15) business days before the replacement's start date.	For the Term of the Contract	Per incident	The Division may assess up to $5,000 per calendar day for each incident of noncompliance, per position.

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Category 5: Enrollment – EN

Reference #	Service/Component	Performance Standard	Measurement Period	Measurement Assessment	Liquidated Damages
EN #1	Section 3.2.11, Enrollment Verification	Within five (5) business days of the date on which the Contractor receives the Member Listing Report from the Division, the Contractor must provide Network Providers and Out-of-Network Providers the ability to verify Enrollment by telephone, internet, or by another timely mechanism.	Ongoing	Per incident, per day	The Division may assess liquidated damages of up to $1,000 per calendar day for each incident of noncompliance.
EN #2	Section 3.2.12, Enrollment Discrimination	The Contractor may not discriminate in any way against any Member in its enrollment practices.	For the Term of the Contract	Per incident	The Division may impose liquidated damages of up to $100,000 for each failure by the Contractor to meet this standard. The Division may also impose other available remedies in accordance with Section 14, Remedies, of this Contract.

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Category 6: Covered Services and Benefits/Member Services – CSB/MS

Reference #	Service/Component	Performance Standard	Measurement Period	Measurement Assessment	Liquidated Damages
CSB/MS #1	Section 4, Covered Services and Benefits Section 5, Member Services	The Contractor fails to timely perform an Administrative Service necessary for the execution of this Contract that is not otherwise associated with a performance standard under this Contract, and in the determination of the Division, such failure either: (1) results in actual harm to a Member or places a Member at risk of imminent harm, and/or (2) materially affects the Division's ability to administer the program.	For the Term of the Contract	Per day, per each incident of noncompliance.	The Division may assess up to $5,000 per calendar day for each incident of noncompliance.
CSB/MS #2	Section 4, Covered Services and Benefits Section 5, Member Services	The Contractor fails to timely provide a Covered Service that is not otherwise associated with a performance standard in this Contract and, in the determination of the Division, such failure results in actual harm to a Member or places a Member at risk of imminent harm.	For the Term of the Contract	Per each incident of noncompliance	The Division may assess up to $25,000 for each instance of noncompliance. The Division may also suspend any capitation payment due to the Contractor for the month following the Division's discovery of the noncompliance.
CSB/MS #3	Contractor's Qualification, as incorporated in this Contract.	The Contractor fails to timely provide an Enhanced Benefit, Value-Added Benefit, or other such benefit offered by the Contractor that is not otherwise associated with a performance standard in this Contract, and, in the determination of the Division, such failure results in actual harm to a Member or places a Member at risk of imminent harm	For the Term of the Contract	Per each incident of noncompliance	The Division may assess up to $25,000 for each instance of noncompliance.
CSB/MS #4	Section 4, Covered Services and Benefits Section 5, Member Services	If the Contractor imposes premiums or charges on Members that are in excess of those permitted by the Contract.	For the Term of the Contract	Per each incidence of noncompliance	The Division may assess liquidated damages of up to $25,000.00 or double the amount of the excess charges, whichever is greater. The Division will also deduct the amount of the overcharge from assessed liquidated damages and return it to the affected Member.

Reference #	Service/Component	Performance Standard	Measurement Period	Measurement Assessment	Liquidated Damages
CSB/MS #5	Section 7, Care Management Section 11.1.2, Payment in Full	Failure to enroll identified Members into a Care Management program will result in a Capitation Payment reduction.	For the Term of the Contract	Per percentage, per month	The Division may assess up to a 1% reduction in Capitation Payments for the year if the Contractor is found out of compliance by more than 2% during any month of the year.
CSB/MS #6	Section 4, Covered Services and Benefits Section 5, Member Services	The Contractor must not discriminate or perform any actions of discrimination against individuals on the basis of their health status or need for health care services.	For the Term of the Contract	Per incident	The Division may assess up to $100,000 for acts of discrimination.
CSB/MS #7	Section 5.5, Provider Directory	The Contractor must also utilize a web-based Provider Directory, which must be updated with accurate information within five (5) business days upon changes to the Provider Network.	For the Term of the Contract	Per incident	The Division may assess liquidated damages of up to $5,000 for each failure to comply.
CSB/MS #8	Section 5.3, Member Identification Card	The Contractor shall provide each Member an identification card within fourteen (14) calendar days after the Contractor receives notice of the Member's Enrollment. The Contractor must mail all Member identification cards, utilizing at least standard mail, in envelopes marked with the phrase "Return Services Requested."	For the Term of the Contract	Per each incident of noncompliance.	The Division may assess up to $500 per each incident of the Contractor's failure to provide Member Materials in the required timeframe.

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Category 7: Marketing and Member Materials – MMM

Reference #	Service/Component	Performance Standard	Measurement Period	Measurement Assessment	Liquidated Damages
MMM #1	Section 5.9, Marketing	The Contractor must meet all Marketing and Member Materials policy requirements and may not engage in prohibited marketing practices.	For the Term of the Contract	Per quarter, per incident of noncompliance	The Division may assess up to $1,000 per quarter per incident of noncompliance.
MMM #2	Section 5.8, Internet Presence	The Contractor must meet all internet policy requirements and may not engage in any prohibited internet practices.	For the Term of the Contract	Per calendar day, per incident of noncompliance	The Division may assess up to $500 per business day for each incident of noncompliance.
MMM #3	Section 5.8, Internet Presence Section 5.9, Marketing	The Contractor will be subject to liquidated damages if it offers or gives something of value to a Member that the Contractor knows or should know is likely to influence the Member's selection of a particular Provider, practitioner, or supplier of any item or service for which payment may be made, in whole or in part, by Medicaid.	For the Term of the Contract	Per incident of noncompliance	If the Division determines that the Contractor has violated the requirements of the Contractor's obligations with respect to Marketing and Marketing materials, the Contractor shall pay up to $25,000 for each violation, in connection with an audit or investigation.
MMM #4	Section 5.9, Marketing	All Marketing activity must be approved by the Division in writing prior to distribution.	For the Term of the Contract	Per incident of noncompliance	The Division may impose a fine of up to $25,000 for each violation of this provision.
MMM #5	Section 5.9, Marketing	Communication activities must comply with all relevant Federal and State laws, including, when applicable, the Health Insurance Portability and Accountability Act, the anti-kickback statute, and civil monetary penalties prohibiting inducements to Members. The Contractor may not conduct any communication activity that is not approved in writing by the Division.	For the Term of the Contract	Per incident of noncompliance	The Division may impose a fine of up to $25,000 for each violation of this provision.

Category 8: Member Grievances and Appeals – MGA

Reference #	Service/Component	Performance Standard	Measurement Period	Measurement Assessment	Liquidated Damages
MGA #1	Section 5.11, Member Grievances and Appeals and Exhibit D	The Contactor must confirm receipt of all Member Grievances within five (5) calendar days of the receipt of the Grievance. This confirmation must be in writing.	For the Term of the Contract	Per incident	The Division may assess up to $1000 per incident.
MGA #2	Section 5.11, Member Grievances and Appeals and Exhibit D	The Contactor must resolve all Member Grievances within thirty (30) calendar days of the date the Contractor receives a grievance, or as expeditiously as the Member's health condition requires, whichever timeframe is shorter The Contractor may extend time frames up to fourteen (14) calendar days in accordance with 42 C.F.R. § 438.408(c).	For the Term of the Contract	Per incident	The Division may assess up to $5000 per incident.
MGA #3	5.11, Member Grievances and Appeals and Exhibit D	The contractor must confirm receipt of a written notice to the Member of a Member Appeal and expected date of resolution within ten (10) calendar days of receipt of the Appeal. The confirmation must be in writing.	For the Term of the Contract	Per incident	The Division may assess up to $1000 per incident.
MGA #4	5.11, Member Grievances and Appeals and Exhibit D	The Contractor must resolve a Member appeal within thirty (30) calendar days of the date the Contractor receives the Appeal or as expeditiously as the Member's health condition requires, and no longer than 72 hours after the Contractor receives the request for an Expedited Resolution of an Appeal. The Contractor may extend time frames by up to fourteen (14) calendar days in accordance with 42 C.F.R. § 438.408(c).	For the Term of the Contract	Per incident	The Division may assess up to $5000 per incident.
MGA #5	5.11, Member Grievances and Appeals and Exhibit D	For MississippiCAN-related State Fair Hearings, the Contractor must ensure that the appropriate staff members who have firsthand knowledge of the Member's appeal are available in order to be able to speak and provide relevant information on the case to attend all State Fair Hearings as scheduled.	For the Term of the Contract	Per incident of noncompliance	The Division may assess up to $1,000 per incident of noncompliance for each State Fair Hearing that the Contractor fails to attend as required by the Division.

Category 9: Provider Services and Network – PSN

Reference #	Service/Component	Performance Standard	Measurement Period	Measurement Assessment	Liquidated Damages
PSN #1	Section 6.5, Provider Credentialing and Qualifications	Contractor will load Provider information into its claims processing system within thirty (30) calendar days of provider contract approval.	For the Term of the Contract	Per incident	The Division may assess up to $5,000 for each instance of noncompliance.
PSN #2	Section 6.6, Provider Agreements	The Contractor may not enter into a Provider agreement that prohibits the Provider from contracting with another Contractor or that prohibits or penalizes the Provider for contracting with other Contractors.	For the Term of the Contract	Per incident	The Division may assess up to $25,000 for each instance of noncompliance. Repeated instances may result in grounds for Termination.
PSN #3	Section 6.6, Provider Agreements7	The Contractor may not require Providers who agree to participate in MississippiCAN and/or CHIP to contract with the Contractor's other lines of business.	For the Term of the Contract	Per incident	The Division may assess up to $25,000 for each instance of noncompliance.
PSN #4	Section 6.8, Mainstreaming	If the Contractor knowingly executes an agreement with a Provider with the intent of allowing or permitting the Provider to implement barriers to care (e.g., the terms of the Provider agreement are more restrictive than this Contract), the Contractor shall be in breach of this contract	For the Term of the Contract	Per incident	The Division may assess up to $25,000 for each instance of noncompliance. Repeated instances may result in grounds for Termination.
PSN #5	Section 6.1, General Requirements	The Contractor shall not employ or contract with Providers excluded from participation in Federal health care programs under either Section 1128 or Section 1128A of the Social Security Act.	For the Term of the Contract	Per incident	The Division may assess up to $25,000 for each instance of noncompliance. Repeated instances may result in grounds for Termination.
PSN #6	Section 6.2, Provider Network Requirements	The Contractor must meet Provider Network access standards. Determination of failure to meet	For the Term of the Contract	Per month, quarterly	Contractor shall pay fifteen thousand dollars ($15,000) for each month that the Contractor fails to meet the Provider Network access standards.

Reference #	Service/Component	Performance Standard	Measurement Period	Measurement Assessment	Liquidated Damages
		network access standards shall be made following a review of the Contractor's Network Geographic Access Assessment (GeoAccess) Report and/or an audit of that information.			Should the Contractor fail to meet the Provider Network access standards for two (2) consecutive reporting quarters, the Division shall immediately suspend enrollment of Members with the Contractor until the Contractor successfully demonstrates compliance with the Provider Network access standards. Continued failure to meet Provider Network access standards may result in termination of the Contract by the Division.
PSN #7	Section 6.12, Provider Discrimination Prohibited	The Contractor may not discriminate in the participation, reimbursement, or indemnification of any provider who is acting within the scope of his or her license or certification under applicable State law, solely on the basis of that license or certification. In all contracts with network providers, the Contractor must comply with the requirements specified in 42 C.F.R. § 438.214.	For the Term of the Contract	Per incident	The Division may assess liquidated damages of up to $25,000 for each failure to comply.

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Category 10: Provider Grievances and Appeals – PGA

Reference #	Service/Component	Performance Standard	Measurement Period	Measurement Assessment	Liquidated Damages
PGA #1	Section 6.10, Provider Grievance, Appeal, and State Administrative Hearing Process	The Contactor must confirm receipt of all Provider Grievances within five (5) calendar days of the receipt of the Grievance. The confirmation must be in writing.	For the Term of the Contract	Per incident	The Division may assess up to $1000 per incident.
PGA# 2	Section 6.10, Provider Grievance, Appeal, and State Administrative Hearing Process	The Contactor must resolve all Provider Grievances within thirty (30) calendar days of the date the Contractor receives an appeal, or as expeditiously as the Member's health condition requires, whichever timeframe is shorter	For the Term of the Contract	Per incident	The Division may assess up to $5,000 per incident.
PGA # 3	Section 6.10, Provider Grievance, Appeal, and State Administrative Hearing Process	The contractor must confirm receipt of and Provider Appeal and expected date of resolution within ten (10) calendar days of receipt of the Appeal.	For the Term of the Contract	Per incident	The Division may assess up to $1,000 per incident.
PGA #4	Section 6.10, Provider Grievance, Appeal, and State Administrative Hearing Process	The Contractor must resolve an appeal within thirty (30) calendar days of the date the Contractor receives the Appeal or as expeditiously as the Member's health condition requires, and no longer than 72 hours after the Contractor receives the request for an Expedited Resolution of an Appeal. The Contractor may extend time frames by up to fourteen (14) calendar days.	For the Term of the Contract	Per incident	The Division may assess up to $5,000 per incident.
PGA #5	Section 6.10, Provider Grievance, Appeal, and State Administrative Hearing Process	The Contractor must ensure that the appropriate staff members who have firsthand knowledge of the Provider's appeal are available in order to be able to speak and provide relevant information on the case to attend all Administrative Hearings as scheduled.	For the Term of the Contract	Per quarter, per incident of noncompliance	The Division may assess up to $1,000 per quarter and per incident of noncompliance for each Administrative Hearing that the Contractor fails to attend as required by the Division.

Category 11: Call Center – CC

Reference #	Service/Component	Performance Standard	Measurement Period	Measurement Assessment	Liquidated Damages
CC #1	Section 5.1, Member Services Call Center	The Contractor's average abandonment rate must not exceed four (4) percent for the per Member Services Call Center per month.	For the Term of the Contract	Per month, per call center	The Contractor shall pay liquidated damages of up to $10,000 per month for failure to meet this standard.
CC #2	Section 5.1.1, Automatic Call Distribution	The average hold time must be less than 2 minutes for the Member Services Call Center.	For the Term of the Contract	Per month, per call center	The Contractor shall pay liquidated damages of up to $10,000 per month, per call center for failure to meet this standard.
CC #3	Section 5.1.3.1, 24-Hour Lines	The Contractor must have a Behavioral Health/Substance Use Disorder line available 24 hours a Day, seven Days a week, toll-free throughout the State of Mississippi.	For the Term of the Contract	Per month, per call center	The Contractor shall pay liquidated damages of up to $10,000 per month for failure to meet this standard.
CC #4	Section 5.1.3.1, 24-Hour Lines	The Behavioral Health/Substance Use Disorder line staff must include or have access to qualified Behavioral Health Services' professionals to assess behavioral health emergencies.	For the Term of the Contract	Per each incident of noncompliance	The Division may assess up to $10,000 per each incident of noncompliance for each occurrence that the Division identifies through its recurring monitoring processes that hotline staff were not qualified or did not have access to qualified professionals to assess behavioral health emergencies.
CC #5	Section 5.1.3.1, 24-Hour Lines	The Contractor must have a Nurse Advice line available 24 hours a Day, seven Days a week, toll-free throughout the State of Mississippi.	For the Term of the Contract	Per each incident of noncompliance	The Division may assess up to $10,000 per each incident of noncompliance for each occurrence that the Division identifies through its recurring monitoring processes that hotline staff were not qualified or did not have access to qualified professionals to assess health emergencies.
CC #6	Section 5.1.3.1, 24-Hour Lines	The Nurse Advice line staff must include or have access to qualified nursing professionals to assess behavioral health emergencies.	For the Term of the Contract	Per each incident of noncompliance	The Division may assess up to $10,000 per each incident of noncompliance for each occurrence that the Division identifies through its recurring monitoring processes that hotline staff were not qualified or did not have access to qualified professionals to assess health emergencies.

Reference #	Service/Component	Performance Standard	Measurement Period	Measurement Assessment	Liquidated Damages
CC #7	Section 6.9.1, Provider Services Call Center	The Contractor's average abandonment rate must not exceed four (4) percent for the Provider Services Call center per month.	For the Term of the Contract	Per month, per call center	The Contractor shall pay liquidated damages of up to $10,000 per month for failure to meet this standard.
CC #8	Section 6.9.1, Provider Services Call Center	The average hold time must be less than 2 minutes for the Provider Network Call Center.	For the Term of the Contract	Per month, per call center	The Contractor shall pay liquidated damages of up to $10,000 per month, per call center for failure to meet this standard.

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Category 12: Performance Measures – PM

Reference #	Service/Component	Performance Standard	Measurement Period	Measurement Assessment	Liquidated Damages
PM #1	General	The Contractor is expected to meet Performance Measure targets as outlined by this Contract and the Performance Measures Manual.	For the Term of the Contract	Per measure, per reporting period	The Division may assess up to a 1% reduction in Capitation Payments for the reporting period of the measure if the Contractor is found out of compliance.
PM #1	Section 8.20, MississippiCAN EPSDT Screening and Immunization Rates Validation	The Contractor is expected to achieve the EPSDT targets specified in Table 8.1of this Contract.	For the Term of the Contract	Per month, per member	The Division requires a refund of $100 per Member for all EPSDT-eligible Members who did not receive the required screening and/or immunization.
PM #2	Section 8.21, CHIP Well-Care Child Assessments and Immunization Rates Validation	The Contractor is expected to achieve the CHIP targets specified in Table 8.2 of this Contract.	For the Term of the Contract	Per month, per member	The Division requires a refund of $100 per Member for all EPSDT-eligible Members who did not receive the required screening and/or immunization.

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Category 13: Claims – CL

Reference #	Service/Component	Performance Standard	Measurement Period	Measurement Assessment	Liquidated Damages
CL #1	Section 9, Claims and Reimbursement	The Contractor must comply with the claims processing requirements and standards as described in Section 9 of the Contract.	For the Term of the Contract	Per month, per claim type	For the first occurrence of noncompliance: The Division may assess up to $1,750 per month, and per claim type that the Contractor's monthly claims performance percentages fall below the performance standards. For each subsequent occurrence of noncompliance: The Division may assess up to $8,500 per month, and per claim type that the Contractor's monthly claims performance percentages fall below the performance standards.
CL #2	Section 9.1, Claims Management	If the Contractor fails to meet the targets outlined in Section 9.1, Claims Payment, of this Contract, the Division shall deem this to be an instance of unsatisfactory claims performance.	For the Term of the Contract	Per month	The Contractor shall pay liquidated damages of $15,000 for each month that such determination is made. Should the Contractor have two (2) consecutive months of unsatisfactory claims performance, the Division shall immediately suspend Enrollment of Members with the Contractor until such time as the Contractor successfully demonstrates that all past due Clean Claims have been paid or denied.
CL #3	Section 9.1, Claims Management	The Contractor must reimburse the Provider for payment of an inpatient hospital claim for the entire stay and ancillary services until discharged from the hospital as outlined in Section 9.1.3, Inpatient Claims.	For the Term of the Contract	Per incident	Failure to comply will result in liquidated damages of one thousand ($1,000) per day for each day beyond thirty (30) calendar days of receipt of the claim and an additional one (1) time assessment of $5,000 per occurrence.

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Category 14: Privacy and Security – PS

Reference #	Service/Component	Performance Standard	Measurement Period	Measurement Assessment	Liquidated Damages
PS #1	Section 15, Federal, State, and General Requirements, as well as any other requirements stated in this Contract	The Contractor must meet all privacy standards under applicable state or federal law, rule, regulation, and Contract requirements.	For the Term of the Contract	Per incident	The Division may assess up to $5,000 per incident for each privacy violation of applicable federal or state law or the Division's privacy standards in the Contract.
PS #2	Section 15, Federal, State, and General Requirements, as well as any other requirements stated in this Contract	The Contractor must meet all security standards under applicable state or federal law, rule, regulation, and Contract requirements	For the Term of the Contract	Per incident, per quarter	The Division may assess up to $5,000 per quarterly reporting period for each security violation of security requirements under federal or state law or the Division's security standards in the Contract.
PS #3	Section 15, Federal, State, and General Requirements, as well as any other requirements stated in this Contract	The Contractor meet all confidentiality standards under applicable state or federal law, rule, regulation, and Contract requirement.	For the Term of the Contract	Per incident, per quarter	The Division may assess up to $5,000 per quarterly reporting period for each breach by the Contractor.

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Category 15: Encounter Data – ED

Reference #	Service/Component	Performance Standard	Measurement Period	Measurement Assessment	Liquidated Damages
ED #1	Section 16.7, Member Encounter Data	The Contractor shall submit complete Member Encounter Data to the Division that meets Federal and Division requirements and allows the Division to monitor the program. The Division will establish minimum standards for financial and administrative accuracy and for timeliness of processing. These standards will be no less than the standards currently in place for the Medicaid fee-for-service program.	For the Term of the Contract	Per month, per encounter data type	The Division may withhold an amount equal to five percent (5%) of the Contractor's capitation payment for the month following non-submission and retain the amount withheld until the data is received, reviewed, and accepted by the Division. The Division, at its sole discretion, may also assess the following liquidated damages: Ten thousand dollars ($10,000) per calendar day for each day Member Encounter Data is received after the due date, Ten thousand dollars ($10,000) per calendar day for each day after the due date that the monthly encounter data has not been received in the format and per specifications outlined in the Contract, and Ten thousand dollars ($10,000) per calendar day for each day the Contractor fails to correct and resubmit Member Encounter Data that was originally returned to the Contractor for correction because the error rate for the submitted data was in excess of the five percent (5%), until acceptance.

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Category 16: Program Integrity – PI

Reference #	Service/Component	Performance Standard	Measurement Period	Measurement Assessment	Liquidated Damages
PI #1	Section 10, Fraud, Waste, and Abuse	Failure to implement an approved Fraud, Waste, and Abuse Compliance Plan within sixty (60) days of approval may result in liquidated damages or imposition of other available remedies by the Division.	For the Term of the Contract	Per day, per each incident of noncompliance.	The Division may assess up to $1,000 per calendar day for each incident of noncompliance. The Office of Program Integrity may reassess the implementation of the Fraud and Abuse compliance plan every sixty (60) days until Program Integrity deems the plan to be in compliance.
PI #2	Section 15.2, Conflict of Interest	When the Contractor becomes aware of an actual, apparent, or potential conflict of interest but not more than two (2) days, the Contractor must develop and submit a mitigation plan for approval by the Division. Any changes to the approved mitigation plan must be approved in advance by the Division. The Contractor must maintain one hundred percent (100%) compliance with this item at all times throughout the term of the Contract.	For the Term of the Contract	Per incident, per day	The Contractor will be fined five thousand dollars ($5,000) per day for each day past two (2) days for each actual, apparent, or potential conflict of interest it fails to disclose. The Contractor shall be fined one hundred thousand dollars ($100,000) for the first failure to comply with the mitigation plan developed by the Contractor and approved by the Division. Each subsequent violation of the mitigation plan shall be twice the amount of the immediately preceding violation fine. In addition, such violation will be reported to the State Ethics Commission, Attorney General, and appropriate federal law enforcement officers for review. This Contract may be terminated by the Division if it is determined that a conflict of interest exists.

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Category 17: Third Party Litigation – TPL

Reference #	Service/Component	Performance Standard	Measurement Period	Measurement Assessment	Liquidated Damages
TPL #1	Section 12.3, Contractor Responsibilities	Failure to utilize the state daily TPL file will result in monetary penalties being assessed.	For the Term of the Contract	Per incident	The Division may impose liquidated damages of up to $1,000 per violation.
TPL #2	Section 12.3.4, Casualty and Subrogation	The Contractor must submit any form letter templates and form document templates to the Division for advance written approval and use approved letters and templates only.	For the Term of the Contract	Per incident	The Division may impose liquidated damages of up to $5,000 per violation.

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Category 18: Remedies – RE

Reference #	Service/Component	Performance Standard	Measurement Period	Measurement Assessment	Liquidated Damages
RE #1	Section 14.1.3, Corrective Action Plan	The Contractor must submit a Corrective Action Plan to the Division within the timeframe requested by the Division.	For the Term of the Contract	Per incident	The Division may assess liquidated damages for each day beyond that time that the Division has not received an acceptable corrective action plan in the amount of $1,000 per day for ten (10) calendar days and $2,500 per calendar day thereafter.
RE #2	Section 14.1.3, Corrective Action Plan	The Contractor must implement or complete the Corrective Action Plan as approved by the Division.	For the Term of the Contract	Per incident	The Division may assess liquidated damages in the amount of $10,000 per calendar day for each day the corrective action plan is not implemented or completed as required.
RE #3	Section 14.2.5, Termination for Cause	After the effective date of a termination of the Contract by the Division for cause, the Contractor will pay damages to the Division.	At Termination of the Contract	At Termination of the Contract	If the Contractor is terminated, the Contractor will pay the Division liquidated damages in the amount of $10,000 for each month of the Contract term remaining after the effective date of termination, plus 5% of the maximum monthly Capitation Payment. This payment must be made no later than 30 calendar days following the date of the notice of termination.

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MSCAN SFY25 Emergency Contract
EXHIBIT H: REPORTING REQUIREMENTS

Detailed instructions are included in the respective template. This list represents what is due in the Reporting Requirements Submission folder located in the DOM - CCO SharePoint site.

CHIP Report Name	Frequency	Due Date	Tabs Information *(excluding History Log and Instructions)*	Reporting Period	Reference	Naming Convention
CHIP Allowed Amount by Mental Health DRGs	Monthly	5th business day of the second month following the reporting month	TBD	From 12:00 a.m. of the first calendar day of the month through 11:59 p.m. of the last calendar day of the month.	TBD	TBD
CHIP Annual Member Fraud, Waste and Abuse (FWA) Activity Report	Annually	Yearly, on or before January 30th	OPI has a template for this report	From 12:00 a.m. of the first calendar day of the previous year through 11:59 p.m. of the last calendar day of the previous year.	Contract Section 16.2.11	TRU_CHIP_Annual_Member_FWA_2025 MOL_CHIP_Annual_Member_FWA_2025 MHP_CHIP_Annual_Member_FWA_2025
CHIP Annual Reporting Template System (CARTS)	Annual	at least 30 calendar days prior to the CMS due date, January 1	CMS template completed by the Division. The Division may request assistance from the CCO	From 12:00 a.m. of the first calendar day of the Federal Fiscal year (October 1) through 11:59 p.m. of the last calendar day of the Federal Fiscal year (September 30).	Section 2108(a) of the Social Security Act	TBD
CHIP Call Center	Monthly	5th business day of the second month after the reporting period	Call Center-Member Services Call Center-NET Call Center-Pharmacy Call Center- Behavioral Health Call Center-Nurse Line Call Center- Provider	From 12:00 a.m. of the first calendar day of the month through 11:59 p.m. of the last calendar day of the month.	42 CFR 438.66	TRU_CHIP_Call Center_Oct. 2020 MOL_CHIP_Call Center_Oct. 2020 MHP_CHIP_Call Center_Oct. 2020
CHIP Call Center Audit	Quarterly	15th business day after the close of the quarter	Prov. Call Center-Audit Prov. Call Center-Issues Memb. Call Center-Audit Memb. Call Center-Issues	From 12:00 a.m. of the first calendar day of the quarter through 11:59 p.m. of the last calendar day of the quarter.	42 CFR 438.66	TRU_CHIP_Call Center Audit_QTR 1_2020 MOL_CHIP_Call Center Audit_QTR 1_2020 MHP_CHIP_Call Center Audit_QTR 1_2020
CHIP Call Center Training	Quarterly	15th business day after the close of the quarter	Call Cent. Train. Prov. Call Cent. Train. Memb. Serv. Call Center Train. Nurse Line	From 12:00 a.m. of the first calendar day of the quarter through 11:59 p.m. of the last calendar day of the quarter.	42 CFR 438.66	TRU_CHIP_Call Center Training_QTR 1_2020 MOL_CHIP_Call Center Training_QTR 1_2020 MHP_CHIP_Call Center Training_QTR 1_2020
CHIP Care Management	Monthly	5th business day of the month after the reporting period	Screenings-Assessments CM Enrollment CM Disenrollment CM Summary	From 12:00 a.m. of the first calendar day of the month through 11:59 p.m. of the last calendar day of the month.	42 CFR 438.208, 42 CFR 438.66(b)(8)	TRU_CHIP_CM_Oct. 2020 MOL_CHIP_CM_Oct. 2020 MHP_CHIP_CM_Oct. 2020
CHIP Cash Disbursement Journal	Monthly	15th calendar day of the month following the reporting period	*Template will be provided to Contractor from the Office of Finance.	From 12:00 a.m. of the first calendar day of the month through 11:59 p.m. of the last calendar day of the month.	Contract Section 16.7.6	MS_MHP_MED_CDJ_202507_20250815 MS_MOL_MED_CDJ_202507_20250815 MS_TRU_MED_CDJ_202507_20250815
CHIP Claims Denial	Monthly	5th business day of the second month after the reporting period	Total Medical Behavioral Dental Vision	From 12:00 a.m. of the first calendar day of the month through 11:59 p.m. of the last calendar day of the month.	42 CFR § 438.818 Contract Section 16.2.4	TRU_CHIP_Claims Denial_Oct. 2020 MOL_CHIP_Claims Denial_Oct. 2020 MHP_CHIP_Claims Denial_Oct. 2020
CHIP Claims Processing	Monthly	5th business day of the second month following the reporting period	Claims Processing Timeliness	From 12:00 a.m. of the first calendar day of the month through 11:59 p.m. of the last calendar day of the month.	42 CFR 447.45, 447.46; Miss.Code Ann. 83-9-5	TRU_CHIP_Claims Processing_Oct. 2020 MOL_CHIP_Claims Processing_Oct. 2020 MHP_CHIP_Claims Processing_Oct. 2020
CHIP Cost Avoidance and Third Party Liability Recoveries	Monthly	30th calendar day of every month except February. February due date is the 28th	Cost Avoid. Recov. from Ins. Carr. Cost Avoid-Rec. Totals	From 12:00 a.m. of the first calendar day of the month through 11:59 p.m. of the last calendar day of the month.	42 CFR 438.66, 433.139(b) through (f)	TRU_CHIP_Cost Avoid.-TPL Recov._Oct. 2020 MOL_CHIP_Cost Avoid.-TPL Recov._Oct. 2020 MHP_CHIP_Cost Avoid.-TPL Recov._Oct. 2020
CHIP Disenrollment Survey	Annual	Yearly, on or before August 1st	Disenrollment Survey	From 12:00 a.m. of the first calendar day of the year through 11:59 p.m. of the last calendar day of the year.	42 CFR 438.66(c)(5)	TRU_CHIP_Disenrollment Survey_Annual_2020 MOL_CHIP_Disenrollment Survey_Annual_2020 MHP_CHIP_Disenrollment Survey_Annual_2020
CHIP Disenrollment Survey Results	Quarterly	30th business day after the close of the quarter	Disenrollment Survey Results	From 12:00 a.m. of the first calendar day of the quarter through 11:59 p.m. of the last calendar day of the quarter.	42 CFR 438.66(c)(5)	MOL_CHIP_Disenrollment Survey Results_QTR 1_2020 MHP_CHIP_Disenrollment Survey Results_QTR 1_2020
CHIP Drug Utilization Data	Weekly	As required by the Fiscal Agent and the Division	**There is no prescribed template for this report.* Fiscal Agent is responsible party for receiving report.	As required by the Fiscal Agent and the Division	Contract Section 16.8	N/A
CHIP Encounter Data Certification	Bi-weekly	Biweekly, every other Monday	Heading Acknowledgment Response	From 12:00 a.m. of the first calendar day (Sunday) of the week through 11:59 p.m. of the last calendar day (Saturday) in the second week of the biweekly period.	42 C.F.R. §§ 438.606 and 438.604 Contract Section 16.10	CCO Name_CHIP_Name of Report_Month and Year of Reporting Period
CHIP Encounter Data Completeness Plan	Annual	Yearly, on or before January 15th of the calendar year following the reporting period	Heading	From 12:00 a.m. of the first calendar day of the year through 11:59 p.m. of the last calendar day of the year.	42 CFR 438.818	TRU_CHIP_Encount.Data Completeness Plan_ Annual_2020 MOL_CHIP_Encount. Data Completeness Plan_ Annual_2020 MHP_CHIP_Encount. Data Completeness Plan_ Annual_2020
CHIP Enhanced Services	Quarterly	30th calendar day after the close of the quarter	TBD	From 12:00 a.m. of the first calendar day of the quarter through 11:59 p.m. of the last calendar day of the quarter.	Contract Section 4.1.7	TBD
CHIP Fraud and Abuse Compliance Plan Matrix	Annual	Yearly, On or before January 15th	Fraud & Abuse CMP	From 12:00 a.m. of the first calendar day of the year through 11:59 p.m. of the last calendar day of the year.	42 CFR 457, Subpart I; 438.608 Contract Section 16.2.11	TRU_CHIP_FWA CPM_Annual_2019 MOL_CHIP_FWA CPM_Annual_2019 MHP_CHIP_FWA CPM_Annual_2019

CHIP Report Name	Frequency	Due Date	Tabs Information *(excluding History Log and Instructions)*	Reporting Period	Reference	Naming Convention
CHIP Fraud, Waste and Abuse Activity	Quarterly	15th business day after the close of the quarter	Annual Prov. FWA Activity	From 12:00 a.m. of the first calendar day of the quarter through 11:59 p.m. of the last calendar day of the quarter.	42 CFR Part 457, Subpart I; 457.1285 Contract Section 16.2.11	TRU_CHIP_Prov. FWA Activity_QTR1_2019 MOL_CHIP_Prov. FWA Activity_QTR1_2019 MHP_CHIP_Prov. FWA Activity_QTR1_2019
CHIP GeoAccess	Quarterly	30th calendar day after the close of the quarter	Heading	From 12:00 a.m. of the first calendar day of the quarter through 11:59 p.m. of the last calendar day of the quarter.	42 CFR 438.66(b)(11), 438.68, 438.206	TRU_CHIP_GeoAccess_QTR 1_ 2020 MOL_CHIP_GeoAccess_QTR 1_2020 MHP_CHIP_GeoAccess_QTR 1_2020
CHIP Health Education-Prevention Work Plan and Updates	Quarterly	30th calendar day after the close of the quarter	Health Educ. Prev. Updates QTR1 Health Educ. Prev. Updates QTR2 Health Educ. Prev. Updates QTR3 Health Educ. Prev. Updates QTR4	From 12:00 a.m. of the first calendar day of the quarter through 11:59 p.m. of the last calendar day of the quarter.	42 CFR 438.66(b)(4), 438.2	TRU_CHIP_Health Educ. Prev. WP & Updates_QTR 1_2020 MOL_CHIP_Health Educ. Prev. WP & Updates_QTR 1_2020 MHP_CHIP_Health Educ. Prev. WP & Updates_QTR 1_2020
CHIP Health Education-Prevention Work Plan and Updates	Annual	Yearly, on or before January 15th	Health Educ. Prev. WP- Annual	From 12:00 a.m. of the first calendar day of the year through 11:59 p.m. of the last calendar day of the year.	42 CFR 438.66(b)(4), 438.2	TRU_CHIP_Health Educ. Prev. WP & Updates_Annual_2020 MOL_CHIP_Health Educ. Prev. WP & Updates_Annual_2020 MHP_CHIP_Health Educ. Prev. WP & Updates_Annual_2020
CHIP Healthcare Experience	Annual	Yearly, on or before September 30th	Heading	From 12:00 a.m. of the first calendar day of the year through 11:59 p.m. of the last calendar day of the year.	42 CFR 438.66(b)(12), (c)(6), 438.330, 457.1240	TRU_CHIP_Healthcare Experience_Annual_2020 MOL_CHIP_Healthcare Experience_Annual_2020 MHP_CHIP_Healthcare Experience_Annual_2020
CHIP Hospice Management	Monthly	15th calendar day of the month after the reporting period	Hospice Mgmt	From 12:00 a.m. of the first calendar day of the month through the 11:59 p.m. of the last calendar day of the month.	42 CFR 438.66(b)(8) Contract Section 16.2.6	TRU_CHIP_Hospice Mgmt_Oct. 2020 MOL_CHIP_Hospice Mgmt_Oct. 2020 MHP_CHIP_Hospice Mgmt_Oct. 2020
CHIP Hospice Prior Authorizations	Monthly	15th calendar day of the month after the reporting period	Hospice PA Summary Hospice PA Denials	From 12:00 a.m. of the first calendar day of the month through the 11:59 p.m. of the last calendar day of the month	42 CFR 438.66(b)(8) Contract Section 16.2.6	TRU_CHIP_Hospice PA_Oct. 2020 MOL_CHIP_Hospice PA_Oct. 2020 MHP_CHIP_Hospice PA_Oct. 2020
CHIP Hospice Provider Detail	Monthly	15th calendar day of the month after the reporting period	Hospice Provider Detail	From 12:00 a.m. of the first calendar day of the month through the 11:59 p.m. of the last calendar day of the month	42 C.F.R. § 438.66(b)(8)	TRU_CHIP_Hospice Provider Detail_Oct. 2020 MOL_CHIP_Hospice Provider Detail_Oct. 2020 MHP_CHIP_Hospice Provider Detail_Oct. 2020
CHIP Marketing Activities Log	Quarterly	15th business day after the close of the quarter	Marketing Activities Log	From 12:00 a.m. of the first calendar day of the quarter through the 11:59 p.m. of the last calendar day of the quarter	42 CFR 438.66(b)(7), 438.104 Contract Section 5.9.1	TRU_CHIP_Marketing Activities Log_QTR 1_2020 MOL_CHIP_Marketing Activities Log_QTR 1_2020 MHP_CHIP_Marketing Activities Log_QTR 1_2020
CHIP Marketing Work Plan	Annual	Yearly, on or before January 15th	Heading	From 12:00 a.m. of the first calendar day of the year through 11:59 p.m. of the last calendar day of the year.	42 CFR 438.66(b)(7), 438.104 Contract Section 5.9.1	TRU_CHIP_Marketing Work Plan-Annual_2020 MOL_CHIP_Marketing Work Plan-Annual_2020 MHP_CHIP_Marketing Work Plan-Annual_2020
CHIP Medical Loss Ratio (MLR)	Quarterly	Sixtieth (60th) calendar day following the end of the MLR Reporting Quarter	Attestation MLR Rebate Calc. MLR Pricing Percentage Calc. PBA Informational Rep. Revenues Expenses Supplemental Adjustments HCQI & HIT Admin Expenses Calc. Non-Claims Cost Calc. Program Integrity Cost Methodology Explanations Annual Fin. Recon. Statement	From 12:00 a.m. of the first calendar day of the reporting year through 11:59 p.m. of the last calendar day of the Reporting Year.	42 CFR §§ 438.8 and 438.6(b)(2) AND 457.1203; and Contract Exhibit C	TRU_CHIP_MLR_QTR 1_2020 MOL_CHIP_MLR_QTR 1_2020 MHP_CHIP_MLR_QTR 1_2020
CHIP Medical Loss Ratio (MLR)	Annual	April 1st following the MLR Reporting Year	MLR Rebate Calc. MLR Pricing Percentage Calc. PBA Informational Rep. Revenues Expenses	From 12:00 a.m. of the first calendar day of the reporting year through 11:59 p.m. of the last calendar day of the Reporting Year.	42 CFR §§ 438.8 and 438.6(b)(2) AND 457.1203; and Contract Exhibit C	TRU_CHIP_MLR_QTR 1_2020 MOL_CHIP_MLR_QTR 1_2020 MHP_CHIP_MLR_QTR 1_2020
CHIP Medical Utilization Statistics and Trends	Quarterly	5th business day of the second month following the close of the quarter	Med.Util.Stats.Trends	Input reporting year from 12:00 a.m. of the first calendar day of the quarter through 11:59 p.m. of the last calendar day of the quarter.	42 CFR 438.66 (a) and (b)(3), (b)(8)	TRU_CHIP_Med.Stats.Trends_QTR 1_2020 MOL_CHIP_Med.Stats.Trends_QTR 1_2020 MHP_CHIP_Med.Stats.Trends_QTR 1_2020
CHIP Member Grievance and Appeal Logs	Monthly	15th calendar day of the month after the reporting period	Heading	From 12:00 a.m. of the first calendar day of the month through 11:59 p.m. of the last calendar day of the month.	42 CFR 438.416, 438.66(c)(2)	TRU_CHIP_Memb. Grievance & Appeal Logs_Oct. 2020 MOL_CHIP_Memb. Grievance & Appeal Logs_Oct. 2020 MHP_CHIP_Memb. Grievance & Appeal Logs_Oct. 2020
CHIP Member State Issues MIG Summary and Details	Monthly	5th business day of the second month following reporting period	TBD	From 12:00 a.m. of the first calendar day of the month through 11:59 p.m. of the last calendar day of the month.	TBD	TBD
MH/SUD Parity Analysis and Report	Annual or Significant change	at least 30 calendar days prior to the CMS due date (TBD)	CMS template completed by the Division. The Division may request assistance from the CCO	TBD	The Mental Health Parity and Addiction Equity Act (MHPAEA)	TBD
CHIP MS Financial Data Request (AKA Financial Templates)		Annual Provided by the Office of Finance	Provided by the Office of Finance (created by the acturial firm)	From 12:00 a.m. of the first calendar day of the reporting year through 11:59 p.m. of the last calendar day of the Reporting Year.	Contract Section 11.1.1.3	Provided by the Office of Finance (created by the acturial firm)
CHIP MS Financial Data Request - CY 20XX Emerging Experience	Annual	Annual Provided by the Office of Finance	Provided by the Office of Finance (created by the acturial firm)	From 12:00 a.m. of the first calendar day of the reporting year through 11:59 p.m. of the last calendar day of the Reporting Year.	Contract Section 11.1.1.3	Provided by the Office of Finance (created by the acturial firm)
CHIP MYPAC/Wraparound Prior Authorizations	Monthly	TBD	TBD	From 12:00 a.m. of the first calendar day of the month through 11:59 p.m. of the last calendar day of the month.	TBD	TBD

CHIP Report Name	Frequency	Due Date	Tabs Information *(excluding History Log and Instructions)*	Reporting Period	Reference	Naming Convention
CHIP New Member Card	Monthly	5th business day of the month following the reporting period	New Memb. Card Mailed New Memb. Card Returned	From 12:00 a.m. of the first calendar day of the month through 11:59 p.m. of the last calendar day of the month. *Data entered for each month must remain on this report during the subsequent report submittals.	42 CFR 438.66(b)(4)	TRU_CHIP_New Member Card_Oct. 2020 MOL_CHIP_New Member Card_Oct. 2020 MHP_CHIP_New Member Card_Oct. 2020
CHIP Overpayments	TBD	TBD	TBD	TBD	TBD	TBD
CHIP Performance Improvement Project Results	Annual	Yearly, on or before August 1st	Heading	From 12:00 a.m. of the first calendar day of the year through 11:59 p.m. of the last calendar day of the year.	42 CFR 457.1240, 438.330(e)	TRU_CHIP_PIP Results_Annual_2020 MOL_CHIP_PIP Results_Annual_2020 MHP_CHIP_PIP Results_Annual_2020
CHIP Performance Improvement Project Updates	Quarterly	30th calendar day after the close of the quarter	Heading	From 12:00 a.m. of the first calendar day of the quarter through 11:59 p.m. of the last calendar day of the quarter.	42 CFR 457.1240, 438.330(e)	TRU_CHIP_PIP Updates_QTR 1_2020 MOL_CHIP_PIP Updates_QTR 1_2020 MHP_CHIP_PIP Updates_QTR 1_2020
CHIP Performance Measures	Annual	Yearly, on or before July 31st	Heading	From 12:00 a.m. of the first calendar day of the year through 11:59 p.m. of the last calendar day of the year.	42 CFR 438.66(b)(12), (c)(6), 438.330, 457.1240	TRU_CHIP_Perform. Meas._Annual_2020 MOL_CHIP_Perform. Meas._Annual_2020 MHP_CHIP_Perform. Meas._Annual_2020
CHIP Performance Measures Results	Annual	Yearly, on or before August 1st	Performance Measure Results	From 12:00 a.m. of the first calendar day of the year through 11:59 p.m. of the last calendar day of the year.	42 CFR 438.66(b)(12), (c)(6), 438.330	TRU_CHIP_Perform. Meas. Results_Annual_2020 MOL_CHIP_Perform. Meas. Results_Annual_2020 MHP_CHIP_Perform. Meas. Results_Annual_2020
CHIP Pharmacy Lock-In	Monthly	5th business day of the month after the reporting period	Pharmacy Lock-In	From 12:00 a.m. of the first calendar day of the month through 11:59 p.m. of the last calendar day of the month.	42 CFR § 431.54, 438.66(b)(9) Contract Section 16.2.11	TRU_CHIP_Pharmacy Lock-In_Oct. 2020 MOL_CHIP_Pharmacy Lock-In_Oct. 2020 MHP_CHIP_Pharmacy Lock-In_Oct. 2020
CHIP Prior Authorization	Monthly	5th business day of the month after the reporting period	Overall PA Advanced Imaging PA Private Duty Nursing PA Orthodontia PA ST, PT, OT PA	From 12:00 a.m. of the first calendar day of the month through 11:59 p.m. of the last calendar day of the month.	42 CFR 438.210, 438.66(b)(8); Miss. Code Ann. 41-83-15	TRU_CHIP_PA_Oct. 2020 MOL_CHIP_PA_Oct. 2020 MHP_CHIP_PA_Oct. 2020
CHIP Provider Appointment Availability	Quarterly	30th calendar day after the close of the quarter	Appt. Avail.- PCP- OBGYN Appt. Avail.- BH	From 12:00 a.m. of the first calendar day of the quarter through 11:59 p.m. of the last calendar day of the quarter.	42 CFR 438.66	TRU_CHIP_Prov. Appt. Avail._QTR 1_2020 MOL_CHIP_Prov. Appt. Avail._QTR 1_2020 MHP_CHIP_Prov. Appt. Avail._QTR 1_2020
CHIP Provider Appointment Availability	Annual	Yearly, on or before April 1st	Appt. Avail.- PCP- OBGYN Appt. Avail.- BH	From 12:00 a.m. of the first calendar day of the year through 11:59 p.m. of the last calendar day of the year.	43 CFR 438.66	TRU_CHIP_Prov. Appt. Avail._Annual_2020 MOL_CHIP_Prov. Appt. Avail._Annual_2020 MHP_CHIP_Prov. Appt. Avail._QTR 1_2020
CHIP Provider Complaints and Appeals Logs	Monthly	15th calendar day of the month after the reporting period	Heading	From 12:00 a.m. of the first calendar day of the month through 11:59 p.m. of the last calendar day of the month.	42 CFR 438.66(c)(3)	TRU_CHIP_Prov. Complaint-Appeal Logs_Oct. 2020 MOL_CHIP_Prov. Complaint-Appeal Logs_Oct. 2020 MHP_CHIP_Prov. Complaint-Appeal Logs_Oct. 2020
CHIP Provider Directory Delivery	Ad Hoc	Ad Hoc	Prov. Direct. Del.	To be specified by DOM	42 CFR 438.66(b)(4), (b)(10)	TRU_CHIP_Prov. Direct. Delivery_Ad Hoc_Oct. 2020 MOL_CHIP_Prov. Direct. Delivery_Ad Hoc_Oct. 2020 MHP_CHIP_Prov. Direct. Delivery_Ad Hoc_Oct. 2020
CHIP Provider Incentive Plan	Semi-Annual	April 30th for Oct.-Mar. Reporting Period	Provider Incentive Plan	From 12:00 a.m. of the first calendar day of the semi-annual period through 11:59 p.m. of the last calendar day of the semi-annual period.	42 CFR 422.208 and 422.210	TRU_CHIP_Prov. Incentive Plan_ Semi-Annual_Oct. 2020 MOL_CHIP_Prov. Incentive Plan_ Semi-Annual_Oct. 2020 MHP_CHIP_Prov. Incentive Plan_ Semi-Annual_Oct. 2020
CHIP Provider Issues	Annual	30th business day of the month following reporting period	TBD	From 12:00 a.m. of the first calendar day of the year through 11:59 p.m. of the last calendar day of the year.	TBD	TBD
CHIP Provider Satisfaction Survey Questions and Methodology	Annual	Yearly, on or before March 1st	Heading	From 12:00 a.m. of the first calendar day of the year through 11:59 p.m. of the last calendar day of the year.	42 CFR 438.66(c)(5)	TRU_CHIP_Prov. Sat. Survey Quest. Method._Annual_2020 MOL_CHIP_Prov. Sat. Survey Quest. Method._Annual_2020 MHP_CHIP_Prov. Sat. Survey Quest. Method._Annual_2020
CHIP Provider Satisfaction Survey Results	Annual	At least 90 calendar days following the completion of the survey and no later than December 1st for the current	Heading	From 12:00 a.m. of the first calendar day of the year through 11:59 p.m. of the last calendar day of the year.	42 CFR 438.66(c)(5)	TRU_CHIP_Prov. Sat. Survey Results_Annual_2020 MOL_CHIP_Prov. Sat. Survey Results_Annual_2020 MHP_CHIP_Prov. Sat. Survey Results_Annual_2020
CHIP Provider Services Representative Visit Log	Quarterly	5th business day after the close of the quarter	Provider Services Rep. Visit	From 12:00 a.m. of the first calendar day of the quarter through 11:59 p.m. of the last calendar day of the quarter.	42 CFR 438.66(b)(10)	TRU_CHIP_Prov. Services Rep. Visit Log_QTR 1_2020 MOL_CHIP_Prov. Services Rep. Visit Log_QTR 1_2020 MHP_CHIP_Prov. Services Rep. Visit Log_QTR 1_2020
CHIP Provider State Issues MIG Summary and Details	Monthly	5th business day of the second month following reporting period	TBD	From 12:00 a.m. of the first calendar day of the month through 11:59 p.m. of the last calendar day of the month.	TBD	TBD
CHIP Provider Statistical Summary Report	Ad Hoc	Ad Hoc	Provided by the Office of Reimbursement	As defined in the contract and provided by the Office of Reimbursement	Contract Section 16.2.5	TBD

CHIP Report Name	Frequency	Due Date	Tabs Information *(excluding History Log and Instructions)*	Reporting Period	Reference	Naming Convention
CHIP Quality Management Program Description	Annual	Yearly, on or before August 1st	Heading	From 12:00 a.m. of the first calendar day of the year through 11:59 p.m. of the last calendar day of the year.	42 CFR 438.66, 438.330, 457.1240	TRU_CHIP_QM Prog. Description_Annual_2019 MOL_CHIP_QM Prog. Description_Annual 2019 MHP_CHIP_QM Prog. Description_Annual_2019
CHIP Quality Management Program Evaluation	Annual	Yearly, on or before August 1st	Heading	From 12:00 a.m. of the first calendar day of the year through 11:59 p.m. of the last calendar day of the year.	42 CFR 438.66, 438.330, 457.1240	TRU_CHIP_QM Prog. Eval._Annual_2020 MOL_CHIP_QM Prog. Eval._Annual_2020 MHP_CHIP_QM Prog. Eval._Annual_2020
CHIP Quality Management Work Plan	Annual	Yearly, on or before August 1st	Annual Work Plan	From 12:00 a.m. of the first calendar day of the year through 11:59 p.m. of the last calendar day of the year.	42 CFR 438.66(b)(12), 438.330, 457.1240	TRU_CHIP_QM Work Plan_Annual_2019 MOL_CHIP_QM Work Plan_Annual_2019 MHP_CHIP_QM Work Plan_Annual_2019
CHIP Quality Management Work Plan and Updates	Quarterly	30th calendar day after the close of the quarter	Quarterly Updates	From 12:00 a.m. of the first calendar day of the quarter through 11:59 p.m. of the last calendar day of the quarter.	42 CFR 438.66(b)(12), 438.330, 457.1240	TRU_CHIP_QM Work Plan Updates_QTR 1_2020 MOL_CHIP_QM Work Plan Updates_QTR 1_2020 MHP_CHIP_QM Work Plan Updates_QTR 1_2020
CHIP Third Party Casualty	Monthly	30th calendar day of every month except February. February due date is the 28th	Third Party Casualty	From 12:00 a.m. of the first calendar day of the month through 11:59 p.m. of the last calendar day of the month.	42 CFR § 438.138(e) Contract Section 16.2.7	TRU_CHIP_Third Party Casualty_Oct. 2020 MOL_CHIP_Third Party Casualty_Oct. 2020 MHP_CHIP_Third Party Casualty_Oct. 2020
CHIP Utilization Management Program Description	Annual	Yearly, on or before August 1st	Heading	From 12:00 a.m. of the first calendar day of the year through 11:59 p.m. of the last calendar day of the year.	42 CFR 438.66	TRU_CHIP_UM Prog. Desc._Annual_2020 MOL_CHIP_UM Prog. Desc._Annual_2020 MHP_CHIP_UM Prog. Desc._Annual_2020
CHIP Web Portal Usage	Monthly	5th business day of the second month following reporting period	TBD	From 12:00 a.m. of the first calendar day of the month through 11:59 p.m. of the last calendar day of the month.	Contract Section 5.8.2	TBD
CHIP Website	As updated	sixty (60) calendar days prior to making the content available and as updated	TBD	TBD	Contract Section 5.8.2	TBD
CHIPAnnual Provider Fraud,Waste and Abuse (FWA) Activity	Annually	Yearly, on or before January 30th	OPI has a template for this report	From 12:00 am of the first calendar day of the previous year through 11:59 p.m. of the last calendar day of the previous year	Contract Section 16.2.11	TRU_CHIP_Annual_Provider FWA_2025 MOL_CHIP_Annual_Provider FWA_2025 MHP_CHIP_Annual_Provider FWA_2025
Insure Kids Now (IKN) - quarterly	Quarterly	30 calendar days prior to the following due dates set forth by the program: February 4 May 4 August 4 November 4	TBD	TBD	https://ikndata.insurekidsnow.gov/WebExternal/Login.aspx	TBD
Insure Kids Now (IKN) - Summary of Benefits	Annual	30 calendar days prior to the following due dates set forth by the program: May 4	TBD	TBD	https://ikndata.insurekidsnow.gov/WebExternal/Login.aspx	TBD
MSCAN and CHIP Cash Disbursement Journal	Monthly	15th calendar day of the month following the reporting period	*Template will be provided to Contractor from the Office of Finance.	From 12:00 a.m. of the first calendar day of the month through 11:59 p.m. of the last calendar day of the month.	N/A	TBD
MSCAN and CHIP Department of Insurance	Annual and 3 quarterly submissions	30th calendar day after the required due date per the NAIC	N/A *There is no prescribed DOM template for this report. Template is provided by Mississippi Departement of Insurance	See instructions provided for the template provided by Mississippi Department of Insurance	Miss. Code Ann. § 83-41-305 Contract Section 16.2.11	TBD
MSCAN Third Party Liability Provider Recoveries	Monthly	30th calendar day of every month except Feb. Feb. due date is the 28th.	TPL Prov. Recov.	From 12:00 a.m. of the first calendar day of the month through 11:59 p.m. of the last calendar day of the month.	42 CFR 433.139(b) through (f) Contract Section 16.2.7	TRU_CHIP_TPL Prov. Recov._Oct. 2020 MOL_CHIP_TPL Prov. Recov._Oct. 2020 MHP_CHIP_TPL Prov. Recov._Oct. 2020

MSCAN Report Name	Frequency	Due Date	Tabs Information *(excluding History Log and Instructions)*	Reporting Period	Reference	Naming Convention
Managed Care Program Annual Report (MCPAR)	Annual	at least 30 calendar days prior to the CMS due date, December 27	CMS template completed by the Division. The Division may request assistance from the CCO	From 12:00 a.m. of the first calendar day of the State Fiscal year (July 1) through 11:59 p.m. of the last calendar day of the State Fiscal year (June 30).	42 CFR § 438.66(e)	TBD
MSCAN Allowed Amount by Mental Health DRGs	Monthly	5th business day of the second month following reporting period	Pediatric-Allowed Amt by MH DRG Adult-Allowed Amt by MH DRGs	From 12:00 a.m. of the first calendar day of the month through 11:59 p.m. of the last calendar day of the month.	42 CFR § 438.66 (a) and (b)(3)&(8) & 42 CFR § 438.242(a)	TRU_MSCAN_Allow. Amt. by Prov. by MH DRGs_Oct. 2020 MOL_MSCAN_Allow. Amt. by Prov. by MH DRGs_Oct. 2020 MHP_MSCAN_Allow. Amt. by Prov. by MH DRGs_Oct. 2020
MSCAN Allowed Amount by Patient Discharge Status	Monthly	5th business day of the second month following reporting period	Allowed Amt by Patient Discharg	From 12:00 a.m. of the first calendar day of the month through 11:59 p.m. of the last calendar day of the month.	42 CFR § 438.66 (a) and (b)(3)&(8)	TRU_MSCAN_Allow. Amt. by Pt. Discharge Status_Oct. 2020 MOL_MSCAN_Allow. Amt. by Pt. Discharge Status_Oct. 2020 MHP_MSCAN_Allow. Amt. by Pt. Discharge Status_Oct. 2020
MSCAN Cash Disbursement Journal	Monthly	15th calendar day of the month following the reporting period	*Template will be provided to Contractor from the Office of Finance.	From 12:00 a.m. of the first calendar day of the month through 11:59 p.m. of the last calendar day of the month.	Contract Section 16.7.6	MS_MHP_MED_CDJ_202507_20250815 MS_MOL_MED_CDJ_202507_20250815 MS_TRU_MED_CDJ_202507_20250815
MSCAN and CHIP Department of Insurance	Annual and 3 quarterly submissions	30th calendar day after the required due date per the NAIC	N/A *There is no prescribed DOM template for this report. Template is provided by Mississippi Departement of Insurance	See instructions provided for the template provided by Mississippi Department of Insurance	Miss. Code Ann. § 83-41-305 Contract Section 16.2.10	TBD
MSCAN Annual Member Fraud, Waste and Abuse (FWA) Activity Report	Annually	Yearly, on or before January 30th	OPI has a template for this report	From 12:00 a.m. of the first calendar day of the previous year through 11:59 p.m. of the last calendar day of the previous year.	Contract Section 16.2.11	TRU_CAN_Annual_Member FWA_2025 MOL_CAN_Annual_Member FWA_2025 MHP_CAN_Annual_Member FWA_2025
MSCAN Annual Provider Fraud,Waste and Abuse (FWA) Activity	Annually	Yearly, on or before January 30th	OPI has a template for this report	From 12:00 am of the first calendar day of the previous year through 11:59 p.m. of the last calendar day of the previous year	Contract Section 16.2.11	TRU_CAN_Annual_Provider_FWA_2025 MOL_CAN_Annual_Provider_FWA_2025 MHP_CAN_Annual_Provider_FWA_2025
MSCAN Call Center	Monthly	5th business day of the second month following the reporting period	Call Center-Member Services Call Center-NET Call Center-Pharmacy Call Center-Behavioral Health Call Center-Nurse Line	From 12:00 a.m. of the first calendar day of the month through 11:59 p.m. of the last calendar day of the month.	42 CFR 438.66	TRU_MSCAN_Call Center_Oct. 2020 MOL_MSCAN_Call Center_Oct. 2020 MHP_MSCAN_Call Center_Oct. 2020
MSCAN Call Center Audit	Quarterly	15th business day after the close of the quarter	Prov. Call Center-Audit Prov. Call Center-Issues Memb. Call Center-Audit Memb. Call Center-Issues	From 12:00 a.m. of the first calendar day of the quarter through 11:59 p.m. of the last calendar day of the quarter.	42 CFR 438.66	TRU_MSCAN_Call Center Audit_QTR 1_2020 MOL_MSCAN_Call Center Audit_QTR 1_2020 MHP_MSCAN_Call Center Audit_QTR 1_2020
MSCAN Call Center Training	Quarterly	15th business day after the close of the quarter	Tab A-Call Cent. Train. Prov. B-Call Cent. Train. Memb. Serv. C-Call Cent. Train. Nurse Line	From 12:00 a.m. of the first calendar day of the quarter through 11:59 p.m. of the last calendar day of the quarter.	42 CFR 438.66	TRU_MSCAN_Call Center Training_QTR 1_2020 MOL_MSCAN_Call Center Training_QTR 1_2020 MHP_MSCAN_Call Center Training_QTR 1_2020
MSCAN Care Management	Monthly	5th business day of the month following reporting period	Tab A-Screenings-Assessments Tab B-CM Enrollment Tab C-CM Disenrollment Tab D-CM Summary	From 12:00 a.m. of the first calendar day of the month through 11:59 p.m. of the last calendar day of the month.	42 CFR 438.208, 42 CFR 438.66(b)(8)	TRU_MSCAN_CM_Oct. 2020 MOL_MSCAN_CM_Oct. 2020 MHP_MSCAN_CM_Oct. 2020
MSCAN Claims Denial	Monthly	5th business day of the second month following the reporting period	TAB H-1 (Total) - formulas totaling the other tabs TAB H-1 (Medical) TAB H-1 (Behavioral) TAB H-1 (Dental) TAB H-1 (Vision) TAB H-1 (Other)	From 12:00 a.m. of the first calendar day of the month through 11:59 p.m. of the last calendar day of the month.	42 CFR § 438.818 Contract Section 16.2.4	TRU_MSCAN_Claims Denial_Oct. 2020 MOL_MSCAN_Claims Denial_Oct. 2020 MHP_MSCAN_Claims Denial_Oct. 2020
MSCAN Claims Processing	Monthly	5th business day of the second month following the reporting period	Tab A-Claims Processing (by Category) Tab B-Timeliness (Percentage of Clean Claims Paid within 30 & 90 Days of Receipt)	From 12:00 a.m. of the first calendar day of the month through 11:59 p.m. of the last calendar day of the month.	42 CFR 447.45, 447.46; Miss. Code Ann. 83-9-5	TRU_MSCAN_Claims Processing_Oct. 2020 MOL_MSCAN_Claims Processing_Oct. 2020 MHP_MSCAN_Claims Processing_Oct. 2020
MSCAN Cost Avoidance and Third Party Liability Recoveries	Monthly	30th calendar day of every month except Feb. Feb. due date is the 28th.	Tab C-Cost Avoid-Rec.Totals	From 12:00 a.m. of the first calendar day of the month through 11:59 p.m. of the last calendar day of the month.	42 CFR 438.66; 433.139(b) through (f)	TRU_MSCAN_Cost Avoid.-TPL Recov._Oct. 2020 MOL_MSCAN_Cost Avoid.-TPL Recov._Oct. 2020 MHP_MSCAN_Cost Avoid.-TPL Recov._Oct. 2020
MSCAN Disenrollment Survey	Annual	Yearly, on or before Aug. 1st	Disenrollment Survey *The CCO will submit its proposed disenrollment survey questions and methodology to DOM for review and approval prior to use.*	From 12:00 a.m. of the first calendar day of the year through 11:59 p.m. of the last calendar day of the year.	42 CFR 438.66(c)(5)	TRU_MSCAN_Disenrollment Survey_Annual_2020 MOL_MSCAN_Disenrollment Survey_Annual_2020 MHP_MSCAN_Disenrollment Survey_Annual_2020
MSCAN Disenrollment Survey Results	Quarterly	30th business day after the close of the quarter	Disenrollment Survey Results *The CCO will attach detailed disenrollment survey results along with the Microsoft Excel template.*	From 12:00 a.m. of the first calendar day of the quarter through 11:59 p.m. of the last calendar day of the quarter.	42 CFR 438.66(c)(5)	TRU_MSCAN_Disenrollment Survey Results_QTR 1_2020 MOL_MSCAN_Disenrollment Survey Results_QTR 1_2020 MHP_MSCAN_Disenrollment Survey Results_QTR 1_2020

MSCAN Report Name	Frequency	Due Date	Tabs Information *(excluding History Log and Instructions)*	Reporting Period	Reference	Naming Convention
MSCAN Drug Utilization Data	Weekly	As required by the Fiscal Agent and the Division	*There is no prescribed template for this report.* Fiscal Agent is responsible party for receiving report.	As required by the Fiscal Agent and the Division	Contract Section 16.8	N/A
MSCAN Encounter Data Certification Attestation	Bi-weekly	Biweekly, every other Monday	Heading Acknowledgment Response	From 12:00 a.m. of the first calendar day (Sunday) of the week through 11:59 p.m. of the last calendar day (Saturday) in the second week of the biweekly period.	42 C.F.R. §§ 438.606 and 438.604 Contract Section 16.10	TBD
MSCAN Encounter Data Completeness Plan	Annual	Yearly, on or before January 15th	Heading *There is no prescribed template for this report.*	From 12:00 a.m. of the first calendar day of the year through 11:59 p.m. of the last calendar day of the year.	42 CFR 438.818	TRU_MSCAN_Encount. Data Completeness Plan_ Annual_2020 MOL_MSCAN_Encount. Data Completeness Plan_ Annual_2020 MHP_MSCAN_Encount. Data Completeness Plan_ Annual_2020
MSCAN Enhanced Services	Quarterly	30th calendar day after the close of the quarter	TBD	From 12:00 a.m. of the first calendar day of the quarter through 11:59 p.m. of the last calendar day of the quarter.	Contract Section 4.1.7	TBD
MSCAN Annual EPSDT Participation Report (CMS Form 416)	Annual	at least 30 calendar days prior to the CMS due date, February 15	CMS template completed by the Division. The Division may request assistance from the CCO Form CMS-416: https://www.medicaid.gov/medicaid/benefits/downloads/cms-416-instructions.pdf	From 12:00 a.m. of the first calendar day of the Federal Fiscal year (October 1) through 11:59 p.m. of the last calendar day of the Federal Fiscal year (September 30).	Section 1905(r) Social Security Act §1905	TBD
MSCAN Fee Schedule Validation	Monthly	30 calendar days from receipt of the monthly Comprehensive DOM Fee Schedule	Heading *There is no prescribed template for this report.*	From 12:00 a.m. of the first calendar day of the month through 11:59 p.m. of the last calendar day of the month.	42 CFR 438.66	TRU_MSCAN_Fee Sched. Val._Oct._2020 MOL_MSCAN_Fee Sched. Val._Oct._2020 MHP_MSCAN_Fee Sched. Val._Oct._2020
MSCAN Fraud and Abuse Compliance Plan Matrix	Annual	Yearly, on or before January 30th	Fraud & Abuse CPM	From 12:00 a.m. of the first calendar day of the year through 11:59 p.m. of the last calendar day of the year.	42 CFR Part 455; 438.608 Contract Section 16.2.11	TRU_MSCAN_FWA CPM_Annual_2019 MOL_MSCAN_FWA CPM_Annual_2019 MHP_MSCAN_FWA CPM_Annual_2019
MSCAN Fraud, Waste, and Abuse (FWA) Activity	Quarterly	15th business day after the close of the quarter	Provider FWA Activity	From 12:00 a.m. of the first calendar day of the quarter through 11:59 p.m. of the last calendar day of the quarter.	42 CFR Part 455; 438.608 Contract Section 16.2.11	TRU_MSCAN_Prov. FWA Activity_QTR1_2019 MOL_MSCAN_Prov. FWA Activity_QTR1_2019 MHP_MSCAN_Prov. FWA Activity_QTR1_2019
MSCAN GeoAccess	Quarterly	30th calendar day after the close of the quarter	Heading	From 12:00 a.m. of the first calendar day of the quarter through 11:59 p.m. of the last calendar day of the quarter.	42 CFR 438.66(b)(11), 438.68, 438.206	TRU_MSCAN_GeoAccess_QTR 1_ 2020 MOL_MSCAN_GeoAccess_QTR 1_2020 MHP_MSCAN_GeoAccess_QTR 1_2020
MSCAN Health Education-Prevention Work Plan	Annual	Yearly, on or before January 15th	Health Educ. Prev. WP- Annual	From 12:00 a.m. of the first calendar day of the year through 11:59 p.m. of the last calendar day of the year.	43 CFR 438.66(b)(4), 438.2	TRU_MSCAN_Health Educ. Prev. WP & Updates_Annual_2020 MOL_MSCAN_Health Educ. Prev. WP & Updates_Annual_2020 MHP_MSCAN_Health Educ. Prev. WP & Updates_Annual_2020
MSCAN Health Education-Prevention Work Plan and Updates	Quarterly	30th calendar day after the close of the quarter	Health Educ. Pre. Updates QTR1 Health Educ. Pre. Updates QTR2 Health Educ. Pre. Updates QTR3 Health Educ. Pre. Updates QTR4	From 12:00 a.m. of the first calendar day of the quarter through 11:59 p.m. of the last calendar day of the quarter.	42 CFR 438.66(b)(4), 438.2	TRU_MSCAN_Health Educ. Prev. WP & Updates_QTR 1_2020 MOL_MSCAN_Health Educ. Prev. WP & Updates_QTR 1_2020 MHP_MSCAN_Health Educ. Prev. WP & Updates_QTR 1_2020
MSCAN Healthcare Experience	Annual	Yearly, on or before Sept. 30th	Heading	From 12:00 a.m. of the first calendar day of the year through 11:59 p.m. of the last calendar day of the year.	42 CFR 438.66(b)(12), (c)(6), 438.330	TRU_MSCAN_Healthcare Experience_Annual_2020 MOL_MSCAN_Healthcare Experience_Annual_2020 MHP_MSCAN_Healthcare Experience_Annual_2020
MSCAN Highest Paying Claims, Top 100 Claims by Allowed Amount	Monthly	5th business day of the second month following reporting period	Highest paying Claims	From 12:00 a.m. of the first calendar day of the month through 11:59 p.m. of the last calendar day of the month.	42 CFR § 438.66 (a) and (b)(3)&(8)	TRU_MSCAN_Claims-Top 100 by Allow. Amt._Oct. 2020 MOL_MSCAN_Claims-Top 100 by Allow. Amt._Oct. 2020 MHP_MSCAN_Claims-Top 100 by Allow. Amt._Oct. 2020
MSCAN Hospice Management	Monthly	15th calendar day of the month after the reporting period	Hospice Mgmt (management)	From 12:00 a.m. of the first calendar day of the month through the 11:59 p.m. of the last calendar day of the month.	42 CFR 438.66(b)(8) Contract Section 16.2.6	TRU_MSCAN_Hospice Mgmt_Oct. 2020 MOL_MSCAN_Hospice Mgmt_Oct. 2020 MHP_MSCAN_Hospice Mgmt_Oct. 2020
MSCAN Hospice Prior Authorization	Monthly	15th calendar day of the month following the reporting period	Hospice PA Summary Hospice PA Denials	From 12:00 a.m. of the first calendar day of the month through the 11:59 p.m. of the last calendar day of the month	42 CFR 438.66(b)(8) Contract Section 16.2.6	TRU_MSCAN_Hospice PA_Oct. 2020 MOL_MSCAN_Hospice PA_Oct. 2020 MHP_MSCAN_Hospice PA_Oct. 2020
MSCAN Hospice Provider Detail	Monthly	15th calendar day of the month after the reporting period	Hospice Provider Detail	From 12:00 a.m. of the first calendar day of the month through the 11:59 p.m. of the last calendar day of the month	42 C.F.R. § 438.66(b)(8)	TRU_MSCAN_Hospice Provider Detail_Oct. 2020 MOL_MSCAN_Hospice Provider Detail_Oct. 2020 MHP_MSCAN_Hospice Provider Detail_Oct. 2020
MSCAN Incentive Withhold Quality Measures	Semi-Annual	August 15 and January 15	Provided by the Office of Finance	As defined in the contract and provided by the Office of Finance	Contract Section 11.1.1.5.1	TBD
MSCAN Long Stays, Top 50 by Length of Stay	Monthly	5th business day of the second month following reporting period	Long Stays Top 50 by LOS (Length of Stay)	From 12:00 a.m. of the first calendar day of the month through 11:59 p.m. of the last calendar day of the month.	42 CFR § 438.66 (a) and (b)(3)&(8)	TRU_MSCAN_Long Stays-Top 50_Oct. 2020 MOL_MSCAN_Long Stays-Top 50_Oct. 2020 MHP_MSCAN_Long Stays-Top 50_Oct. 2020
MSCAN Marketing Activities Log	Quarterly	15th business day after the close of the quarter	Marketing Activities Log	From 12:00 a.m. of the first calendar day of the quarter through the 11:59 p.m. of the last calendar day of the quarter	42 CFR 438.66(b)(7), 438.104 Contract Section 5.9.1	TRU_MSCAN_Marketing Activities Log_QTR 1_2020 MOL_MSCAN_Marketing Activities Log_QTR 1_2020 MHP_MSCAN_Marketing Activities Log_QTR 1_2020

MSCAN Report Name	Frequency	Due Date	Tabs Information *(excluding History Log and Instructions)*	Reporting Period	Reference	Naming Convention
MSCAN Marketing Work Plan	Annual	Yearly, on or before January 15th	Heading	From 12:00 a.m. of the first calendar day of the year through 11:59 p.m. of the last calendar day of the year.	42 CFR 438.66(b)(7), 438.104 Contract Section 5.9.1	TRU_MSCAN_Marketing Work Plan-Annual_2020 MOL_MSCAN_Marketing Work Plan-Annual_2020 MHP_MSCAN_Marketing Work Plan-Annual_2020
MSCAN Medical Loss Ratio (MLR)	Quarterly	Sixtieth (60th) calendar day following the end of the MLR Reporting Quarter	Attestation MLR Rebate Calculation MLR Pricing Percentage Calc. PBA and VBP Informational Rep. Revenues Expenses Supplemental Adjustments HCQI and HIT Admin Expenses Calc. Non-Claims Cost Calc. Program Integrity Cost Methodology Explanations Annual Financial Reconciliation Statement	From 12:00 a.m. of the first calendar day of the reporting year through 11:59 p.m. of the last calendar day of the Reporting Year.	42 CFR §§ 438.8 and 438.6(b)(2); and MSCAN Contract Exhibit C	TRU_MSCAN_MLR_QTR 1_2020 MOL_MSCAN_MLR_QTR 1_2020 MHP_MSCAN_MLR_QTR 1_2020
MSCAN Medical Loss Ratio (MLR)	Annual	April 1st following the MLR Reporting Year	Attestation MLR Rebate Calculation MLR Pricing Percentage Calc. PBA and VBP Informational Rep. Revenues Expenses Supplemental Adjustments HCQI and HIT Admin Expenses Calc. Non-Claims Cost Calc. Program Integrity Cost Methodology Explanations Annual Financial Reconciliation Statement	From 12:00 a.m. of the first calendar day of the reporting year through 11:59 p.m. of the last calendar day of the Reporting Year.	42 CFR §§ 438.8 and 438.6(b)(2); and MSCAN Contract Exhibit C	TRU_MSCAN_MLR_Annual_2020 MOL_MSCAN_MLR_Annual_2020 MHP_MSCAN_MLR_Annual_2020
MSCAN Medical Utilization Statistics and Trends	Quarterly	5th business day of the second month following the close of the quarter	Medical Util.Stats &Trends	Input the correct reporting year from 12:00 a.m. of the first calendar day of the quarter through 11:59 p.m. of the last calendar day of the quarter.	42 CFR 438.66 (a) and (b)(3), (b)(8)	TRU_MSCAN_Med.Util.Stats.Trends_QTR 1_2020 MOL_MSCAN_Med.Util.Stats.Trends_QTR 1_2020 MHP_MSCAN_Med.Util.Stats.Trends_QTR 1_2020
MSCAN Member Grievance and Appeal Logs	Monthly	15th calendar day of the month following the reporting period	Heading	From 12:00 a.m. of the first calendar day of the month through 11:59 p.m. of the last calendar day of the month.	42 CFR 438.416, 438.66(c)(2)	TRU_MSCAN_Memb. Grievance & Appeal Logs_Oct. 2020 MOL_MSCAN_Memb. Grievance & Appeal Logs_Oct. 2020 MHP_MSCAN_Memb. Grievance & Appeal Logs_Oct. 2020
MSCAN Member State Issues MIG Summary and Details	Monthly	5th business day of the second month following reporting period	TBD	From 12:00 a.m. of the first calendar day of the month through 11:59 p.m. of the last calendar day of the month.	TBD	TBD
MH/SUD Parity Analysis and Report	Annual or Significant change	at least 30 calendar days prior to the CMS due date (TBD)	CMS template completed by the Division. The Division may request assistance from the CCO	TBD	The Mental Health Parity and Addiction Equity Act (MHPAEA)	TBD
MSCAN MOMS Summary	Monthly	15th business day of the following month following reporting period	Summary MOMS Assessment MOMS Timely Follow-Up	From 12:00 a.m. of the first calendar day of the month through 11:59 p.m. of the last calendar day of the month.	Contract Section 11.2.4	TRU_MSCAN_MOMS_May_2025 MOL_MSCAN_MOMS_May_2025 MAG_MSCAN_MOMS_May_2025
MSCAN MS Financial Data Request (AKA Financial Templates)	Annual	Provided by the Office of Finance	Provided by the Office of Finance (created by the acturial firm)	From 12:00 a.m. of the first calendar day of the reporting year through 11:59 p.m. of the last calendar day of the Reporting Year.	Contract Section 11.1.1.3	Provided by the Office of Finance (created by the acturial firm)
MSCAN MS Financial Data Request - CY 20XX Emerging Experience	Annual	Provided by the Office of Finance	Provided by the Office of Finance (created by the acturial firm)	From 12:00 a.m. of the first calendar day of the reporting year through 11:59 p.m. of the last calendar day of the Reporting Year.	Contract Section 11.1.1.3	Provided by the Office of Finance (created by the acturial firm)
MSCAN MYPAC/Wraparound Prior Authorizations	Monthly	TBD	TBD	From 12:00 a.m. of the first calendar day of the month through 11:59 p.m. of the last calendar day of the month.	TBD	TBD
MSCAN NET Denials	Monthly	5th business day of the second month following the reporting period	Denials Top 5 Denials	From 12:00 a.m. of the first calendar day of the month through 11:59 p.m. of the last calendar day of the month.	42 CFR 438.66	TRU_MSCAN_NET Denials_Oct. 2020 MOL_MSCAN_NET Denials_Oct. 2020 MHP_MSCAN_NET Denials_Oct. 2020
MSCAN NET Pre-Post Validation	Quarterly	30th calendar day after the close of the quarter	NET Pre-Post Val.	From 12:00 a.m. of the first calendar day of the quarter through 11:59 p.m. of the last calendar day of the quarter.	42 CFR 438.66	TRU_MSCAN_NET Pre-Post Val._QTR 1_2020 MOL_MSCAN_NET Pre-Post Val._QTR 1_2020 MHP_MSCAN_NET Pre-Post Val._QTR 1_2020
MSCAN NET Provider Record Inspections	Quarterly	30th calendar dayt after the close of the quarter	Heading	From 12:00 a.m. of the first calendar day of the quarter through 11:59 p.m. of the last calendar day of the quarter.	42 CFR 438.66	TRU_MSCAN_NET Prov. Record Inspect._QTR 1_ 2020 MOL_MSCAN_NET Prov. Record Inspect._QTR 1_ 2020 MHP_MSCAN_NET Prov. Record Inspect._QTR 1_ 2020

MSCAN Report Name	Frequency	Due Date	Tabs Information *(excluding History Log and Instructions)*	Reporting Period	Reference	Naming Convention
MSCAN NET Subcontractor Oversight	Monthly	5th business day of the second month following the reporting period	Heading	From 12:00 a.m. of the first calendar day of the month through 11:59 p.m. of the last calendar day of the month.	42 CFR 438.66	TRU_MSCAN_NET Subcont. Oversight_Oct. 2020 MOL_MSCAN_NET Subcont. Oversight_Oct. 2020 MHP_MSCAN_NET Subcont. Oversight_Oct. 2020
MSCAN NET Trip Processing Timeliness	Monthly	15th calendar day of the month following the reporting period	Trip Process. Time Trip Process. Time Sum.	From 12:00 a.m. of the first calendar day of the month through 11:59 p.m. of the last calendar day of the month.	42 CFR 438.66	TRU_MSCAN_NET Process. Time_Oct. 2020 MOL_MSCAN_NET Process. Time_Oct. 2020 MHP_MSCAN_NET Process. Time_Oct. 2020
MSCAN NET Trip Timeliness	Monthly	5th business day of the second month following the reporting period	Every reporting month	From 12:00 a.m. of the first calendar day of the month through 11:59 p.m. of the last calendar day of the month.	42 CFR 438.66	TRU_MSCAN_NET Trip Timelines_Oct. 2020 MOL_MSCAN_NET Trip Timelines_Oct. 2020 MHP_MSCAN_NET Trip Timelines_Oct. 2020
MSCAN New Member Card	Monthly	5th business day of the month following the reporting period	New Memb. Card Mailed New Memb. Card Returned	From 12:00 a.m. of the first calendar day of the month through 11:59 p.m. of the last calendar day of the month.	42 CFR 438.66(b)(4)	TRU_MSCAN_New Member Card_Oct. 2020 MOL_MSCAN_New Member Card_Oct. 2020 MHP_MSCAN_New Member Card_Oct. 2020
MSCAN Overpayments	TBD	TBD	TBD	TBD	TBD	TBD
MSCAN Performance Improvement Project Results	Annual	Yearly, on or before Aug. 1st	Heading	From 12:00 a.m. of the first calendar day of the year through 11:59 p.m. of the last calendar day of the year.	42 CFR 438.330(e)	TRU_MSCAN_PIP Results_Annual_2020 MOL_MSCAN_PIP Results_Annual_2020 MHP_MSCAN_PIP Results_Annual_2020
MSCAN Performance Improvement Project Updates	Quarterly	30th calendar day after the close of the quarter	Heading	From 12:00 a.m. of the first calendar day of the quarter through 11:59 p.m. of the last calendar day of the quarter.	42 CFR 438.330(e)	TRU_MSCAN_PIP Updates_QTR 1_2020 MOL_MSCAN_PIP Updates_QTR 1_2020 MHP_MSCAN_PIP Updates_QTR 1_2020
MSCAN Performance Measure Results	Annual	On or before August 1 (following the reporting calendar year)	Heading **There is no prescribed template for this report. Annual submission must contain audited results of performance measures.*	From 12:00 a.m. of the first calendar day of the year through 11:59 p.m. of the last calendar day of the year.	42 CFR 438.66(b)(12), (c)(6), 438.330	TRU_MSCAN_Perform. Meas. Results_Annual_2020 MOL_MSCAN_Perform. Meas. Results_Annual_2020 MHP_MSCAN_Perform. Meas. Results_Annual_2020
MSCAN Performance Measures	Annual	Yearly, on or before July 31st	Heading	From 12:00 a.m. of the first calendar day of the year through 11:59 p.m. of the last calendar day of the year.	42 CFR 438.66(b)(12), (c)(6), 438.330	TRU_MSCAN_Perform. Meas._Annual_2020 MOL_MSCAN_Perform. Meas._Annual_2020 MHP_MSCAN_Perform. Meas._Annual_2020
MSCAN Pharmacy Lock-In	Monthly	5th business day of the month after the reporting period	Pharmacy Lock-In	From 12:00 a.m. of the first calendar day of the month through 11:59 p.m. of the last calendar day of the month.	42 CFR § 431.54, 438.66(b)(9) Contract Section 16.2.11	TRU_MSCAN_Pharmacy Lock-In_Oct. 2020 MOL_MSCAN_Pharmacy Lock-In_Oct. 2020 MHP_MSCAN_Pharmacy Lock-In_Oct. 2020
MSCAN Prior Authorization	Monthly	5th business day of the month after the reporting period	Overall PA Advanced Imaging PA Private Duty Nursing PA Orthodontia PA ST,PT,OT PA PPEC PA DME PA NET PA	From 12:00 a.m. of the first calendar day of the month through 11:59 p.m. of the last calendar day of the month.	42 CFR 438.210, 438.66(b)(8); Miss. Code Ann. 41-83-15	TRU_MSCAN_PA_Oct. 2020 MOL_MSCAN_PA_Oct. 2020 MHP_MSCAN_PA_Oct. 2020
MSCAN Provider Appointment Availability	Quarterly	30th calendar day after the close of the quarter	Appt. Avail. PCP-OBGYN Appt. Avail. BH	From 12:00 a.m. of the first calendar day of the quarter through 11:59 p.m. of the last calendar day of the quarter.	42 CFR 438.66	TRU_MSCAN_Prov. Appt. Avail._QTR 1_2020 MOL_MSCAN_Prov. Appt. Avail._QTR 1_2020 MHP_MSCAN_Prov. Appt. Avail._QTR 1_2020
MSCAN Provider Appointment Availability	Annual	Yearly, on or before April 1st	Appt. Avail. PCP-OBGYN Appt. Avail. BH	From 12:00 a.m. of the first calendar day of the year through 11:59 p.m. of the last calendar day of the year.	43 CFR 438.66	TRU_MSCAN_Prov. Appt. Avail._Annual_2020 MOL_MSCAN_Prov. Appt. Avail._Annual_2020 MHP_MSCAN_Prov. Appt. Avail._Annual_2020
MSCAN Provider Complaint and Appeal Logs	Monthly	15th calendar day of the month following the reporting period	Heading	From 12:00 a.m. of the first calendar day of the month through 11:59 p.m. of the last calendar day of the month.	42 CFR 438.66(c)(3)	TRU_MSCAN_Prov. Complaint-Appeal Logs_Oct. 2020 MOL_MSCAN_Prov. Complaint-Appeal Logs_Oct. 2020 MHP_MSCAN_Prov. Complaint-Appeal Logs_Oct. 2020
MSCAN Provider Directory Delivery	Ad Hoc	Ad Hoc	Prov. Direct. Del.	To be specified by DOM	42 CFR 438.66(b)(4), (b)(10)	TRU_MSCAN_Prov. Direct. Delivery_Ad Hoc_Oct. 2020 MOL_MSCAN_Prov. Direct. Delivery_Ad Hoc_Oct. 2020 MHP_MSCAN_Prov. Direct. Delivery_Ad Hoc_Oct. 2020
MSCAN Provider Incentive Plan	Semi-Annual	April thirtieth (30th) following the October thru March reporting period October thirty-first (31st) following the April thru September reporting period	Provider Incentive Plan	From 12:00 a.m. of the first calendar day of the semi-annual period through 11:59 p.m. of the last calendar day of the semi-annual period.	42 CFR 422.208 and 422.210	TRU_MSCAN_Prov. Incentive Plan_Semi-Annual_Oct. 2020 MOL_MSCAN_Prov. Incentive Plan_Semi-Annual_Oct. 2020 MHP_MSCAN_Provi. Incentive Plan_Semi-Annual_Oct. 2020