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

WHEREAS, pursuant to Sections 1.2.1 and 15.13.1 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, 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. Section 11, Financial Requirements is hereby amended and superseded to be replaced with the following:

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 drug product DOM allows to be paid outside the DRG rates. 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) Casgevy
ii) Lyfgenia
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 Pharmacy Benefit Administrator (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.

Should Contractor file an annual insurance premium tax return with the State which includes Premium Revenue paid under this Contract and Premium Revenue paid to Contractor from product lines which are not included in this contract, Contractor shall be required to demonstrate, to the satisfaction of the Division, that it paid the full three percent (3%) premium tax on all premiums paid under this contract.

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 Amendment No. 1 for MLR calculation methodology and classification of costs.

11.5 Value Based Payments

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.

Effective July 1, 2024, 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. CCOs will have sixty (60) calendar days' notice prior to the required implementation date of any ad hoc changes made by DOM. Changes made for each new State Fiscal Year are to be expected by the CCO.

2. **EXHIBIT A: Capitation Rates** is hereby attached to this Amendment No. 1 and incorporated as part of the Contract.

3. **EXHIBIT C: Medical Loss Ratio (MLR) Requirements** is hereby attached to this Amendment No. 1 and incorporated as part of the Contract.

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. 1.

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

Mississippi Division of Medicaid

By: Cindy Bradshaw
Cindy Bradshaw
Executive Director

Date: 6/26/2025 | 7:15:33 AM CDT

Magnolia Health Plan, Inc.

By:
Aaron Sisk
President & Chief Executive Officer

Date: 06/24/2025

Exhibit A: Capitation Rates

The table below are the rates for State Fiscal Year 2026 (July 1, 2025 through June 30, 2026).

Magnolia Health Plan, Inc.	
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) and are included as part of this Exhibit A to this Amendment No. 1 as Attachment 1A. 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 as Attachment 1A.

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milliman.com

May 30, 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

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.*

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.

❖ ❖ ❖ ❖ ❖

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

JAB/bl

Attachments

MILLIMAN REPORT

State of Mississippi Division of Medicaid

State Fiscal Year 2026 MississippiCAN Preliminary Rate Calculation and Certification

May 30, 2025

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

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Milliman

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EXHIBITS (Provided in Excel format only)

Capitation Rate Development

Capitation Rate Support

Expenditure Projection

Risk Corridor Calculations

Table of Contents *(continued)*

APPENDICES

Supporting Documentation

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.
- Appendix D contains an Actuarial Certification for all MississippiCAN rate cells.
- Appendix E documents our reliance on DOM for data and other assumptions in the development of the capitation rates.

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.

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.

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.

- 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. 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.

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

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).

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 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.

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 SFY 2026 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.

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.

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, Principal and Consulting Actuary for Milliman, is a member of the American Academy of Actuaries, and meets the Qualification Standards of the Academy to render the actuarial opinion contained herein. To the best of her knowledge and belief, this report is complete and accurate and has been prepared in accordance with generally recognized and accepted actuarial principles and practices.

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.

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 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.*

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.

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.

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 to 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.

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.

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).

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

- 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.

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.

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).

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.

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).

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.

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.

- **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
Annualized 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
Annualized 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.

- **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
Annualized 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)

- 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.

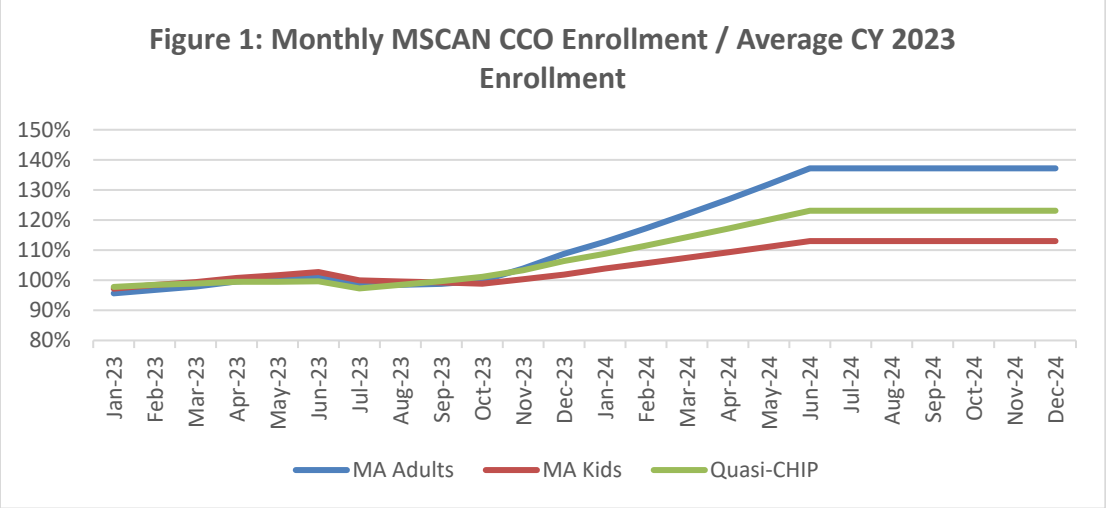
- Population Changes: Change in the mix of individuals already enrolled in MississippiCAN.
- Program Changes: Changes to populations and / or services included in MississippiCAN.
- Reimbursement Methodology Changes: Updates to Medicaid FFS reimbursement methodologies (assumes a parallel impact on MississippiCAN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

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).



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*

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.

- 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

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.

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.

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 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.

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. 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.

- 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

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 and the final 10% of 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. Consideration will be applied in establishing the baseline A/E ratio to account for membership changes occurring July 1, 2025 with the introduction of the new CCO contracts and a new CCO.

For all metrics, if a CCO does not have sufficient data to consider their 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, where applicable.

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 intend to implement a regional cost component in the risk adjustment models for the following rate cells.

- Breast and Cervical Cancer
- Non-SSI Newborns 0 to 2 Months
- Non-SSI Newborns 3 to 12 Months
- Pregnant Women
- SSI / Disabled Newborn

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.

Normally for July 2025 to December 2025 risk scores, we would use an enrollment snapshot of June 2025 as a proxy for all months for use in risk adjustment. However, as MississippiCAN CCOs are changing for SFY 2026, using an enrollment snapshot prior to the rating period is not feasible. Therefore, for July 2025 to December 2025, we will use an enrollment snapshot of July 2025 to September 2025, with consideration to which portion of this snapshot is most applicable for October 2025 through December 2025. This will allow us to estimate CCO enrollment during the risk adjustment period while still providing prospective risk scores prior to the end of the risk adjustment period.

For January 2026 to June 2026, we plan to return to using an October 2025 enrollment snapshot if enrollment levels by CCO are stable. In the event that enrollment levels by CCO are still in flux, we plan to use a similar process as July 2025 to December 2025 and use January 2026 to March 2026 as an enrollment snapshot for January 2026 to June 2026 risk adjustment.

Table 18 summarizes the risk adjustment schedule for SFY 2026.

Table 18
Mississippi Division of Medicaid
CCO Capitation Rate Risk Adjustment Schedule
SFY 2026 Capitation Payments

Rate Cell	Capitation Payments	Diagnosis Source Data	Enrollment Source
Non-Newborn SSI / Disabled, MA Adult, MA Children, and Quasi-CHIP	July 2025 to December 2025	CY 2024 Encounter and FFS claims with runout through April 30, 2025	July 2025 to September 2025
Non-Newborn SSI / Disabled, MA Adult, MA Children, and Quasi-CHIP	January 2026 to June 2026	SFY 2025 Encounter and FFS claims with runout through August 31, 2025	TBD

Risk Adjustment for the Foster Care Rate Cell

Starting in SFY 2021, the Foster Care rate cell is concurrently risk adjusted after the risk adjustment period ends. The Foster Care rate cell will be risk adjusted using a custom risk adjustment model that does not depend on the CDPS + Rx risk adjuster. After testing the predictive ability of several potential models, we determined the member's eligibility for either state or federal financial assistance was the most accurate indicator of the member's risk score. This status is captured by the money code field on DOM's enrollment records. Updated risk weights for each money code, as well as enrollment region, will be calculated using recent data and reflect 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.

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 19 displays the two components of MHAP (FSA and QIPP) and compares the total dollars in each component for SFY 2025 and SFY 2026.

Table 19
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

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.

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 20 below shows a summary of the state directed payment amounts for SFY 2025 and SFY 2026.

Table 20 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.

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 21 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 21 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 22 summarizes the share of gains and losses relative to the estimated high-cost pharmacy costs for each party.

Table 22 Mississippi Division of Medicaid Proposed High-Cost Pharmacy Risk Corridor Parameters		
CCO Gain / Loss	**CCO Share of Gain / Loss in Corridor**	**DOM Share of Gain / Loss in Corridor**
Less than -6.0%	0%	100%
-6.0% to -3.0%	50%	50%
-3.0% to +3.0%	100%	0%
+3.0% to +6.0%	50%	50%
Greater than +6.0%	0%	100%

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

- Estimated high-cost pharmacy costs are calculated separately for each rate cell based on the expected mix of high-cost products.
- Each rate cell's actual high-cost pharmacy costs will include payments made for the following:
  - All drugs billed as medical claims with a HCPCS code that starts with the letter "J."
  - Inpatient stays for the administration and monitoring for select gene therapies and other select products. The estimated pharmacy costs included in the high-cost risk corridor include the following; however, DOM will monitor and revise the list of approved products if additional products are covered by DOM for use during SFY 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.

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 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.

EXHIBITS 1 THROUGH 14

(Provided in Excel Format Only)

APPENDIX A

SFY 2026 Rate Cell Definitions

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.

APPENDIX B

Data Sources and Processing

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

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*™ (*HCG*s) 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.

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.

APPENDIX C

CMS Managed Care Rate Setting Guide Response

APPENDIX C

Responses to 2024-2025 CMS Managed Care Rate Development Guide

RESPONSES TO 2024-2025 CMS MANAGED CARE RATE DEVELOPMENT GUIDE

At the time of this report the 2025-2026 CMS Managed Care Rate Development Guide has not been released.

SECTION I. MEDICAID MANAGED CARE RATES

1. General Information Appropriate Documentation

i. Rate period – This report documents and certifies capitation rates in effect from July 1, 2025 to June 30, 2026 (SFY 2026).

ii. Actuarial rate certification – See Appendix D for the actuarial certification of SFY 2026 capitation rates. In addition, Sections III and IV of the report outline the data used, assumptions made, and methods for analyzing the data and developing the assumptions and adjustments.

iii. Medical Loss Ratio (MLR) – The program includes a minimum MLR requirement of 91.3% of revenue. The sum of medical expenses, directed payments, and health care quality initiative (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. This mechanism has been developed in accordance with applicable regulation and generally accepted actuarial principles and practices. Please see Section IV Step 8 for more information about the minimum MLR requirement. Prior MLR experience is considered when reviewing emerging experience and developing trends for the capitation rates. Specifically, we develop quarterly MLR summary files comparing actual program-level and CCO-specific MLRs to target MLRs set as part of capitation rate setting. Additionally, claims information provided in the MLR templates are also reviewed as part of the trend setting process. Please see Section IV Step 1 for information on trend setting.

iv. Final capitation rates – See Exhibit 4 for final capitation rates by rate cell. Sections III and IV of the report support the specific data and assumptions used to develop each rate cell. No assumptions vary between managed care plans in the preliminary rates.

v. Rate ranges – rate ranges are not included in this certification.

vi. Index – Appendix C serves as the index that includes report section numbers, appendices, and where specific step numbers are referenced to where additional documentation can be found for each item included in the CMS Managed Care Guide.

vii. No difference in assumptions, methodologies, or factors were applied in the development of capitation rates for covered populations, in compliance with 42 CFR § 438.4(b)(1).

viii. Federal Medical Assistance Percentage (FMAP) – DOM receives an enhanced FMAP family planning services, breast and cervical cancer services, Indian health services, home health services, rehabilitation services, private duty nursing services, and Quasi-CHIP members that prior to the Affordable Care Act were covered under the CHIP program. Any differences in capitation rates according to covered populations are based on valid rate development standards and not based on the FMAP associated with the covered populations.

ix. Rate change from SFY 2025 capitation rates – See Section I. The state did not adjust the capitation rates in SFY 2025 by a *de minimis* amount using the authority in 42 CFR § 438.7(c)(3)

x. Known rate amendments – The capitation rates included in this report will require recertification to account for the following:

   a. CCO specific MHAP, MAPS, TREAT, and MOMS payments made to providers. This initial certification includes a PMPM estimate of these amounts across all CCOs in Exhibit 12. We anticipate that this adjustment will be submitted by February 2027.

   b. Final charge trends for inpatient, outpatient, and certain physician services as calculated by DOM's payment methodology development vendor.

   c. Population adjustments related to procedural changes in presumptive eligibility or passive enrollment starting in SFY 2025.

xi. Impact of COVID-19 – See Section I.

2. Data

i. Service and enrollment data sources – See Appendix B for an overview of the data sources and Appendix E for a data reliance letter.

ii. Data processing, validation and quality adjustments – See Section III for encounter data and financial reporting processing and validation.

iii. Data adjustments – SFY 2026 capitation rates use CY 2023 CCO encounter and financial data as the base period data sources. Rate cells with less than 100,000 member months in CY 2023 relied on blended CY 2022 and CY 2023 experience. SFY 2025 capitation rates used CY 2022 CCO encounter and financial as the base period data sources. Please see Section III.

3. Projected Benefit Costs and Trends

i. Final projected benefit costs – See Exhibit 4.

ii. Projected benefit cost costs:

a. See Section IV for a description of the data, assumptions and the methodologies used to develop the projected benefit costs.

b. The following material changes in the methodologies were used in the development of SFY 2026 projected benefit costs compared to SFY 2025 capitation rates:

- Children previously in the MYPAC rate cell will be enrolled in the rate cell consistent with their category of eligibility rather than the specific codes historically used to identify MYPAC children. The MYPAC population is blended into the future rate cells in Exhibit 2B.

- Capitation rates will be paid on a statewide basis for SFY 2026, removing the area adjustments included in SFY 2025 capitation rates. Regional difference, where applicable, will be considered in risk adjustment.

c. Overpayments to providers – Section III summarizes recoveries for overpayments to providers by CCOs and how these recoveries are accounted for when summarizing the base data used to develop SFY 2025 2026 capitation rates.

iii. Projected benefit cost trends:

a. Annual trend assumptions – Section IV: Step 1 outlines the trend assumptions from CY 2023 to the rating period. Please refer to Exhibits 7A to 7E for more information. Negative unit cost trends for CY 2023 to the rating period for inpatient hospital services shown in Table 9 are due to decreases in fee schedules over time.

b. Reimbursement changes – Section IV: Step 2 describes the reimbursement changes between the base period and rating period.

c. Variation in projected benefit cost trends are based upon the mix of services included for each population within the category of service and historical utilization trends observed by population.

d. No material adjustments were applied.

e. A list of non-material adjustments is included in Section IV. No change in projected benefit costs were modeled for these items.

iv. Mental Health Party and Addiction Equity Act – No additional services were necessary to add to the program to achieve compliance with the act.

v. In-lieu-of services – The MississippiCAN CCOs reported $0 for amounts of in-lieu-of services in their CY 2023 financial templates. We do not anticipate any material changes for in-lieu-of-services and project $0 for in-lieu-of services for SFY 2026.

vi. Retrospective eligibility periods – No consideration for retroactive eligibility periods is included in the base data or rate development, because such services are covered under FFS.

vii. Changes in covered services and benefits: There are four benefit changes between the base period and the rate year:

a. Expansion of postpartum coverage for pregnant women from 60 days to 12 months (described in Section IV, Step 2).

b. Members diagnosed with Hemophilia or Von Willebrand disease are now covered as part of the MississippiCAN program (described in Section IV, Step 2).

c. Zolgensma is included as a covered therapy after carved out prior to SFY 2024 (described in Section IV, Step 2).

d. Effective July 1, 2024 pharmacy services are paid by DOM's pharmacy benefit administrator (PBA) (removed from base data as described in Section III).

viii. Other adjustments:

a. A population change adjustment was applied to reflect that some children in the Non-Newborn SSI / Disabled rate cell were historically moved into FFS after a PRTF stay. Starting in SFY 2022, these individuals will remain in the MississippiCAN program. This adjustment was applied in Section III.

b. A list of non-material adjustments is included in Section IV. No change in projected benefit costs were modeled for these items.

4. Special Contract Provisions Related to Payment

i. Incentive Arrangements – In SFY 2026, CCOs will have the opportunity to earn up to 0.25% of revenue based on performance in the Value Base Payment (VBP) program. Payments to CCOs will be based on their performance across three primary focus areas: maternal health, metabolic health, and mental health. Please see Section IV Step 8 for more information.

ii. Withhold Arrangements – A quality withhold will be implemented for the SFY 2026 capitation rates. Please see Section IV: Step 4 for a description of the quality withhold.

iii. Risk sharing Mechanisms.

a. For SFY 2026 the program is subject to a high-cost pharmacy risk corridor. Please see Section IV: Step 7 for details of the implementation of this risk corridor. Any risk-sharing arrangements are consistent with pricing assumptions and no remittance / payment is calculated using pricing assumptions.

b. The program includes a minimum MLR requirement of 91.3% of revenue. The sum of medical expenses, directed payments, and health care quality initiative (HCQI) expenses, must meet or exceed 91.3% of revenue. Revenue for premium taxes are excluded from the MLR calculation. If the 91.3% threshold is not met, MCOs return revenue to DOM until the threshold is met. This mechanism has been developed in accordance with applicable regulation and generally accepted actuarial principles and practices. Please see Section IV Step 8 for more information on the minimum MLR requirement.

c. The program does not have any reinsurance requirements.

iv. State Directed Payments.

The SFY 2026 capitation rates included in this certification reflect four directed payment arrangements that will be in effect for SFY 2026 as described in Section IV, Step 6. The necessary information for the four state directed payment arrangements included in these preliminary capitation rates is summarized below.

APPENDIX C

Responses to 2024-2025 CMS Managed Care Rate Development Guide

Summary of All State Directed Payments			
Control Name of the State Directed Payment	**Type of Payment**	**Brief Description**	**Is the Payment Included as a Rate Adjustment or Separate Payment Term?**
MS_Fee.VBP_IPH.OPH_Renewal_20250701-20260630	Uniform dollar or percentage increase	Enhanced hospital reimbursement for inpatient and outpatient hospital services for qualifying facilities	Separate payment term
TBD	Uniform dollar or percentage increase	Enhanced payments to physicians and other eligible professional service practitioners who are employed by a qualifying hospital or who assigned Mississippi Medicaid payments to a qualifying hospital	Separate payment term
TBD	Uniform dollar or percentage increase	Enhanced reimbursement for ambulance providers	Separate payment term
TBD	Uniform dollar or percentage increase	Enhanced reimbursement for hospitals and outpatient providers to improve maternal outcomes	Separate payment term

Summary of State Directed Payments Included as a Separate Payment Term					
Control Name of the State Directed Payment	**Aggregate Amount Included in the Certification**	**Statement that the Actuary is Certifying the Separate Payment Term**	**The Magnitude on a PMPM Basis**	**Confirmation the Rate Development is Consistent with the Preprint**	**Confirmation that the State and Actuary will Submit Required Documentation at the End of the Rating Period**
MS_Fee.VBP_IPH.OPH_Renewal_20250701-20260630	FSA component of MHAP: $694.7 million QIPP component of MHAP: $815.6 million	Confirmed the actuarial certification covers this separate payment term	See Exhibit 12 FSA component of MHAP: allocated across rate cells based on projected IP / OP spend. 65% is allocated based on projected IP spend and 35% is allocated based on projected OP spend. Ranges from $39.76 to $4,166.57 PMPM. QIPP component of MHAP: allocated as a fixed PMPM of $148.97 across all rate cells.	Confirmed	Confirmed
TBD	$31.0 million	Confirmed the actuarial certification covers this separate payment term	See Exhibit 12 Allocated as a fixed PMPM of $5.66 across all rate cells	Confirmed	Confirmed
TBD	$26.5 million	Confirmed the actuarial certification covers this separate payment term	See Exhibit 12 Allocated as a fixed PMPM of $5.66 across all rate cells	Confirmed	Confirmed
TBD	$6.6 million	Confirmed the actuarial certification covers this separate payment term	See Exhibit 12 Allocated as a fixed PMPM of $1.21 across all rate cells	Confirmed	Confirmed

All services covered under the MississippiCAN program are subject to a minimum fee schedule of the FFS rate. This minimum fee schedule is set in accordance with the provisions of §438.6(c). It is our understanding that this type of minimum fee schedule does not necessitate prior approval from CMS and no preprint is required.

DOM has confirmed that there are no additional directed payments in the program that are not addressed in the certification.

DOM has also confirmed that there are no requirements regarding the reimbursement rates the managed care plans must pay to any providers unless specifically specified in the certification as a state directed payment or authorized under applicable law, regulation, or waiver.

v. Pass Through Payments – Not applicable.

5. Projected Non-Benefit Costs

i. Administrative cost data, projected costs, premium tax and margin – See Section IV: Step 3.

ii. Non-benefit costs are projected separately for administrative costs, premium tax, and margin. – See Section IV: Step 3.

iii. CY 2022 administrative costs for the three CCOs were $34.70 PMPM, as reported on the audited financial templates. Please see Section IV: Step 3 for a description of adjustments applied to this base data to project the SFY 2026 administrative allowance.

6. Risk Adjustment

i. A custom prospective risk adjustment model will be developed for the MA Children, Quasi-CHIP, MA Adult, and Non-Newborn SSI / Disabled rate cells using the Chronic Disability Payment System (CDPS) model. See Section IV: Step 5.

ii. A custom retrospective risk adjustment model will be developed for the Foster Care rate cell using information from members' enrollment information. See Section IV: Step 5.

iii. New custom risk adjustment models will be developed for SFY 2026 to account for the transition of the MYPAC beneficiaries to other rate cells and the removal of geographical area adjustments in the capitation rates. All risk adjustment will be applied on a budget neutral basis, as in accordance with 42 CFR § 438.5(g).

7. Acuity Adjustments

i. See Section IV: Step 2 for a description of the acuity adjustment applied to reflect changes in member acuity from CY 2023 to SFY 2026.

SECTION II. MEDICAID MANAGED CARE RATES WITH LONG-TERM SERVICES

This section does not apply as MississippiCAN is not a long-term care service program.

SECTION III. NEW ADULT POPULATION CAPITATION RATES

This section does not apply as the state of Mississippi has not expanded coverage as a result of the Affordable Care Act.

APPENDIX D

Actuarial Certification of SFY 2026 MississippiCAN Capitation Rates

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.

May 30, 2025

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

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May 30, 2025

Mississippi Division of Medicaid
Capitated Contracts Ratesetting
Actuarial Certification
SFY 2026 MississippiCAN Capitation Rates

I, Jill A. Bruckert, am associated with the firm of Milliman, Inc., am a member of the American Academy of Actuaries, and meet its Qualification Standards for Statements of Actuarial Opinion. I was retained by the Mississippi Division of Medicaid (DOM) to perform an actuarial certification of the Mississippi Coordinated Access Network (MississippiCAN) coordinated care capitation rates for July 1, 2025 to June 30, 2026 (SFY 2026) for filing with the Centers for Medicare and Medicaid Services (CMS).

I reviewed the capitation rate development and am familiar with the following regulation and guidance:

- The requirements of 42 CFR §438.3(c), 438.3(e), 438.4, 438.5, 438.6, and 438.7
- CMS "Appendix A, PAHP, PIHP, and MCO Contracts Financial Review Documentation for At-risk Capitated Contracts Ratesetting dated November 10, 2014"
- 2024 to 2025 Medicaid Managed Care Rate Development Guide
- Actuarial Standard of Practice 49 and other applicable standards of practice

I examined the actuarial assumptions and actuarial methods used in setting the capitation rates for SFY 2026 dated May 30, 2025 and accompanying this certification.

To the best of my information, knowledge, and belief, for the SFY 2026 period, the capitation rates offered by DOM are in compliance with the relevant requirements of 42 CFR 438.4. The attached actuarial report describes the capitation rate setting methodology. Please note, as outlined in the cover letter of the report, there are a number of outstanding program changes that will be incorporated into an update to SFY 2026 capitation rates.

In my opinion, the capitation rates are actuarially sound, as defined in Actuarial Standard of Practice 49, were developed in accordance with generally accepted actuarial principles and practices, and are appropriate for the populations to be covered and the services to be furnished under the contract. This certification includes all prospective health plan payments, as well as the components of the MHAP, MAPS, TREAT, and MOMS programs that will be settled retrospectively.

In making my opinion, I relied upon the accuracy of the underlying claim and eligibility data records and other information prepared by DOM and participating CCOs. I did not audit the data and calculations, but did review them for reasonableness and consistency and did not find material defects. In other respects, my examination included such review of the underlying assumptions and methods used and such tests of the calculations as I considered necessary. The reliance letter from DOM is included in Appendix E of the rate report issued on May 30, 2025.

Actuarial methods, considerations, and analyses used in forming my opinion conform to the appropriate Standards of Practice as promulgated from time-to-time by the Actuarial Standards Board, whose standards form the basis of this Statement of Opinion.

It should be emphasized that capitation rates are a projection of future costs based on a set of assumptions. Actual costs will be dependent on each contracted coordinated care organization's situation and experience.

This Opinion assumes the reader is familiar with the MississippiCAN program, Medicaid coordinated care programs, and actuarial rating techniques. The Opinion is intended for the State of Mississippi and the Centers for Medicare and Medicaid Services and should not be relied on by other parties. The reader should be advised by actuaries or other professionals competent in the area of actuarial rate projections of the type in this Opinion, so as to properly interpret the projection results.

Jill A. Bruckert
Member, American Academy of Actuaries
Principal and Consulting Actuary
May 30, 2025

APPENDIX E

Data Reliance Letter

OFFICE OF THE GOVERNOR
Walter Sillers Building | 550 High Street, Suite 1000 | Jackson, Mississippi 39201

MISSISSIPPI DIVISION OF MEDICAID

May 19, 2025

Jill A. Bruckert, FSA, MAAA
Principal and Consulting Actuary
Milliman, Inc.
17335 Golf Parkway, Suite 100
Brookfield, WI 53045

Re: Data Reliance for Actuarial Certification of SFY 2026 MississippiCAN Capitation Rates

Dear Jill:

I, Jennifer Wentworth, Chief of Staff for the Mississippi Division of Medicaid (DOM), hereby affirm that the data prepared and submitted to Milliman, Inc. (Milliman) for the purpose of certifying MississippiCAN capitation rates was prepared under my direction and, to the best of my knowledge and belief, is accurate, complete, and consistent with the data used to develop the capitation rates. Capitation rates are effective July 1, 2025 to June 30, 2026 (SFY 2026).

Provided data or information used in the development of the capitation rates includes:

1. Data from DOM's Medicaid Management Information Systems (MMIS) vendor (Gainwell Technologies):
    a. Encounter claims through September 2024.
    b. Medicaid eligibility through December 2024.
2. Data from DOM's vendor Myers and Stauffer:
    a. Detailed encounter claim status reports, including identification of duplicative or voided claims through December 27, 2024.
3. Supporting documentation provided by DOM:
    a. Data identification logic:
        i. Logic for identifying members historically eligible for the MYPAC rate cell.
        ii. Logic for identifying members with hemophilia.
        iii. Logic for identifying Institution for Mental Disease (IMD) facilities.
        iv. Logic for identifying claims above state plan covered service limits.
    b. Reimbursement and / or program changes:
        i. SB 2799 passed April 19, 2021.
            1. Preventative and diagnostic dental reimbursement increases of 5% effective July 1, 2022 and July 1, 2023.
            2. Fee schedules frozen effective July 1, 2021.
        ii. HB 657 signed into law on April 19, 2022.

1. Restorative dental reimbursement increases of 5% effective July 1, 2022, July 1, 2023, and July 1, 2024.

iii. SB 2212 signed into law on March 16, 2023.

1. Postpartum coverage for eligible members extended from 60 days to 12 months.

iv. Professional, inpatient DRG, and outpatient APC fee re-pricing impacts for July 2022 and July 2023 prepared by Conduent.

v. Professional, inpatient DRG, and outpatient APC fee re-pricing impacts for July 2023 and July 2024 prepared by Myers & Stauffer.

vi. Estimates of uptake rates of certain gene therapies used to treat Hemophilia A, Hemophilia B, Sickle Cell Disease, Beta-Thalassemia, and Duchene Muscular Dystrophy.

vii. Fee schedule updates for the following categories of service:

1. Psychiatric Residential Treatment Facilities (PRTF) – January 2023, January 2024, and January 2025
2. Ambulatory Surgical Center (ASC) – October 2023, January 2024, October 2024, and January 2025
3. Autism Spectrum Disorder (ASD) – January 2023 and March 2025
4. Orthodontia Services – October 2023
5. Behavioral Health Services – July 2023 and July 2024
6. MYPAC Services – November 2023
7. Home Health Agency (HHA) Services – October 2024
8. Prescribed Pediatric Extended Care (PPEC) Services – October 2022
9. Private Duty Nursing (PDN) Services – October 2022 and July 2023

ix. CY 2022 and CY 2023 fee schedules for the following categories of service:

1. Psychiatric Residential Treatment Facilities (PRTF)
2. Ambulatory Surgical Center (ASC)
3. Autism Spectrum Disorder (ASD)
4. Orthodontia Services
5. Behavioral Health Services
6. MYPAC Services
7. Home Health Agency (HHA) Services

8. Prescribed Pediatric Extended Care (PPEC)

9. Private Duty Nursing (PDN)

c. Directed payments (all amounts below are prior to premium tax application):

   i. SFY 2026 Mississippi Hospital Access Program (MHAP) total funding amount of $1,510,325,958 along with splits for a quality incentive payment program (QIPP) amount of $815,576,017, the inpatient fee schedule adjustment (FSA) amount of $451,587,462, and the outpatient FSA amount of $243,162,479 to be used in capitation rate development.

   ii. SFY 2026 Mississippi Medicaid Access to Physician Services (MAPS) funding amount of $31,002,486.

   iii. SFY 2026 Transforming Reimbursement for Emergency Ambulance Transportation (TREAT) funding amount of $26,549,485.

   iv. SFY 2026 Mississippi Outcomes for Maternal Safety (MOMS) funding amount of $6,603,083.

d. Historical data:

   i. Files summarizing individuals in the Non-Newborn SSI / Disabled rate cell moved to FFS due to a PRTF stay in CY 2022.

   ii. MLR reports through December 2024.

e. Other data:

   i. Quality withhold parameters for SFY 2026.

   ii. Value-based payment program parameters for SFY 2026.

   iii. High-cost drug risk corridor parameters for SFY 2026.

   iv. Other computer files and clarifying correspondence.

Milliman relied on DOM and their MMIS vendor for the collection and processing of the CCO encounter data. Milliman relied on Myers and Stauffer's review of encounter data for duplicative or voided claims. Milliman relied on the CCOs to provide accurate CY 2022, CY 2023, and emerging CY 2024 financial data as certified by each CCO. Milliman did not audit the CCO financial data, or the encounter data, but did assess the data for reasonableness as documented in the capitation rate report.

Jennifer Wentworth

Name

Chief of Staff

Title

May 19, 2025

Date

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Milliman leverages deep expertise, actuarial rigor, and advanced technology to develop solutions for a world at risk. We help clients in the public and private sectors navigate urgent, complex challenges—from extreme weather and market volatility to financial insecurity and rising health costs—so they can meet their business, financial, and social objectives. Our solutions encompass insurance, financial services, healthcare, life sciences, and employee benefits. Founded in 1947, Milliman is an independent firm with offices in major cities around the globe.

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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 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.

Jill Bruckert is a Principal and Consulting Actuary for Milliman, a member of the American Academy of Actuaries, and meets the Qualification Standards of the Academy to render the actuarial opinion contained herein. To the best of her knowledge and belief, these 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 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
All Regions SFY 2026 MississippiCAN Capitation Rate Development
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**

Exhibit 1
Mississippi Division of Medicaid
All Regions SFY 2026 MississippiCAN Capitation Rate Development
CY 2023 Encounter Data

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**

Exhibit 1
Mississippi Division of Medicaid
All Regions SFY 2026 MississippiCAN Capitation Rate Development
CY 2023 Encounter Data

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**

Exhibit 1
Mississippi Division of Medicaid
All Regions SFY 2026 MississippiCAN Capitation Rate Development
CY 2023 Encounter Data

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**

Exhibit 1
Mississippi Division of Medicaid
All Regions SFY 2026 MississippiCAN Capitation Rate Development
CY 2023 Encounter Data

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**

Exhibit 2A
Mississippi Division of Medicaid
All Regions SFY 2026 MississippiCAN Capitation Rate Development
Final Base Data and Projection Assumptions

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**

Exhibit 2A
Mississippi Division of Medicaid
All Regions SFY 2026 MississippiCAN Capitation Rate Development
Final Base Data and Projection Assumptions

MA Adult Rate Cell

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

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
All Regions SFY 2026 MississippiCAN Capitation Rate Development
Final Base Data and Projection Assumptions

SSI / Disabled Newborn Rate Cell

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

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

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

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

Calculation Step	SFY 2026 PMPM Cost Development	Category of Service: Inpatient Hospital - Maternity / Deliveries	Inpatient Hospital - Psychiatric / Substance Abuse	Inpatient Hospital - Other	Outpatient Hospital - Emergency Room	Outpatient Hospital - Pharmacy	Outpatient Hospital - Other	Physician - Maternity / Deliveries	Physician - Psychiatric / Substance Abuse	Physician - Other	Dental	Other	Total
	Base Period Summaries												
	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

Calculation Step	SFY 2026 PMPM Cost Development	Category of Service: Inpatient Hospital - Maternity / Deliveries	Inpatient Hospital - Psychiatric / Substance Abuse	Inpatient Hospital - Other	Outpatient Hospital - Emergency Room	Outpatient Hospital - Pharmacy	Outpatient Hospital - Other	Physician - Maternity / Deliveries	Physician - Psychiatric / Substance Abuse	Physician - Other	Dental	Other	Total
	Base Period Summaries												
a	CY 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.

Exhibit 8
Mississippi Division of Medicaid
SFY 2026 MississippiCAN Capitation Rate Development
Enhanced Match Services

Rate Cell	Medical Portion of Capitation Rate	Family Planning (Non-waiver)	Breast and Cervical Cancer	Indian Health Services	Home Health Services	Rehab Services	Private Duty Nursing
Non-Newborn SSI / Disabled	$764.97	$0.23	$0.38	$0.62	$3.02	$25.58	$6.57
Breast and Cervical Cancer	$3,966.05	$0.00	$3,403.76	$0.00	$0.00	$0.04	$0.00
MA Adult	$323.93	$1.38	$0.00	$0.23	$0.30	$0.88	$0.00
Pregnant Women	$571.72	$7.54	$0.00	$0.00	$0.11	$0.27	$0.00
SSI / Disabled Newborn	$6,299.56	$0.00	$0.00	$0.00	$2.17	$0.00	$78.17
Non-SSI Newborns 0 to 2 Months	$2,109.67	$0.00	$0.00	$0.17	$0.02	$0.00	$0.01
Non-SSI Newborns 3 to 12 Months	$248.95	$0.00	$0.00	$0.36	$0.02	$0.00	$0.53
Foster Care	$633.95	$0.27	$0.00	$0.00	$0.04	$18.88	$3.81
MA Children	$183.30	$0.20	$0.00	$0.27	$0.01	$5.06	$0.14
Quasi-CHIP	$179.21	$0.29	$0.00	$0.26	$0.01	$3.52	$0.00

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 Del	$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 Delive	$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-Deliverie	$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 Del	$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 Delive	$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-Deliverie	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 Del	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 Delive	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 Month	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 Mont	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%**

[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 NIU/Disabled		Pregnant/Postpartum		MA Adult		Pregnant Women		SSI Disabled Newborn		Non-SSI Newborns 0 to 3 Months		Non-SSI Newborns 3 to 12 Months		Foster Care		MA Children		Dual/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		$50.68		$2.85		$2.85		$3.16		$2.31		$3.57	
	Outpatient Hospital - Other	$139.24		$737.25		$67.98		$53.24		$239.08		$37.75		$39.86		$46.86		$29.17		$23.74	
	Physician - Other	$207.60		$1,318.64		$112.72		$158.05		$1,598.65		$508.13		$133.39		$117.94		$66.38		$59.04	
(a)	**Projected SFY 2026 Eligible Risk Corridor Spend***	$404.45	$299,615,810	$3,714.98	$2,221,859	$195.24	$117,821,589	$220.05	$48,845,879	$36.20	$212,388	$548.72	$49,327,159	$176.10	$40,979,968	$167.96	$16,401,366	$97.86	$395,261,844	$86.34	$32,746,144
(b)	**Hemophilia Population Carve-in Eligible Spend***	$0.03	$20,403	$0.00	$0	$0.00	$1,680	$0.00	$831	$0.00	$0	$0.00	$0	$0.00	$1	$0.00	$0	$0.00	$2,179	$0.00	$365
(c)	**Sickle Cell Disease Gene Therapy (Casgevy / Lyfgenia)** 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
(d)	**Duchene Muscular Dystrophy Gene Therapy (Elevidys)** 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
(e)	**Spinal Muscular Atrophy Gene Therapy (Zolgensma)** Gross Risk Corridor Eligible Costs	$0.00	$0	$0.00	$0	$0.00	$0	$0.00	$0	$0.00	$0	$27.43	$7,176,148	$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**	**$2,221,859**	**$195.24**	**$117,819,909**	**$220.05**	**$48,845,047**	**$36.20**	**$212,388**	**$451.09**	**$33,152,043**	**$176.10**	**$40,979,967**	**$167.96**	**$16,401,366**	**$95.80**	**$389,799,665**	**$86.34**	**$32,746,779**
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*	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*	14.9%	14.9%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	50.4%	50.4%	0.0%	0.0%	0.0%	0.0%	46.0%	46.0%	0.0%	0.0%	0.0%	0.0%
(i) = (f) x (g) x (h)	**Anticipated SFY 2026 Risk Corridor Eligible Cost Over Threshold, Prior to Program Changes**	**$10.37**	**$7,665,316**	**$0.00**	**$0**	**$0.36**	**$215,008**	**$0.00**	**$0**	**$0.22**	**$1,360**	**$0.00**	**$0**	**$0.00**	**$0**	**$4.91**	**$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 (d) through (e)																					
	Sickle Cell Disease Gene Therapy (Casgevy / Lyfgenia)																				
(k)	*Risk Corridor Eligible Spend*	$7.00	$4,900,000	$0.00	$0	$0.00	$0	$0.00	$0	$0.00	$0	$0.00	$0	$0.00	$0	$0.00	$0	$0.00	$0	$0.00	$0
	Duchene Muscular Dystrophy Gene Therapy (Elevidys)																				
(m)	*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	$6,400,000	$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**	**$12,565,316**	**$0.00**	**$0**	**$0.36**	**$215,008**	**$0.00**	**$0**	**$0.22**	**$1,360**	**$87.43**	**$6,425,116**	**$0.00**	**$0**	**$4.91**	**$440,467**	**$1.89**	**$6,840,650**	**$0.36**	**$134,650**

** PMPM amounts tie to the final rows of Exhibit 2A and Exhibit 2B*
*** SFY 2025 claims for members with hemophilia that transitioned from FFS to MPD/MCOs on January 1, 2024 trended forward to SFY 2026*
** 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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May 30, 2025

Jennifer Wentworth
Chief of Staff
Mississippi Division of Medicaid
550 High Street, Suite 1000
Jackson, MS 39201
jennifer.wentworth@medicaid.ms.gov

Re: Report09 State Fiscal Year 2026 CHIP Preliminary Rate Calculation and Certification

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 the removal of benefit limits. We will amend the capitation rate accordingly in a subsequent release for these items.

Jennifer, please call me 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

JAB/tm

Attachments

[1] *"Report19 - SFY 2025 Preliminary CHIP Rate Calculation and Certification.pdf" dated December 4, 2024.*

MILLIMAN REPORT

State of Mississippi Division of Medicaid

State Fiscal Year 2026 CHIP Preliminary Rate Calculation and Certification

May 30, 2025

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

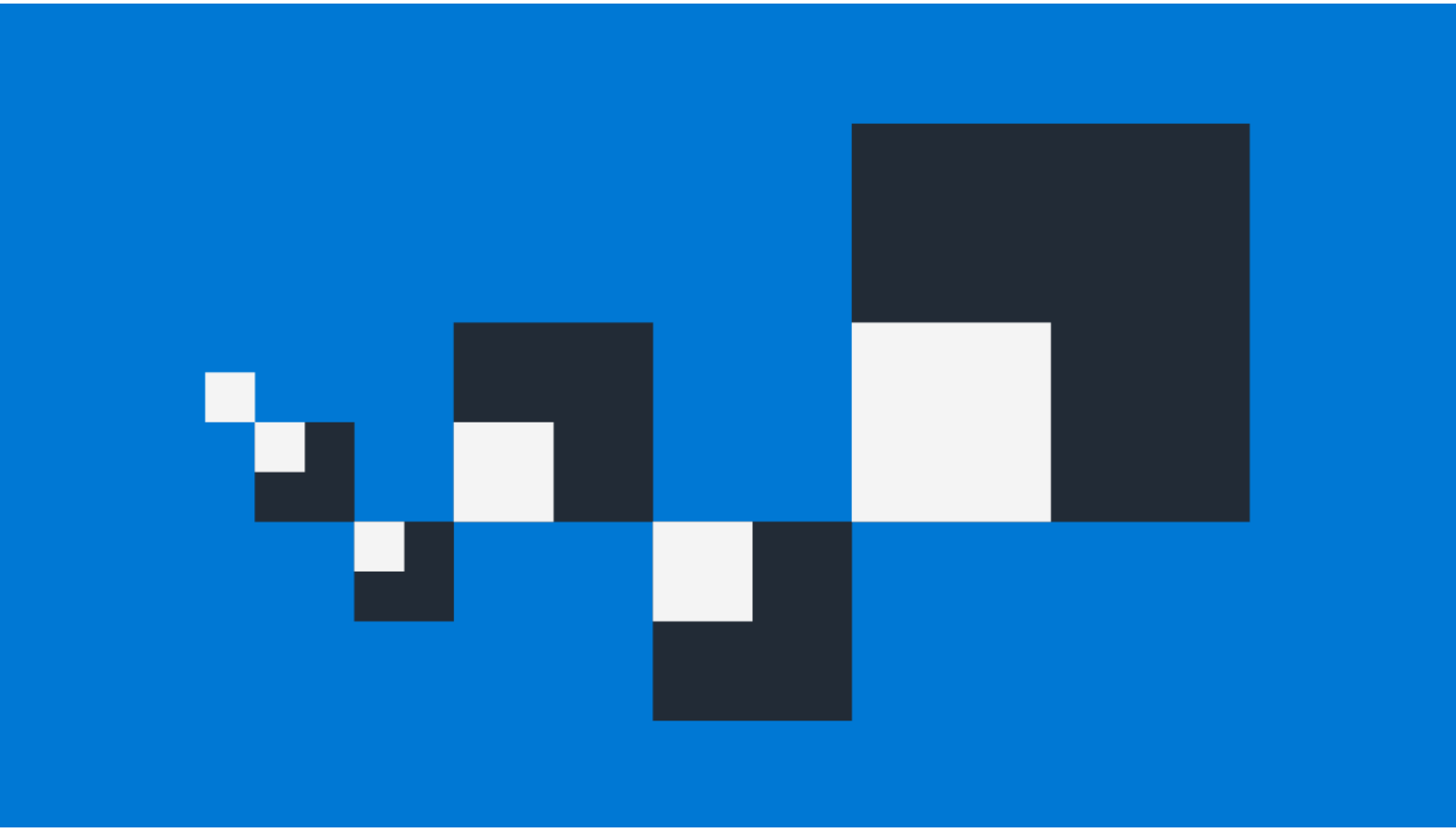

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Table of Contents

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.
- Appendix C documents our reliance on DOM for data and other assumptions in the development of the capitation rate.

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

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.

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 is a Principal and Consulting Actuary for Milliman, a member of the American Academy of Actuaries, and meets the Qualification Standards of the Academy to render the actuarial opinion contained herein. To the best of her knowledge and belief, this report is complete and accurate and has been prepared in accordance with generally recognized and accepted actuarial principles and practices.

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.

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.

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.

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.

- ***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.

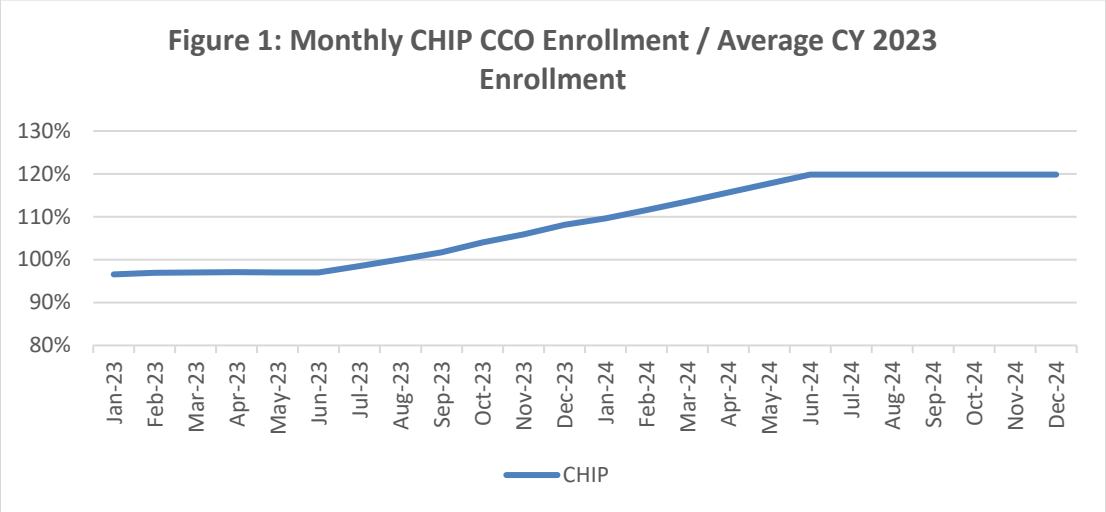
Based on our analyses, we estimate annualized utilization and unit cost trends of 1.81%, respectively, from CY 2023 to SFY 2026.

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).

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.*

Removal of Benefit Limits

Effective June 3, 2025 per 42 CFR § 457.480 the State may not impose any annual, lifetime or other aggregate dollar limitations on any medical or dental services for CHIP populations which are covered under the State plan. We are working with DOM to identify these benefit limits and quantify the impact on projected benefit costs and will adjust the CHIP capitation rate, if material, after this analysis is complete.

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.

[2] *Wentworth13 – July 2024 MSCAN Risk Weight Development.pdf, dated October 31, 2024."*

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.

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.

Normally for July 2025 to December 2025 risk scores, we would use an enrollment snapshot of June 2025 as a proxy for all months for use in risk adjustment. However, as a new CHIP CCO is joining the program in SFY 2026, using an enrollment snapshot prior to the rating period is not feasible. Therefore, for July 2025 to December 2025, we will use an enrollment snapshot of July 2025 to September 2025, with consideration to which portion of this snapshot is most

applicable for October 2025 through December 2025. This will allow us to accurately represent CCO enrollment during the risk adjustment period while still providing prospective risk scores prior to the end of the risk adjustment period.

For January 2026 to June 2026, we plan to return to using an October 2025 enrollment snapshot if enrollment levels by CCO are stable. In the event that enrollment levels by CCO are still in flux, we plan to use a similar process as July 2025 to December 2025 and use January 2026 to March 2026 as an enrollment snapshot for January 2026 to June 2026 risk adjustment.

Table 6 summarizes the CHIP risk adjustment schedule for SFY 2026.

Table 6
Mississippi Division of Medicaid
CCO Capitation Rate Risk Adjustment Schedule
SFY 2026 Capitation Payments

Rate Cell	Capitation Payments	Diagnosis Source Data	Enrollment Source
CHIP	July 2025 to December 2025	CY 2024 Encounter and FFS claims with runout through April 30, 2025	July 2025 to September 2025
CHIP	January 2026 to June 2026	SFY 2025 Encounter and FFS claims with runout through August 31, 2025	TBD

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.

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

Table 7
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.

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.

EXHIBITS 1 THROUGH 10

(Provided in Excel Format Only)

APPENDIX A

Data Processing

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"

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.

APPENDIX B

Actuarial Certification of the SFY 2026 CHIP Capitation Rate

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

jill.bruckert@milliman.com

May 30, 2025

Mississippi Division of Medicaid
Capitated Contracts Ratesetting
Actuarial Certification
SFY 2026 CHIP Capitation Rates

I, Jill Bruckert, am associated with the firm of Milliman, Inc., am a member of the American Academy of Actuaries, and meet its Qualification Standards for Statements of Actuarial Opinion. I was retained by the Mississippi Division of Medicaid (DOM) to perform an actuarial certification of the Children's Health Insurance Program (CHIP) capitation rates for July 1, 2025 through June 30, 2026 (SFY 2026) for filing with the Centers for Medicare and Medicaid Services (CMS).

I reviewed the capitation rate development and am familiar with the following regulation and guidance:

- The relevant requirements of 42 CFR §438.3(c), 438.3(e), 438.4, 438.5, 438.6, and 438.7
- CMS "Appendix A, PAHP, PIHP, and MCO Contracts Financial Review Documentation for At-risk Capitated Contracts Ratesetting" dated November 10, 2014
- 2024 to 2025 Medicaid Managed Care Rate Development Guide
- Actuarial Standard of Practice 49

I examined the actuarial assumptions and actuarial methods used in setting the capitation rates for SFY 2026 dated May 30, 2025 and accompanying this certification.

To the best of my information, knowledge, and belief, for the SFY 2026 period, the capitation rates offered by DOM are in compliance with the relevant requirements of 42 CFR 438.4(b). The attached actuarial report describes the capitation rate setting methodology.

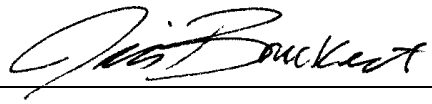
In my opinion, the capitation rates are actuarially sound, as defined in Actuarial Standard of Practice 49, were developed in accordance with generally accepted actuarial principles and practices and are appropriate for the populations to be covered and the services to be furnished under the contract.

In making my opinion, I relied upon the accuracy of the underlying claim and eligibility data records and other information. I did not audit the data and calculations, but did review them for reasonableness and consistency and did not find material defects. In other respects, my examination included such review of the underlying assumptions and methods used and such tests of the calculations as I considered necessary. The reliance letter from DOM is included in Appendix C.

Actuarial methods, considerations, and analyses used in forming my opinion conform to the appropriate Standards of Practice as promulgated from time to time by the Actuarial Standards Board, whose standards form the basis of this Statement of Opinion.

It should be emphasized that capitation rates are a projection of future costs based on a set of assumptions. Actual costs will be dependent on each contracted coordinated care organization's situation and experience.

This Opinion assumes the reader is familiar with the CHIP program and actuarial rating techniques. The Opinion is intended for the State of Mississippi and the Centers for Medicare and Medicaid Services and should not be relied on by other parties. The reader should be advised by actuaries or other professionals competent in the area of actuarial rate projections of the type in this Opinion, so as to properly interpret the projection results.



Jill A. Bruckert
Member, American Academy of Actuaries
Principal and Consulting Actuary
May 30, 2025

APPENDIX C

Data Reliance Letter

OFFICE OF THE GOVERNOR
Walter Sillers Building | 550 High Street, Suite 1000 | Jackson, Mississippi 39201

MISSISSIPPI DIVISION OF MEDICAID

May 19, 2025

Jill A. Bruckert, FSA, MAAA
Principal and Consulting Actuary
Milliman, Inc.
17335 Golf Parkway, Suite 100
Brookfield, WI 53045

Re: Data Reliance for Actuarial Certification of SFY 2026 CHIP Capitation Rate

Dear Jill:

I, Jennifer Wentworth, Chief of Staff for the Mississippi Division of Medicaid (DOM), hereby affirm that the data prepared and submitted to Milliman, Inc. (Milliman) for the purpose of certifying the CHIP capitation rate was prepared under my direction and, to the best of my knowledge and belief, is accurate, complete, and consistent with the data used to develop the capitation rate. The capitation rate is effective July 1, 2025 to June 30, 2026 (SFY 2026).

Provided data or information used in the development of the capitation rate includes:

1. Data from DOM's Medicaid Management Information Systems (MMIS) vendor (Gainwell Technologies):
    a. Encounter claims through September 2024.
    b. Eligibility through December 2024.
2. Data from DOM's vendor Myers and Stauffer:
    a. Detailed encounter claim status reports, including identification of duplicative or voided claims through December 27, 2024.
3. Supporting documentation provided by DOM:
    a. MLR reports through December 2024.
    b. Estimates of uptake rates of certain gene therapies used to treat Hemophilia A, Hemophilia B, Sickle Cell Disease, Beta-Thalassemia, and Duchene Muscular Dystrophy.
    c. High-cost drug risk corridor parameters for SFY 2026.
4. Other computer files and clarifying correspondence.

Milliman relied on DOM and their MMIS vendor for the collection and processing of the CCO encounter data. Milliman relied on Myers and Stauffer's review of encounter data for duplicative or voided claims. Milliman relied on the CCOs to provide accurate CY 2022, CY 2023, and emerging CY 2024 financial data as certified by each CCO. Milliman did not audit the CCO financial data or the encounter data but did assess the data for reasonableness as documented in the capitation rate report.

Jennifer Wentworth

Name
Chief of Staff
Title
May 19, 2025
Date

For more information about Milliman, please visit us at:

milliman.com

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Milliman leverages deep expertise, actuarial rigor, and advanced technology to develop solutions for a world at risk. We help clients in the public and private sectors navigate urgent, complex challenges—from extreme weather and market volatility to financial insecurity and rising health costs—so they can meet their business, financial, and social objectives. Our solutions encompass insurance, financial services, healthcare, life sciences, and employee benefits. Founded in 1947, Milliman is an independent firm with offices in major cities around the globe.

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Milliman

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 is a Principal and Consulting Actuary for Milliman, a member of the American Academy of Actuaries, and meets the Qualification Standards of the Academy to render the actuarial opinion contained herein. To the best of her 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.*

Exhbit 8
Mississippi Division of Medicaid
SFY 2026 CHIP Capitation Rate Development
Enhanced Match Services

Rate Cell	Medical Portion of Capitation Rate	Family Planning (Non-waiver)	Breast and Cervical Cancer	Indian Health Services	Home Health Services	Rehab Services	Private Duty Nursing
CHIP	$202.61	$0.27	$0.00	$1.26	$0.01	$1.39	$0.03

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 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 at the time of the audit. 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

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 Providers that are tied to clearly-defined, objectively measurable, and well-documented clinical or quality improvement standards that apply to providers;

b. The amount of claims payments recovered through fraud reduction efforts, not to exceed the amount of fraud reduction expenses. The amount of fraud reduction expenses must not include activities specified in paragraph 42 C.F.R. § 438.8(e)(4); (This allows for a potential offset against a portion of the recovery amounts deducted from the incurred claims as required in Section B.2.a.)

Note: DOM will only allow fraud prevention expenses in the MLR calculation for program integrity activities as they are aligned with standards adopted in the private market rule. In addition, claim payment recoveries must be separately distinguishable as a result of fraud reduction efforts versus other types of claim payment recoveries.

Fraud Prevention Expenses are defined as expenses incurred 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 as specified 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.

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 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. Marketing expenses;

k. Costs associated with calculating and administering individual Member or employee incentives;

l. That portion of prospective utilization that does not meet the definition of activities that improve health quality;

m. Any cost that is not directly applicable to providing measurable quality improving activities such as corporate administrative allocations, amounts exceeding actual cost of providing service, or other overhead expenses that do not directly support the healthcare quality initiative;

n. State and federal taxes, licensing and regulatory fees; and

o. 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, the allocation 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, the allocation methodology and statistics utilized for any allocation.

Note: DOM has adopted the definitions and guidelines provided in the Patient Protection and Affordable Care Act, 45 CFR Parts 144, 147, 153, 155, 156, and 158 as recorded in the Federal Register, Vol. 87, No. 88, issued on May 6, 2022. Qualifying direct quality improvement activity (QIA) expense is limited to the QIA portion of salaries and benefits for employees directly performing QIA functions for inclusion in the MLR calculation. 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 or 79.88 percent, 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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